PROVIDER CREDENTIALING

Subject to limited exceptions, Fidelis Care is required to credential each health care professional, prior to the professional providing services to Fidelis Care members.

Provider Responsibilities
Providers shall immediately notify Fidelis Care’s Chief Medical Officer, in writing, if their ability to practice medicine is restricted or impaired in any way, if any adverse action is taken, or an investigation is initiated by any authorized City, State or Federal agency, or of any new or pending malpractice actions, or of any reduction, restriction, or denial of clinical privileges at any affiliated hospital.

Provider Rights
Review information submitted to support their credentialing application – This includes information from outside sources. However, Fidelis does not need to disclose references, recommendations or peer-review protected information.

Correct erroneous information – In the event that a Fidelis Credentialing Associate discovers inconsistent information in the application/reapplication, the Associate will reach out to the provider for correct information with a request for a response within 15 business days. In the event that the practitioner discovers incorrect information in the application/reapplication after exercising the above right, the practitioner may then contact the Fidelis Credentialing Associate via letter or email and request that the application/reapplication be updated. Fidelis will process and document receipt of the corrected information in the file within 15 business days.

Receive the status of their credentialing or recredentialing application upon request – Fidelis Care will share what documentation is outstanding to complete the application/reapplication and/or will inform the provider when the application/reapplication will be reviewed by the Fidelis Care Credentialing Committee (CR). Fidelis Care will respond to the practitioner’s request by phone or via email.

Credentialing/Re-Credentialing Process
Fidelis Care’s credentialing process uses standards set forth by the New York State Department of Health and National Committee on Quality Assurance (NCQA), including primary verification of training/experience, office site visits, etc. Each provider will be re-credentialled at least every three (3) years. It is the provider’s responsibility to ensure that Fidelis Care has the correct service address(es) to contact when re-credentialing is due. If a provider fails to re-credential, the provider would be terminated and any claims following that date would not be paid without prior authorization. Fidelis Care’s Credentials Committee reviews credentialing information and recommends appointment to the panel.

It is the applicant’s responsibility to supply all requested documentation in a form satisfactory to the Credentials Committee. Fidelis Care’s Provider Application or the CAQH Universal Credentialing DataSource Form is required, in addition to applicable credentialing documents/certifications. Applications lacking supporting documentation shall not be considered by the Committee.

Fidelis Care will process the initial application and present for Committee review within ninety (90) calendar days upon receipt of a completed application and contract. The practitioner will be notified in writing of the Credentials Committee’s decision.

During processing of the initial application, if additional time is necessary to make a determination due to failure of a third party to provide necessary documentation, Fidelis Care will notify the practitioner of the missing information, and will make every effort to obtain such information as soon as possible.
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Practitioners considered to have non-routine or unusual circumstances may require additional time for review.

Fidelis Care will make every effort to make a determination regarding participation status as soon as possible and will notify the practitioner in writing as to whether he/she is credentialed after the Credentials Committee review and decision.

Confidentiality
All credentialing documents or other written information developed or collected during the approval processes are maintained in strict confidence. Except with authorization, or as required by law, information contained in these records will not be disclosed to any person not directly involved in the credentialing process.

Credentialing of Ancillary Staff Working in a Participating Provider’s Office
Each provider must require that all ancillary staff be appropriately licensed, registered, or certified in their field, and that such staff practice in accordance with all applicable laws and regulations. Providers must also provide appropriate supervision to ancillary staff and ensure that ancillary staff’s responsibilities do not exceed those responsibilities set forth in applicable New York State laws and regulations for such practices.

Under certain circumstances, ancillary staff working in a participating provider’s office and providing care to Fidelis Care members must also be credentialed by Fidelis Care. It is the responsibility of the participating provider to notify Fidelis Care when any of the following professionals are hired/contracted to provide services:

- Nurse Practitioners
- Physical Therapists/Occupational Therapists/Speech Therapists
- Certified Nurse Midwives
- Physician Assistants

OMH-Licensed/OASAS Certified Behavioral Health Providers and HCBS Providers
Fidelis Care will accept State issued HCBS providers, OMH and OASAS-certified providers with OMH and OASAS license and certifications in place of any credentialing process for individual employees, subcontractors or agents of such providers. The contract shall collect and will accept program integrity related information as part of the licensing and certification process. Fidelis Care requires that such providers not employ or contract with any employee, subcontractor or agent who has been debarred or suspended by the federal or stat government, or otherwise excluded from participation in the Medicare or Medicaid program.

PROVIDER SUSPENSION

Policy Statement
Fidelis Care may elect to suspend providers who have been charged and/or arrested until final resolution of the charges or that are subject to an OPMC or other regulatory agency investigation/action. Providers who are suspended are excluded from participation in all Fidelis Care’s programs.

PROVIDER TERMINATION

Policy Statement
It is the policy of Fidelis Care to provide due process to providers who are terminated by Fidelis Care consistent with Section 4406-d of the New York State Public Health Law. Accordingly, Fidelis Care has a hearing procedure in place allowing providers, in certain circumstances, to appeal a proposed decision terminating their contract with Fidelis Care.
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Fidelis Care will immediately remove any provider from the network who is unable to provide healthcare services due to a final disciplinary action by a state licensing board or other governmental agency that impairs the provider’s ability to practice.

Providers who are excluded or terminated by the State Department of Health (SDOH) Medicaid Program will be excluded from participation in Fidelis Care network of providers.

Definitions

Healthcare Professional – a person licensed, registered, or certified pursuant to Title 8 of New York’s Education Law.

Quality Concerns – concerns regarding the healthcare professional’s competence or professional conduct which adversely affect, or could adversely affect the health or welfare of a Fidelis Care member or any other patient of a healthcare professional.

Clinical Privileges – the ability to furnish medical care to persons enrolled in Fidelis Care, as determined by Fidelis Care.

Members – any subscriber, enrollee, member, patient, designated representative or, where appropriate, prospective enrollee of Fidelis Care.

Applicability

The hearing procedure is available in the following circumstance:

- When Fidelis Care proposes to terminate a participating healthcare professional’s contract with Fidelis Care prior to the termination date of the contract.

The hearing procedure is not available in any other circumstances, including but not limited to the following:

- An initial denial of a healthcare professional’s application for clinical privileges;

- When Fidelis Care decides not to renew a healthcare professional’s contract.

- When the termination involves imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the healthcare professional’s ability to practice.

Fidelis Care will not terminate or refuse to renew a contract solely because a healthcare professional has:

- Advocated on behalf of a member.

- Filed a complaint against Fidelis Care.

- Appealed a decision of Fidelis Care.

- Provided information to a member regarding a condition or course of treatment, including the availability of other therapies, consultations, or tests.

- Provided information to a member regarding the provisions, terms, or other requirements of Fidelis Care’s products as they related to the member.
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- Made a report to an appropriate governmental body regarding the policies or practices of Fidelis Care that the healthcare professional believes may negatively impact upon the quality of, or access to, patient care.

- Requested a fair hearing or review as provided herein.

Procedure
When Fidelis Care receives information that raises quality concerns regarding a health care professional who has been granted clinical privileges, it will initiate a review and a notation will be placed in the health care professional’s record. Review will also be initiated when Fidelis Care decides to terminate a health care professional, except where the decision to terminate involves imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the health care professional’s ability to practice.

If the results of the review indicate that action is required which requires a hearing, the health care professional will be notified in writing regarding the proposed action. Such notice shall include the following:

- The proposed action.
- The reasons for the proposed action.
- A statement that the health care professional has the right to request a hearing or review, at the professional’s discretion, before a panel appointed by Fidelis Care.
- The time limit, not less than thirty (30) calendar days, for requesting a hearing.
- A statement that the hearing will be held within thirty (30) calendar days after the date the hearing request is received.
- A summary of the hearing rights.

If the health care professional does not request a hearing within thirty (30) calendar days of the date of the notice, the proposed action will be final, not subject to arbitration or review by a court of law, and the provider will have no additional appeal rights. If a hearing request is received, the health care professional will be apprised, in writing, of the place, time, and date of the hearing and provided a list of the witnesses expected to testify at the hearing on behalf of Fidelis Care. The health care professional will also be told that the failure to appear at the hearing will not delay a decision by the hearing panel. Hearing dates and times may be granted at the discretion of Fidelis Care, but within thirty (30) days of the health care professional’s request for a hearing.

The hearing panel shall be comprised of at least three (3) persons appointed by Fidelis Care. At least one member of the panel will be a clinical peer in the same discipline and the same or similar specialty as the health care professional under review. The hearing panel may consist of more than three (3) persons, provided however, that the number of clinical peers on such panel shall constitute one-third or more of the total membership of the panel. If the health care professional participates in the Medicare Advantage program, the hearing panel shall be comprised of a majority of individuals who are clinical peers in the same discipline and the same or similar specialty as the healthcare professional under review.

The health care professional shall have the following rights at the hearing:

- The right to call, examine and cross-examine witnesses.
- The right to present evidence that is deemed relevant by the hearing panel. The determination of relevancy shall be determined solely by the panel.
- The right to submit a written statement at the close of the hearing.

After the hearing panel has convened, deliberated, and rendered a decision, it will notify the health care professional, in writing, of the decision not more than fifteen (15) business days after its adjournment. The notification will include a statement of the basis for the decision. Decisions
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will include one of the following and will be provided in writing to the health care professional: reinstatement; provisional reinstatement with conditions set forth by the MCO, or termination. The decision of the hearing panel is final, and it is not subject to arbitration or review by a court of law.

A decision by the hearing panel to terminate a healthcare professional shall be effective not less than thirty (30) calendar days after the receipt by the healthcare professional of the hearing panel’s decision. In no event will the termination be effective earlier than sixty (60) calendar days from the receipt of the initial notice provided to the health care professional. The date of receipt will be presumed to be five (5) calendar days from the date of the initial notice.

Unless the decision to terminate the healthcare professional involves imminent harm to patient care, a determination of fraud, or final disciplinary action by a state licensing board or other governmental agency that impairs the health care professional’s ability to practice, Fidelis Care would consider allowing a member to continue an ongoing course of treatment with the professional as outlined in section, 4.6, “Provider Leaves the Network” in this Provider Manual.

The health care professional’s record will be noted with the appropriate status determination and all hearing correspondence.

When the decision of the hearing panel will adversely affect the clinical privileges of a health care professional for a period longer than thirty (30) calendar days, Fidelis Care must notify the New York State Board of Medical Examiners within fifteen (15) calendar days from the date the adverse action was taken. Other regulatory and accrediting agencies will be notified as required.

Subject to the due process rights described above, Fidelis Care reserves the right to terminate the participation status of any participating provider, without cause, upon ninety (90) calendar days prior written notice delivered to the provider, or as otherwise required under the terms of the provider contract.

In the event that a provider’s license, certification or registration is restricted, revoked, surrendered, or suspended by any State in which they may hold a license, the provider may be terminated without the right to an appeal. In addition, such action may be taken should restrictions, suspension, revocation or termination occur for the provider:

- Malpractice Coverage
- DEA Registration
- Medicaid or Medicare Privileges - Qualified & Approved

A provider terminated due to a case involving imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the health care professional’s ability to practice is not eligible for a hearing or a review, and such termination shall not be subject to arbitration.

Fidelis Care’s Duty to Report
Fidelis Care is legally obligated to report to the appropriate professional disciplinary agency within thirty (30) calendar days of the occurrence of any of the following:

1. Termination of a healthcare provider for reasons relating to alleged mental or physical impairment, misconduct, or impairment of member safety or welfare.

2. Voluntary or involuntary termination of a contract or employment, or other affiliation to avoid the imposition of disciplinary measures.
3. Termination of a healthcare provider contract, in the case of a determination of fraud, or in a case of imminent harm to a member’s health.