
 <b>JOHNS HOPKINS</b> HEALTH PLANS	<b>JOHNS HOPKINS HEALTH PLANS</b>	<b>Policy Number: PCR.004</b> Effective Date: 1/1/10 Revision Date: 5/13/15 Review Date: 6/23/20
	<b>Subject: Termination of Network Participation, Reporting Terminations, Fraud and Abuse (Practitioner)</b> <b>Department: Credentialing</b> <b>Lines of Business: All lines of business</b>	<b>Page 1 of 5</b>

**ACTION**

- Revised Policy
- Superseding Policy Number: \_\_\_\_\_
- Repealing Policy Number: \_\_\_\_\_

**POLICY:**

1. Johns Hopkins Health Plans ensures that individual/ organizational practitioners continue to meet minimum credentialing criteria, and that mechanisms are available through which Johns Hopkins Health Plans will allow the individual/ organizational practitioner to appeal actions that affect or place conditions upon the individual/ organizational practitioner's network participation.
2. Johns Hopkins Health Plans reports actions against individual/ organizational practitioners to the National Practitioner Data Bank (NPDB) and/or Healthcare Integrity and Protection Data Bank (HIPDB) and state licensing agencies as required by law.
3. It is the policy of the Johns Hopkins Health Plans Quality Improvement (QI) Department to investigate and report possible misconduct committed by employees, members (including beneficiaries and enrollees), health care practitioners and /or vendors.
4. Credentialing employees will report any questionable documentation to the Credentialing Manager.
5. The Credentialing Manager or designee will request validation of submitted documentation.
6. Depending on the outcome, referral will be made to the Corporate Compliance Department for further investigation and action.
7. Terminations for cause are immediate, and not subject to appeal rights as outlined in PCR.005. Terminations for cause are initiated when a practitioner is deemed to be an immediate threat to the patient population or when a practitioner appears on the Office of the Inspector General (OIG) List of Excluded Individual/Entities (LEIE).
8. Terminations as a result of non-compliance with re-credentialing requirements, or due to SCRC decision follow a 90 day termination process. Notification of termination will be made to the provider within 1 week. Second notice of intent to terminate will be made 30 days prior to the set termination date. A final termination notification will be made on the date of termination. All termination notifications are made via regular postal service.

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9. Terminations as a result of an SCRC decision are subject to the appeals procedures outlined in PCR.004.
10. Termination actions taken as a result of non-compliance with re-credentialing requirements may be rescinded, if the provider successfully submits all necessary documents to perform a full re-credentialing cycle, prior to the set date of final termination.

**SCOPE:**

The policy applies to participating individual/ organizational practitioners in the Johns Hopkins Health Plans network who have been terminated or disciplined by Johns Hopkins Health Plans and whose participation status has been adversely affected due to quality of care, and to the Johns Hopkins Health Plans Credentialing Department staff (permanent and temporary).

**RESPONSIBILITIES:**

It is the responsibility of the Credentialing Manager to ensure that individual/ organizational practitioners receive appropriate termination notification in accordance with Johns Hopkins Health Plans policy and statutory regulations.

It is the responsibility of the Credentialing Manager to notify appropriate authorities whenever an individual/ organizational practitioner has been terminated from network participation for cause.


The Credentialing Manager will ensure that individual/ organizational practitioners whose network participation is terminated based on competency or professional conduct are offered the right to appeal the decision and that any appeal requested will be processed pursuant to Johns Hopkins Health Plans PCR.005 Practitioner Discipline and Appeal Process.

The individual/ organizational practitioner has the responsibility of requesting an appeal subsequent to adverse decisions within 30 days. If the individual/ organizational practitioner waives his/her/ their right to appeal or fails to request an appeal, or if the final action of the appeal process is to uphold the adverse determination, the Credentialing Manager will ensure that the individual/ organizational practitioner is notified.

The Credentialing Manager will ensure that written notification to the individual/ organizational practitioner of the final adverse determinations will be made. Such notification will include that the adverse action will be reported to the appropriate reporting agencies as required by law.


The Credentialing Manager will ensure that adverse actions are reported to the NPDB, HIPDB, and other governing or licensing agencies in accordance with requirements.

The Credentialing Manager will maintain a log of all individual/ organizational practitioners reported with adverse actions and the agency to which the practitioner was reported.

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**PROCEDURES:**

- I) Termination for Cause:
  - a. The Credentialing Manager may immediately terminate an individual/ organizational practitioner for loss of license, loss of Medicare/Medicaid certification, loss of professional liability insurance, when a practitioner appears on the Office of the Inspector General (OIG) List of Excluded Individual/Entities (LEIE).
  - b. The Credentialing Manager may immediately terminate an individual/ organizational practitioner when it is found that the individual/ organizational practitioner is participating with the USFHP line of business does not possess a license at full clinical practice level. Termination will take place from the USFHP line of business only.
  - c. An individual/ organizational practitioner who is terminated for the reasons above may reapply for network participation after the date of agency reinstatement or reinstatement of the lost element.
  - d. Terminations will be reported to the appropriate State and Federal agencies through the Johns Hopkins Health Plans Compliance Department via a monthly report. HealthCare Integrity and Protection Data Bank (HIPDB) and National Practitioner Data Bank (NPDB) in accordance with the applicable regulations is reported by the Credentialing Manager.
  - e. This procedure does not preclude Johns Hopkins Health Plans from immediately suspending or restricting an individual/ organizational practitioner’s network status, subject to subsequent procedures, where in the judgment of Johns Hopkins Health Plans, failure to take such action may pose a threat or imminent danger to the health of any Johns Hopkins Health Plans member.
- II.) Termination for Administrative Reasons:
  - a. Terminations of network participation for administrative reasons are subject to the Practitioner Discipline and Appeals Policy and may be reportable to outside agencies. Administrative reasons for termination may include, but are not limited to:
    - i. Failure to respond to requests for credentialing information;
    - ii. Failure to report actions by licensing or regulatory agencies;
    - iii. Failure to follow Johns Hopkins Health Plans operational policies and procedures; and
    - iv. Practitioner terminating from a delegated entity
  - b. Administrative termination of network participation for business reasons, including but not limited to, the cancellation of a client contract or line of business in the individual/ organizational practitioner’s geographic region will be made at the discretion of Johns Hopkins Health Plans and in accordance with the terms of the Provider Services Agreement.

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- c. Administrative terminations for business reasons are final, not subject to the appeals process and not reportable to outside agencies.

III.) Notice: Individual/ organizational practitioners terminated from Johns Hopkins Health Plans participation will be notified of the termination via certified mail.

IV.) Voluntary Termination from Participation

- a. A participating individual/ organizational practitioner who desires, at any time, to voluntarily terminate participation with Johns Hopkins Health Plans or any one or more of the lines of business managed by Johns Hopkins Health Plans must notify, in writing, the Senior Director of Provider Relations, or designee, specifying the changes to be made.
- b. The procedure set forth in this section does not apply to situations where the individual/ organizational practitioner’s participation was involuntarily terminated.
- c. Voluntary termination of participation while under an investigation or in exchange for not conducting an investigation will not be considered a “voluntary withdrawal” from participation for purposes of reporting to outside agencies.

- V.) Withdrawal of Request for Participation - When an applicant for initial credentialing does not provide additional information within specified time frames, this shall be considered a voluntary withdrawal of request for Johns Hopkins Health Plans network participation. Withdrawals of requests for participation are not reportable to outside agencies.


**REPORTING FRAUD AND ABUSE:**

Johns Hopkins Health Plans employees have a responsibility to report any misconduct by employees, members, individual/ organizational practitioners and vendors involving violations of:

- a.) Federal and state laws and regulations
- b.) Johns Hopkins Health Plans contractual agreements
- c.) Johns Hopkins Health Plans policies
- d.) Ethical business practices

**EXAMPLES OF FRAUDULENT OR ABUSIVE PRACTICES:**

- a.) Falsifying information on the credentialing application.
- b.) Failure to disclose information relevant to the credentialing process, such as:
  - 1.) Prior criminal prosecutions or civil actions;
  - 2.) Non-disclosure of questionable previous employment.
  - 3.) Non-disclosure of any sanctions (e.g., allegations of or investigations into fraud or abuse)
  - 4.) Requesting credentialing outside of the individual/ organizational practitioner’s scope of practice or expertise

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**REFERENCE:**

NCQA Credentialing Standards  
 45 CFR Part 61  
 Health Care Quality Improvement Act of 1986  
 COMAR  
 Provider Discipline and Appeals Policy PCR.005  
 Policy No. COM.001: Handling of Suspected Fraud and Abuse  
 CMS Guidelines

**SIGNATURES:**

Approval Signature: \_\_\_\_\_  
 Credentialing Manager

Date: \_\_\_\_\_

Approval Signature: \_\_\_\_\_  
 Senior Director of Operations Support

Date: \_\_\_\_\_

Review/Revision Dates: 6/10/04, 11/28/05, 12/18/06, 12/20/07, 12/22/08; 12/21/09;  
 10/18/2010; 10/17/2011; 11/12/2012, 9/1/13, 07/31/14, 10/13/14, 9/1/15, 7/12/16, 7/25/17,  
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