

NOTICE OF NETWORK TERMS AND CONDITIONS*

***The following constitutes formal NOTICE OF PAYER POLICIES AND PROCEDURES, CREDENTIALING POLICIES AND PROCEDURES, AND TERMS AND CONDITIONS OF NETWORK PARTICIPATION (“NETWORK TERMS AND CONDITIONS”) APPLICABLE TO ALL INDIVIDUAL NETWORK PARTICIPANTS AND APPLICANTS FOR PREFERRED PAYMENT PLAN, MEDI-PAK® ADVANTAGE PFFS, MEDI-PAK® ADVANTAGE LPPO, MEDI-PAK® ADVANTAGE HMO ARKANSAS’ FIRSTSOURCE® PPO, TRUE BLUE PPO, AND HEALTH ADVANTAGE HMO NETWORKS (the foregoing referred to collectively hereinafter as the “Networks”). As referenced in the provider network agreements for each network, this Notice, when published in *Providers’ News* constitutes an amendment to the provider network agreement of each provider participating in any networks of Arkansas Blue Cross and Blue Shield, USABLE Corporation or Health Advantage.**

Arkansas Blue Cross and Blue Shield, USABLE Corporation and Health Advantage are announcing clarifications and extensions of current Network Terms and Conditions (as defined above) applicable to all qualified individual providers who participate in or seek admission to Arkansas Blue Cross and Blue Shield’s Preferred Payment Plan, Medi-Pak® Advantage PFFS and LPPO networks, USABLE’s Arkansas’ FirstSource® PPO and True Blue PPO networks or Health Advantage’s HMO network (including those individuals who may contract through physician-hospital organizations and other group agreements). Even though the majority of the content of this Notice covers policies that have been in place for several years, we encourage everyone to read the entire document to make sure you and your staff are aware of all Network Terms and Conditions. The following information may contain additions and changes to previously published network terms and conditions. Such changes are considered to be effective immediately¹.

I. Regional Network Administration

Participation in the Networks is divided into regional service areas in which the applying/participating provider is located. Providers wishing to participate in the network for any given region must (a) maintain a practice location within the geographic limits of that region; (b)

¹ While these Network Terms and Conditions shall be deemed to be effective immediately (unless a later effective date is specifically referenced in the text of any specific policy, below), review for compliance and application of the policies/terms to individual providers will be conducted according to the following schedule: (a) for new network applications, these new policies/terms will apply upon review for initial credentialing, and upon any subsequent recredentialing review; (b) for current network participants, these new policies/terms will apply upon the earlier of (i) the next recredentialing review or (ii) any complaint or notice to the Networks that a particular network participant fails to meet the requirements of these new policies/terms; or (iii) any other method (including but not limited to claims review, customer service calls or inquiries, newspaper or other media reports, etc.) by which alleged non-compliance is brought to the attention of the network-sponsoring companies, following the publication date of this document.

meet all credentialing standards and terms and conditions for the Networks generally; and (c) be willing to accept the allowances, fee schedules, and payment policies for that specific region. Additionally, should any provider furnish services for any reason to any Member outside the region in which the provider's practice is located, network participating providers must agree to be bound by and accept the allowances, fee schedules, and payment policies in effect for the region in which the provider is enrolled. The Networks' regional service areas currently are based on seven regions, organized by counties and defined as the Northwest, Northeast, West Central, Central, South Central, Southwest and Southeast Regions.

II. Re-Application after Termination from the Networks

If a provider is terminated or excluded from the Networks, such termination or exclusion may render the provider ineligible to re-apply or be considered again for network participation for certain specified periods, as referenced more specifically in the subsections, below. Additionally, a previously terminated or excluded provider may be subject to special conditions for re-admission, based on the history of past conduct or violations of contract terms or policies and procedures. It should also be noted that USABLE, Health Advantage and their parent entity, Arkansas Blue Cross and Blue Shield have determined that if a provider is removed from one of their separate Networks (e.g., if Arkansas Blue Cross removes a provider from its Preferred Payment Plan network) based on a violation of that network's terms and conditions, the removed provider is rendered ineligible to participate in the remaining Networks, i.e., once a provider joins any of the Networks, the network sponsors (USABLE, Health Advantage and Arkansas Blue Cross and Blue Shield) intend to require good standing with that network as an additional term and condition of participation in the other Networks.

(a) Exclusion for Breach of Network Participation Agreement

If a participating provider is excluded from the network for any breach² of the network participation agreement, such excluded provider shall not be eligible to apply for re-admission for a minimum period of three years. Depending on the nature of the breach, the network-sponsoring companies further reserve the right to attach special conditions to any such re-admission after three years. By way of example (and without excluding any other possible special conditions), if a provider is excluded for failure to refund duplicate payments when requested, upon re-applying, such provider may be subject to the special condition of a percentage hold-back on claims payments, an interest charge for un-reimbursed duplicate payments, or other requirements to address the past history of contract violations. NOTE: Exclusions for a contract breach that involve violations of utilization, claims or coding policies, Coverage Policy, refusal to recognize member health plan exclusions, or other written standards are subject to special re-application standards and waiting periods, as referenced in subpart (b), below. If a payer or its agent has published a written policy that providers may or

² Except for a breach that involves a "restricted" license, as defined in the Practitioner Credentialing Standards of Arkansas Blue Cross and Blue Shield, USABLE Corporation or Health Advantage; in such cases, once any applicable license restriction has been lifted by the relevant disciplinary board, the affected provider shall be eligible for immediate credentialing or re-credentialing review and potential network admission or re-admission, provided no other disqualifications apply.

should file claims that are known to be excluded from coverage under applicable Coverage Policies whenever such a filing and denial are necessary because of the need to furnish proof of such denials to a secondary payer (under applicable coordination of benefits rules), the preceding standard would not be grounds for a provider's exclusion in such limited circumstances, provided that secondary payer requirements are in fact the basis for such claims filings. In addition, if a provider has fully complied with the member waiver requirements of the network participation agreement, prior to administering any services to a member that would not be covered under applicable payer Coverage Policies, then such provision of services shall not be grounds for exclusion from the Networks, so long as provider does not bill the applicable payer for such services.

(b) Exclusion for Violations of Utilization, Claims or Coding, Coverage Policy or other Written Standards

If a participating provider is excluded from the network for a failure or refusal to comply with the utilization standards, claims filing or coding policies, Coverage Policies or any other written standards of the network-sponsoring companies after provider receives written warning of non-compliance with such standards or policies, such excluded provider shall not be eligible to apply for re-admission until five years have elapsed following such exclusion. Depending on the nature of the breach, the network-sponsoring companies further reserve the right to attach special conditions to any such re-admission after five years, including but not limited to any measure that, in the network-sponsoring company's judgment, is needed to address the history of past violations. Such measures may include but are not limited to reducing the allowance or fee schedule applicable to such re-admitted provider, or requiring such previously excluded provider to submit to pre-admission audit of random samples of medical records, patient files or insurance claims (such audits to be conducted as part of credentialing activity, which allows covered entity payers access to protected health information under applicable HIPAA Privacy rules) for the purpose of investigating whether the previous violations of standards have been corrected in the intervening five years. If the provider fails to fully cooperate in such an audit, or if ongoing violation of standards is found in any such pre-admission audit, the applying provider shall not be eligible for readmission to the Networks.

(c) Exclusion for False or Misleading Claims

(1) Permanent Ineligibility

If a participating provider is excluded from the network for filing any false or misleading claim, or engaging in or assisting any other person or individual in the presentation of any false or misleading information (including but not limited to any claims data, medical background or records, employment history or status, or other coverage eligibility information) to any insurer, HMO, government program, third party administrator or self-funded payer, such excluded provider shall not be eligible to apply for re-admission to the Networks, and shall be permanently disqualified from participation.

NOTE: Providers are deemed responsible for all actions of any employee or agent of the provider, including but not limited to nursing or administrative staff, office managers or

personnel, billing clerks, billing services, practice management agents or vendors, software vendors or others working on provider's behalf to file any claims data or to otherwise furnish any information to insurers, HMOs or other claims administrators or payers. If false or misleading claims (or any other data) are sent to any insurer, HMO, claims administrator or payer accessing the Networks, participating providers may be excluded and permanently disqualified from network participation even though such providers contend or could show that participating provider was not personally aware of or involved in the presentation of such information. The Networks cannot conduct continual, full-scale audits of all claims or all providers, and must therefore be able to rely on providers to appropriately monitor their staff and vendors, and to take prompt corrective action if any problem is identified.

(2) Limited Exception to Permanent Ineligibility

Any practitioner who has engaged (either directly or via any billing agent or staff member responsible for submission of claims on behalf of the practitioner) in fraudulent claims, fraudulent claims coding or fraudulent billing practices (whether such activity relates to a Network member or Network payer, or to third parties such as other payers and their member, or to government programs) shall be permanently ineligible for network participation unless the following additional conditions apply, as determined in the sole judgment and discretion of the Networks:

1. **Minimum Network Exclusion Period.** At least five years have elapsed between the date that the Networks first issued final notice (including any period for appeals) of termination or rejection of network participation due to fraudulent actions and the date of any application or re-application for admission to the networks; and
2. **Complete Restitution.** Practitioner must, prior to submitting any application or re-application, have made full restitution to any defrauded insurer, health plan or government program (including but not limited to Arkansas Blue Cross and Blue Shield, Health Advantage and US Able Corporation and/or their self-funded health plan customers) of all amounts paid with respect to any fraudulent claims, coding or billing activities of practitioner; and
3. **Evidence of Rehabilitation.** Practitioner must present evidence, satisfactory to the Networks in their sole discretion, demonstrating that in the past five years (or longer period, as applicable), Practitioner has been rehabilitated and has conducted all personal and professional activities with the utmost integrity, showing exemplary conduct with no further or additional infractions of law or ethics, including but not limited to absence of any other allegations or incidents of fraudulent conduct or activities involving any persons or entities. The Networks may require the submission of personal and professional references but shall not be bound to give weight or credence to any such references.
4. **Lack of other issues/disciplinary actions.** Practitioner must not have been subject, during the five years (or longer period, as applicable) intervening between Practitioner's termination or rejection for network participation and Practitioner's application or re-application to the network, to any other legal, regulatory or disciplinary investigations, proceedings, citations, fines, penalties, mandatory appearances, voluntary or involuntary

monitoring or oversight, proctoring, revocation of license, restrictions on licensure or scope, location or manner of practice, voluntary or involuntary surrender or suspension of any license, permit, certificate or authorization of any practice activities, or any other form of disciplinary action, reprimand or sanction by any regulatory or disciplinary authority in any state or jurisdiction.

5. **Full compliance with all other network standards.** Practitioner must, at the time of consideration under this exception to permanent ineligibility for past fraudulent activities, be qualified and capable and demonstrably ready to meet all other terms and conditions of network participation, including but not limited to network credentialing standards and network participation contract terms.

Special Note 1: The preceding exception to the network's permanent ineligibility standard for past fraudulent activities is primarily intended to address the situation in which a practitioner is re-applying after a network termination or rejection for network participation that was based on fraudulent activity. However, in the event that any first-time applicant to the network should be found to have engaged in past fraudulent activities, and seeks to be considered for an exception to the permanent ineligibility standard, the terms of this exception shall apply to such applicants as well, i.e., any such first-time applicant shall not be eligible to be considered for any exception to the permanent ineligibility standard for fraudulent activities until all of the above-stated conditions are met (in the sole discretion of the network), including but not limited to lapse of five years following the submission of a network application.

Special Note 2: The preceding notwithstanding, the Networks reserves the right to refuse network participation to any practitioner in a given case, based on an assessment of all the available data and known circumstances, in the sole judgment and discretion of the Networks. Factors that may be considered in this regard (in the sole judgment and discretion of the Networks) include but are not limited to whether practitioner has engaged in a pattern of deception, misrepresentation, abusive or fraudulent claims practices, impact of past misconduct on third parties or entities, including but limited to any impact on the Networks or their customers or members, and general personal or business reputation and conduct.

(d) Curing a Contract Breach Prior to Termination

Current network participation agreements recognize that a material breach of the contract may be cured to avoid immediate termination if the network-sponsoring company requests such cure, and if an offending provider fully cures the breach within five business days after written request from the network-sponsoring company. While this provision is not being changed, it should be noted that not all contract breaches are capable of being cured, and if a breach is one that cannot be fully cured then immediate termination cannot be avoided in such instances. For example, a provider who breaches the contract and network term that minimal malpractice coverage be maintained, could fully cure that breach, upon request of the network sponsor, by obtaining malpractice coverage within five business days of written request from the network sponsor. However, a provider who breaches the contract and network terms requiring compliance with applicable utilization standards, or coding or claims filing policies, or

Coverage Policies, or medical records/documentation standards (among other possible examples) will ordinarily not be able to fully cure such breaches because past actions cannot be erased or reversed completely (even if financial restitution is made). Likewise, a provider who knowingly files false or misleading claims or related data with any payer cannot fully cure such action. Accordingly, participating providers agree that only those contract breaches for which the network sponsor (in its sole discretion) specifically requests cure within the five business day period will be eligible for cure to avoid termination.

(e) Exclusions Based on Quality or Competency or Member Health and Safety Concerns

If a provider is excluded from the networks on grounds that the provider has a competency or quality problem, or that his or her participation would raise member health and safety concerns, such excluded provider shall be ineligible to participate or re-apply for participation in the networks for a period of four years from the date of the networks' final denial or termination notice (a "final" notice meaning the last letter of denial or termination issued in response to any written request or appeal, or series of requests/appeals, of the practitioner or of any representative of the practitioner acting on the practitioner's behalf).

Upon expiration of the four-year ineligibility period referenced above, a practitioner excluded from network participation on grounds of a past quality or competency issue, or concerns for member health and safety, shall be permitted to re-apply for network participation and shall become eligible to be considered by the networks' Credentialing Committee if and only if the following additional conditions are met and adequately verified to the satisfaction of the networks and their Credentialing Committee:

- (1) No new competency or quality problems or issues of any kind have arisen or have been alleged by any source with respect to the provider since the original network denial or exclusion decision; and
- (2) No new concerns of any kind about member health or safety have arisen or been alleged by any source with respect to the provider since the original network denial or exclusion decision; and
- (3) No competency or quality problems of any kind not previously known to the networks, and not considered in the original network denial or termination decision, have since been discovered; and
- (4) No concerns of any kind about member health or safety not previously known to the networks, and not considered in the original network denial or termination decision, have since been discovered; and
- (5) No hospital privileges actions of any kind (including but not limited to voluntary or involuntary surrender of privileges while under investigation) have been taken or reported against the practitioner during the four-year ineligibility period; and

- (6) No hospital privileges actions of any kind (including but not limited to voluntary or involuntary surrender of privileges while under investigation) not previously known to the networks, and not considered in the original network denial or termination decision, have since been discovered; and
- (7) The practitioner has not been subject during the four-year ineligibility period to any actions or required appearances before the Arkansas State Medical Board or any equivalent licensing or disciplinary board, committee or entity in Arkansas or in any other jurisdiction; and
- (8) No such Medical Board (or equivalent licensing or disciplinary board or entity) actions or required appearances of any kind not previously known to the networks, and not considered in the original network denial or termination decision, have since been discovered; and
- (9) No malpractice lawsuits have been filed against the practitioner during the four-year ineligibility period; and
- (10) No malpractice lawsuits not previously known to the networks, and not considered in the original network denial or termination decision, have since been discovered; and
- (11) The practitioner must not be disqualified by any other network standard, term or condition, including but not limited to the networks' published credentialing standards, terms and conditions of network participation, or network participation agreements.

Special Notes on Additional Conditions:

- The preceding provisions of this subsection (e) do NOT apply in cases where the competency or quality problem or the concern for member health and safety exclusively involve problems with hospital privileges and related denial, termination, limitation, restriction or suspension, or voluntary or involuntary surrender, of hospital privileges; in such cases, the specific "Hospital Privileges" provisions of Section XIV hereof shall apply.
- **NOTWITHSTANDING ANY OF THE PRECEDING AND REGARDLESS OF WHETHER ALL OF THE CONDITIONS OUTLINED ABOVE ARE MET-** the networks reserve the right to refuse network participation to any provider whose competency or quality problem or potential threat to member health and safety is, in the judgment of the networks, egregious and has not been fully remediated by appropriate corrective action during the four-year ineligibility period. In all such cases, the networks or the Credentialing Committee shall be entitled to decline to approve any such provider for network participation despite the passage of the four-year ineligibility period, and the

ineligibility period may be extended in the discretion of the networks or the Credentialing Committee as applicable circumstances may warrant, in their judgment.

III. Providers' News Notices and Articles

Network participation agreements currently stipulate that participating providers may receive notices of policy changes via *Providers' News* (as well as through websites of applicable payers such as Arkansas Blue Cross and Blue Shield or Health Advantage). It is important for all participating providers to understand the role of *Providers' News* as a source of notice concerning network terms and conditions. All participating providers are responsible for ensuring that such providers and their office staff monitor and pay regular and close attention to the notices and articles published in *Providers' News*, as it represents an efficient method of communication with network-participating providers on a state-wide basis. Furthermore, the network participation agreement of any participating provider is subject to formal amendment via the publication of a notice in *Providers' News*. Claims filed or other actions taken by a participating provider or their office staff or other representatives that fail to follow instructions published in *Providers' News* shall constitute grounds for exclusion from the Networks, regardless of whether a participating provider has personally received or read the *Providers' News* publication, and regardless of whether any individual employed or otherwise working with provider has been assigned responsibility for monitoring *Providers' News*. It should be noted that past editions of *Providers' News* are available on the website of Arkansas Blue Cross and Blue Shield, to which all participating providers have access via the internet.

IV. Provider Manuals

All participating providers have been and will continue to be subject to the terms and conditions set forth in Provider Manuals of payers such as Arkansas Blue Cross and Blue Shield and Health Advantage, as well as any separate Provider Manual of non-payer networks such as USABLE Corporation or True Blue PPO. The Provider Manual is an operational handbook and set of guidelines furnished for the convenience and guidance of providers and their office staff. The Provider Manual serves as a resource for answers to common provider questions about health plan coverage policies and procedures, as well as an outline of some basic required administrative procedures for proper processing of claims and participation as a participating provider. The current versions of the Arkansas Blue Cross and Blue Shield Provider Manual and the Health Advantage Provider Manual are posted to the respective websites of Arkansas Blue Cross and Blue Shield and Health Advantage. Applying providers must agree, as a term and condition of participation, to abide by the Provider Manuals of applicable payers and all participating providers must follow the guidelines, procedures and policies set forth in such Provider Manuals, if they are to remain eligible for network participation. In the absence of a separate published Provider Manual for USABLE Corporation (True Blue PPO and Arkansas' FirstSource® PPO), participating providers in the USABLE PPO Networks shall be obligated to follow the general provisions and

guidelines of the Provider Manual of Arkansas Blue Cross and Blue Shield. Failure to accept or follow any term or condition of the Provider Manual shall constitute grounds for exclusion from the Networks, regardless of whether a participating provider has personally received or read the Provider Manual, and regardless of whether any individual employed or otherwise working with provider has been assigned responsibility for monitoring Provider Manuals. Participating providers who lack internet access may request a hard copy of the Provider Manuals, but in doing so must recognize that updates may be posted at any time to the website version, and hard copy updates will not be provided, except upon specific follow-up request from such provider. As a term and condition of network participation, providers are expected to make their own arrangements for internet access so as to have and maintain ready access to posted materials, including the Provider Manuals. (Written notice of changes to the Provider Manual ordinarily will also be published in *Providers' News*, although a complete new edition of a Provider Manual ordinarily will not be issued or published in that manner.)

V. Coverage Policies

Network-participating providers must, in order to be eligible for continuing network participation, agree to accept and abide by the Coverage Policy of the insurer, HMO, government program or self-funded payer for whose members' benefit the network is operated. Coverage Policies for payers such as Arkansas Blue Cross and Blue Shield (accessing the True Blue PPO network for some of its members) and Health Advantage have been established with input from practicing Arkansas physicians as well as physicians in other states with relevant expertise. Coverage Policies are written to reflect evidence-based medical care as reflected in peer-reviewed medical literature and to reflect concurrence with the Primary Coverage Criteria, which is a coverage standard incorporated into many health plans or insurance contracts for Members of Arkansas Blue Cross and Blue Shield or Health Advantage. Coverage Policies and the rationale for such policies are publicly accessible on the websites of Arkansas Blue Cross and Blue Shield and Health Advantage. The rationales are based on the evidence listed in each separate Coverage Policy. Appeal mechanisms are available to both the affected Member and provider when they disagree with the application of a particular Coverage Policy to a specific claim. Coverage Policies may change (either to broaden or restrict coverage) based on new information that meets the Primary Coverage Criteria or other required standards of a Member's health benefit plan or insurance contract. Requests for changes in Coverage Policies are welcome, if the requesting party presents supporting data from multicenter randomized trials, adequately populated prospective controlled trials, or expert opinion, as such expert opinion is defined in the Primary Coverage Criteria or other provisions of a Member's health benefit plan or insurance contract. Coverage Policies specific to self-funded payer health benefit plans (if any) may also be posted to the Blue Advantage Administrators website. Compliance with such Coverage Policies is a specific condition of the written network participation agreement, so this policy/term is not new; however, the following supplements the formal contract provision to provide additional details and requirements:

(a) Individual Provider Responsibility for Compliance

Participating providers are responsible for making sure that claims filed with any insurer, HMO or self-funded payer accessing the Networks comply with applicable Coverage Policies as posted to the websites, regardless of whether a participating provider has personally accessed

the websites, and regardless of whether any individual employed or otherwise working with provider has been assigned responsibility for monitoring the websites. Participating providers who lack internet access may request a hard copy of specific Coverage Policies, but in doing so must recognize that updates may be posted at any time to the website version, and hard copy updates will not be provided, except upon specific follow-up request from such provider. As a term and condition of network participation, providers are expected to make their own arrangements for internet access so as to have and maintain ready access to posted materials, including the Coverage Policies (however, it should be noted that changes to Coverage Policies will also ordinarily be published by notice in *Providers' News*.)

(b) Noncompliance is grounds for network exclusion

A provider who receives written notice directed specifically to such provider of a violation of published Coverage Policies of a payer accessing the Networks, and who thereafter fails or refuses to accept and follow the Coverage Policies of such payer, as posted to the websites (or as otherwise published to providers generally through *Providers' News* or specific correspondence of any payer or its agent to providers) shall be subject to exclusion from the Networks. Providers who disagree with such Coverage Policies shall remain free to follow any course of practice or treatment they deem appropriate with respect to patients, and such providers may choose to challenge a reimbursement decision based on a Coverage Policy by internal appeals, external review, arbitration or any other avenue otherwise open to such provider for administrative or legal challenge; however, if an internal appeal within the insurer, HMO or self-funded payer is denied, or if provider loses any external review, arbitration or other administrative or legal challenge, or if provider fails to pursue any internal appeal or administrative or legal challenge, participating providers who thereafter persist in refusing to accept or follow Coverage Policies, after receiving written warning from the applicable payer or its agent, shall not be eligible for continued network participation, and shall be excluded from participation on that basis. If a payer or its agent has published a written policy that providers may or should file claims that are known to be excluded from coverage under applicable Coverage Policies whenever such a filing and denial are necessary because of the need to furnish proof of such denials to a secondary payer (under applicable coordination of benefits rules), or in other exceptional circumstances identified by written notice in *Providers' News*, the preceding standard would not be grounds for a provider's exclusion in such limited circumstances, provided that secondary payer requirements are in fact the basis for such claims filings, or provided that claims have been filed under a published exception policy. In addition, if a provider has fully complied with the member waiver requirements of the network participation agreement, prior to administering any services to a member that would not be covered under applicable payer Coverage Policies, then such provision of services shall not be grounds for exclusion from the Networks, so long as provider does not bill the applicable payer for such services.

NOTE: Even if a provider wins an external review, arbitration or other administrative or legal challenge, if the provider thereafter refuses to comply with the challenged Coverage Policy, such provider may still be excluded from the network unless the insurer, HMO or self-funded payer whose Coverage Policy was challenged changes the policy as a result of the external review, arbitration or other administrative or legal challenge. In other words, merely because

an external reviewer, arbitrator, agency or court requires payment to a provider on a particular claim or set of claims does not mean the provider can ignore the Coverage Policy adopted by payers accessing the network, if provider wishes to continue to be a network participant. (Of course, if a final, binding court decision invalidates and enjoins enforcement of the Coverage Policy, or mandates its modification, payers will be obligated to comply, but in the absence of any such decision, providers cannot circumvent the network participation terms and conditions merely by winning a claims payment dispute with the payer). Providers in such circumstances, are choosing to disqualify and exclude themselves from participation if they persist in rejecting applicable Coverage Policy.

VI. Utilization Standards

A. Utilization Standards Applicable to All Disciplines

Network participation agreements currently require compliance by participating providers with applicable utilization policies and programs of the Networks or payers utilizing the Networks. The network-sponsoring companies or payers utilizing the Networks may establish utilization standards, including but not limited to ratings of a participating provider in comparison to a designated peer group of other participating providers, or to state or national statistical averages, or the recommendations of any independent source such as medical research or analysis organizations, Medicare or other government programs. Participating providers must cooperate fully in all such utilization programs (including but not limited to furnishing of all claims or practice data needed to evaluate participating provider's compliance with utilization criteria), and must comply with such standards, as a term and condition of continuing network participation. Failure to accept and meet all utilization standards shall be grounds for exclusion from the Networks. Prior to implementation of new utilization standards not currently in use, Arkansas Blue Cross and Blue Shield, US Able Corporation and Health Advantage intend to review such new standards with a representative group of practicing physicians to solicit and obtain their input, and may also elect to have such new utilization standards reviewed by an external organization having expertise in clinical or practice guidelines and standards.

Network sponsors or payers may elect to refer any perceived utilization issue of a participating provider to an external reviewer or external review organization. Participating providers must fully cooperate with any such external review in responding to inquiries and furnishing any requested information. Failure to fully cooperate shall be grounds for exclusion from the Networks.

NOTE: Providers with identified utilization issues or outlier status may be subject to probationary status and special conditions for continued participation, or other measures short of network termination, including by way of example, and not to exclusion of any other conditions, requirement to submit medical records with all claims or percentage hold-backs on claims payments. If a participating provider under review for utilization issues refers patients to another provider, or otherwise takes any steps to hide over-utilization, the utilization on such referrals may be attributed to such participating provider.

VII. Publication of Utilization, Quality and Other Practice Data

As a term and condition of network participation, all participating providers are deemed to authorize insurers, HMOs or self-funded payers whose members utilize the Networks, to publish to such members, group health plans, employers, hospitals or other categories of providers, consultants, vendors, government agencies and to the public generally (subject, of course, to applicable member confidentiality requirements and HIPAA Privacy standards) any data, including information obtained from claims submissions, regarding the rates of utilization or performance of services by such participating provider, any data concerning costs of care or services, any data regarding quality of services provided to members, any data (again, subject to protection of member identification/confidentiality) regarding member complaints, any data regarding malpractice claims, including but not limited to the filing of such claims, settlement of any such claims, insurance payments made as to such claims, judgments or awards made as to such claims, any data regarding complaints to the State Medical Board or other regulatory or disciplinary authorities regarding such participating provider, any data regarding provider's education, professional training, practice history, prior locations and licensure in any jurisdiction, and any other data concerning participating provider and provider's professional qualifications, competency or practice that may be useful and informative to such members, group health plans, employers, hospitals or other categories of providers, consultants, vendors, government agencies and the public generally.

As a term and condition of network participation, participating providers agree to release the insurer, HMO or self-funded payer and their agents or representatives from any claims or liabilities related to the publication of any provider data to members, group health plans, employers, hospitals or other categories of providers, consultants, vendors, government agencies or the public generally, so long as such publication is not deliberately and maliciously false. If publication of provider data includes a rating or comparison of a provider's relative cost or quality of services, and if publication of the rating or comparison will be made in a general distribution to all members, group health plans, employers or other network providers or the general public, then in such circumstances, affected providers will be given a copy of the utilization and practice data that the network sponsor proposes to publish. The network sponsors will endeavor to give advance notice so that affected providers will have a 45-day review period before any such general publication of cost or quality ratings or comparisons is made. For more limited releases of provider claims, utilization, quality or other practice data to specific members, group health plans, employers, hospitals or other categories of providers, consultants, or vendors, or subsets of such audiences, advance copies of such releases will not be provided, but upon written request, interested providers will be furnished with a copy of the cost or quality rating or comparison information specific to their practice that has been released by US Able Corporation, Health Advantage or Arkansas Blue Cross and Blue Shield in the 12 calendar months preceding the date of the written request.

VIII. Criminal Investigations, Charges or Convictions, or Government Programs Investigations

Any provider who is charged with commission of a crime may be excluded from the Networks, regardless of whether the crime is a misdemeanor³ or a felony, and regardless of whether a trial has been held, a conviction is obtained, or the charges are later withdrawn, settled or otherwise dismissed or resolved. The network sponsors and payers shall have the right to take all circumstances into account in consideration of their member's safety and the general business reputations of the network sponsors and payers.

In appropriate cases, the network sponsors or payers shall be entitled to exclude providers under investigation by any criminal law enforcement agency or process (including but not limited to grand juries or prosecuting attorneys), or by any government program (including but not limited to Medicare, Medicaid, state attorneys general or the U.S. Office of Inspector General). NOTE: While the preceding addresses possible exclusion for criminal charges or investigations prior to conviction, it remains a network credentialing standard that any felony conviction is grounds for network exclusion, the only exceptions being in specified circumstances involving a government executive pardon or exemplary conduct demonstrated over time.

IX. Malpractice Claims

The Networks' credentialing standards have always taken malpractice claims into account in evaluating providers for initial and ongoing credentialing for participation in the Networks. Providers have been and will continue to be subject to exclusion based on their malpractice history. In looking at malpractice history, the Networks reserve the right to exclude a provider based on the number of cases filed against a provider, the types of cases filed, the amount of any settlement made on behalf of the provider, as well as any combination of the preceding factors or any other factors that appear relevant to evaluating the provider's degree of culpability or responsibility for alleged harm to a patient. The Networks shall be entitled to exclude a provider based on their assessment of the provider's malpractice background, regardless of whether some or all claims have been dismissed, withdrawn, settled or resolved at trial, i.e., the Networks reserve the right to make an independent judgment regarding whether the provider's conduct, as questioned in the malpractice allegations, was negligent or otherwise culpable so as to disqualify the provider from network participation. While most malpractice activity is of such a nature that it must be evaluated on a case-by-case basis, the Networks have determined that it is necessary to set some minimal

³ Not all misdemeanors shall be grounds for network exclusion. For example, in most circumstances, minor traffic violations, speeding tickets, etc. would not be considered relevant (although a pattern of repeat offenses, especially if others are injured by such violations, might be deemed appropriate grounds for network action). The intention is to consider primarily those misdemeanors that indicate either possible danger to or indifference to the well being of patients or other individuals (e.g., a misdemeanor involving physical violence or threats or abusive conduct) or fraudulent or disreputable claims or business practices or other egregious misconduct reflecting negatively on personal reliability and professional or business reputation.

standards of disqualification, regardless of any other factors or circumstances. These minimal standards⁴ include the following:

- (a) Any provider who has been named in 5 or more malpractice lawsuits that resulted in settlements or an adverse judgment against the provider in the most recent ten year period prior to the date of application or credentialing/recredentialing review is disqualified and shall be excluded from the Networks on that basis alone, irrespective of any other factors.
- (b) Any provider who has moved practice locations⁵ three or more times in the most recent ten year period prior to the date of application or credentialing/recredentialing review, and who also had three or more malpractice lawsuits that resulted in settlements or an adverse judgment against the provider during the same ten year period, is disqualified and shall be excluded from the Networks on that basis alone, irrespective of any other factors.
- (c) Any provider who moves to Arkansas from another state or jurisdiction and whose malpractice history reflects more than three malpractice lawsuits that resulted in settlements or an adverse judgment against the provider in the most recent ten year period prior to the date of application or credentialing/recredentialing review is disqualified for a minimum period of three years on that basis alone, irrespective of any other factors.
- (d) Any provider who has had three or more malpractice lawsuits that resulted in settlements or an adverse judgment against the provider, and who also has received any form of discipline, probation, warning, reprimand, censure, admonition, educational requirement, fine, penalty or other adverse action (“Sanction”) from any state medical board or similar state or federal disciplinary authority or agency is disqualified for a minimum period of three years on that basis alone, irrespective of any other factors, including the fact that the medical board or other disciplinary authority or agency may have withdrawn, modified, stayed or suspended its original Sanction at the time of Provider’s initial credentialing or recredentialing review. The foregoing notwithstanding, if it is clear that a Sanction, as referenced in this section, is not related to any patient health or safety issue or any quality or competency issue or concern with a practitioner’s practice, and is instead simply and exclusively a matter of an administrative oversight or formality of paperwork completion unrelated to the quality of medical services or appropriateness of the practitioner’s professional or personal conduct, then in such circumstances, the Sanction shall not be considered when applying this subpart (d), so long as (i) no questions or concerns related to patient health or safety, quality, competency or misconduct of the practitioner were involved or implicated in any way in the proceedings; and (ii) the practitioner promptly

⁴ NOTE: The fact that a provider’s malpractice history falls within these minimal standards does NOT mean that such provider is exempt from exclusion based on malpractice history. For example, a provider who has 2 malpractice lawsuits filed against him in the past 10 years could still be excluded because of the nature of those lawsuits, the amount of the settlements or judgments, or other related circumstances. The minimal standards are merely for purposes of setting a standard, below which the Networks will decline to look at alleged extenuating circumstances or explanations, and will mechanically apply the minimal standards without further inquiry or evaluation.

⁵ A move of practice locations, for purposes of these policies/terms is defined in the “Moving Practice Locations” section, below.

pays any applicable fine or penalty, timely completes all compliance mandates, and fully resolves the matter with the applicable disciplinary board or agency; and (iii) provided that the administrative oversight or problem with paperwork completion was a single incident and has not been repeated.

NOTE: The minimum three-year disqualification period referenced in subsections (c) and (d) above, shall begin upon the date of the credentialing or recredentialing decision that first follows the publication date of this Notice, except that if the affected provider appeals the credentialing or recredentialing decision, the minimum three-year disqualification period shall begin upon the date of the final adverse Appeals Committee decision on such appeal. The minimum three-year disqualification period may be extended based on the number of malpractice claims, the nature of such claims, the amount of any settlement(s), or the number or nature of any Sanctions.

X. Moving Practice Locations

A. General Standard

Because providers with competency, quality or other problems arising in one location sometimes move to another, the Networks reserve the right to take into account how often a provider has moved practice location, and may, in some circumstances, exclude a provider from network participation based on the number or nature of such moves. For purpose of these policies/terms, the phrase “moving” or “moved” in reference to “practice locations” means and includes the following two-part definition (1 and 2):

- (1) Changing the physical location at which the provider spends the majority of the provider’s weekly work activities from one country to another country, from one state to another state, from one city to another city, or from one county to another county; or
- (2) Time spent in the military or medical school or a residency or fellowship program shall not count as a “practice location” except in the following circumstances: (i) any resident who begins a residency program and fails to satisfactorily complete that residency in the original location shall be deemed to have moved practice locations upon entering into any subsequent residency program in a different country, state or city; and (ii) any discharge, termination or other cessation of a military medical position that is involuntary or dishonorable shall be deemed a move of practice location (and may also independently disqualify such provider from participation in the Networks, depending on the nature of the discharge, termination or other cessation of a military medical position).

B. Minimal Standards of Disqualification

While review of practice location moves will generally be conducted on a case-by-case basis, taking the relevant circumstances into account, the Networks have established the

following minimal standards⁶ of disqualification, regardless of any other factors or circumstances. These minimal standards include the following:

- (1) A provider who has moved practice locations between states 6 times or more during the most recent past 10 year period is disqualified and shall be excluded from the Networks on that basis alone, irrespective of any other factors.
- (2) A provider who has moved practice locations between cities, or between counties, or between a combination of cities and counties, 10 times or more during the most recent past 6 year period is disqualified and shall be excluded from the Networks on that basis alone, irrespective of any other factors.
- (3) A provider who has moved practice locations between countries 3 times or more during the most recent past 5 year period is disqualified and shall be excluded from the Networks on that basis alone, irrespective of any other factors.

C. Locum Tenens Exception

Notwithstanding the Minimal Standards of Disqualification outlined above, the Networks may, in appropriate cases, recognize an exception for certain providers whose frequent moves are attributable solely to participation in a bona fide *locum tenens* program(s), and are shown not to be related to any licensing, malpractice, hospital privileging, peer review or other practice issues, disciplinary actions or efforts to escape an adverse or unfavorable practice history. In order to qualify for a *locum tenens* exception, a provider must meet the following criteria:

- (a) Demonstrate a clean credentialing and practice history not marred by *any* (i) disciplinary or licensing actions or sanctions of any kind, including but not limited to any reprimands, fines, penalties, CME requirements, Medical Board or other disciplinary agency appearances, physician health committee participation (or similar program for non-physicians); or (ii) problems of any kind with hospital privileges; or (iii) peer review actions, citations or findings, including but not limited to any peer review investigations opened but not concluded for any reason (including voluntary surrender of privileges or other practice prerogatives while under investigation; and
- (b) Demonstrate a clean practice history not marred by *any* problems with the provider's participation in any government program, including but not limited to Medicare and Medicaid, whether or not such problems have been resolved (e.g., a temporary suspension; and

⁶ NOTE: The fact that a provider's history of moving practice locations falls within these minimal standards does NOT mean that such provider is exempt from exclusion based on moving practice locations. For example, a provider who has moved practice locations between states 5 times in the past 10 years could still be excluded because of the nature of or reasons for those moves, or other related circumstances. The minimal standards are merely for purposes of setting a standard, below which the Networks will decline to look at alleged extenuating circumstances or explanations, and will mechanically apply the minimal standards without further inquiry or evaluation.

- (c) Demonstrate that *no* malpractice lawsuits have been filed against provider (regardless of whether such lawsuits were later voluntarily withdrawn, dismissed or judgment was entered in favor of the provider) during the past five years, and that no lawsuit is now pending; and
- (d) Provide evidence satisfactory to the Networks that each practice location move that counts toward the minimal disqualification in subsection (B), above, was made as part of a bona fide *locum tenens* program(s) in which the provider's exclusive practice activity for the time periods in question was devoted to providing health care services on a temporary basis only, with no intention by either the provider or the employing or compensating person or entity that the provider would establish a permanent residence or practice within the community; and
- (e) Provide evidence satisfactory to the Networks that for each *locum tenens* practice location of provider within the past five years, provider is eligible to return to such practice location, i.e., that the clinic, facility, practice, employer or payer for each such *locum tenens* location will verify that provider is eligible for re-hire or return without conditions; and
- (f) Provide references (that are deemed satisfactory in the discretion of the Networks) from provider's supervisor at each of the five most recent *locum tenens* practice locations.

XI. Claims Filing and Coding Policies

Network-participating providers must, in order to be eligible for continuing network participation, agree to accept and abide by the claims filing and coding policies of the insurer, HMO or self-funded payer for whose members' benefit the network is operated. (Access to coding information is available to providers through the Advanced Health Information Network ("AHIN"), an on-line claims filing and data service offered free of charge to all providers participating in the separate Networks of Arkansas Blue Cross and Blue Shield, USABLE Corporation and Health Advantage. For additional guidelines and sources on coding policies, code-specific coding information ("CSCI") and coding combinations are available to providers via AHIN's CSCI functionality, as well as via the "Clear Claim Connection" software program that may be accessed via links on AHIN). Compliance with such claims filing and coding policies is a specific condition of the written network participation agreement, so this policy/term is not new; however, the following supplements the formal contract provision to provide additional details and requirements:

(a) Individual Provider Responsibility for Compliance

Participating providers are responsible for making sure that claims filed with any insurer, HMO or self-funded payer accessing the Networks comply with applicable claims filing and coding policies as established by the insurer, HMO or self-funded payer and announced to participating providers by any form of written communication, including but not limited to remittance advices, *Providers' News* articles, individual letters or email, or postings to websites of Arkansas Blue Cross and Blue Shield, Health Advantage or Blue Advantage Administrators of Arkansas. Participating providers are responsible for compliance with all claims filing and coding policies regardless of whether a participating provider has personally accessed the

websites, or has personally read any *Providers' News* article, email, letter or remittance advice, and regardless of whether any individual employed or otherwise working with provider has been assigned responsibility for monitoring the websites, *Providers' News*, emails, letters or remittance advices.

(b) Noncompliance is grounds for network exclusion

A provider who receives written notice directed specifically to such provider of a violation of claims filing and coding policies of a payer accessing the Networks, and who thereafter fails or refuses to accept and follow such policies shall be subject to exclusion from the Networks. Providers who disagree with such policies/ terms may choose to challenge a particular claims decision or determination by internal appeals, external review, arbitration or any other avenue otherwise open to such provider for administrative or legal challenge; however, if an internal appeal within the insurer, HMO or self-funded payer is denied, or if provider loses any external review, arbitration or other administrative or legal challenge, or if provider fails to pursue any internal appeal, or administrative or legal challenge, participating providers who thereafter persist in refusing to accept or follow claims filing or coding policies/terms shall not be eligible for continued network participation, and shall be excluded from participation on that basis.

NOTE: Even if a provider wins an external review, arbitration or other administrative or legal challenge, if the provider thereafter refuses to comply with the challenged claims filing and coding policy or term, such provider may still be excluded from the network unless the network or the insurer, HMO or self-funded payer whose claims filing or coding policy or term was challenged changes the policy or term as a result of the external review, arbitration or other administrative or legal challenge. In other words, merely because an external reviewer, arbitrator, agency or court requires payment to a provider on a particular claim or set of claims does not mean the provider can ignore the claims filing or coding policies or terms adopted by the network or by payers accessing the network, if provider wishes to continue to be a network participant. (Of course, if a final, binding court decision invalidates and enjoins enforcement of the claims filing or coding policy or term, or mandates its modification, the Networks and payers will be obligated to comply, but in the absence of any such decision, providers cannot circumvent the network participation terms and conditions merely by winning a claims payment dispute with the payer). Providers in such circumstances are choosing to disqualify and exclude themselves from participation if they persist in rejecting applicable claims filing or coding policies or terms.

(c) Abusive or Deceptive Claims Practices

Network-participating providers must be aware and agree that payers who receive claims from such providers are relying on the completeness and accuracy of the data submitted on the claim form, whether the form is submitted electronically or otherwise. Each data entry is critical to the correct processing of the claim. Participating providers who use the American Medical Association's CPT Manual, ICD-9/ICD-10 procedure codes, HCPCS codes, or the successor or updated versions of any of these established coding conventions to file claims with payers are deemed to make an affirmative representation of fact to the payer that the services or procedures performed are, in fact, the services or procedures described in the code the provider

selected and used from the CPT Manual or ICD-9/ICD-10 or HCPCS publications, as reflected on the claim submitted. Submission of a claim that uses an incorrect CPT, ICD-9/ICD-10 or HCPCS code shall be deemed to be an abusive and deceptive practice (and may even constitute fraud) unless clearly accidental and limited to a single source of error (e.g., multiple claims submitted at the same time due to one human or computer error). Any participating provider who, after receiving written notice of incorrect or inaccurate coding or other incorrect or inaccurate claims submission practices, submits any claim under an incorrect code, or uses a code that does not, in fact, describe the service performed, or who submits other inaccurate or misleading information in connection with a claim, shall be subject to exclusion from the network on that basis. Furthermore, even if submission of incorrect claims was accidental and limited to a single source of error, if the error is repeated after being brought to the attention of participating provider, such provider shall be subject to network exclusion on that basis alone, regardless of whether the inaccuracy was done knowingly, and regardless of the reasons for the repeat error because the network-sponsoring companies must be able to rely on participating providers to diligently correct any claims submission errors and problems to avoid repetition, particularly where such problems have been brought to participating provider's attention. (NOTE If it is found that a provider had actual knowledge of submitting a false or inaccurate claim, such provider may be subject to network exclusion without first receiving a written notice of the deliberately inaccurate or false submission, i.e., if actual knowledge of false submission is shown, a second chance after notice/warning need not be given).

(i) Billing Services or Agents Do Not Excuse Non-Compliance

The fact that the participating provider uses a billing service, practice management company, or other third party, or a software program created or managed by any such third party, or that any current or former employee, office staff, office manager or other personnel or agents of participating provider ("Agents") may be partly or wholly responsible for the submission of participating provider's claims, or that participating provider can show that provider had no actual knowledge of the actions or representations of such Agents, shall NOT constitute grounds for avoiding responsibility or network exclusion for submission of incorrect claims, or any abusive or deceptive claims practices. The network-sponsoring companies and payers cannot constantly audit all participating providers on a day-to-day basis, and must therefore rely on participating provider for assurances that billing services, employees, and agents of any kind who assist participating provider in the submission of claims will comply with all applicable claims filing and coding policies/terms, and will accurately represent the services performed.

(ii) Specific Examples of Abusive/Fraudulent Claims or Coding Practices

Specific examples of other claims filing or coding practices that are deemed to be abusive or fraudulent may be found in past or future editions of *Providers' News*, or in the Provider Manual or websites of Arkansas Blue Cross and Blue Shield, Health Advantage or US Able Corporation and all participating providers in the Networks shall be held accountable for such specific examples (in addition to the general standards outlined here), where previously published, or, for updated Provider Manuals, immediately upon publication to the respective websites of updated Provider Manuals.

XII. Review and Use of Claims Data

Network participation agreements for Arkansas' FirstSource®, True Blue PPO and Health Advantage already recognize and agree that US Able and Health Advantage may conduct utilization studies or programs, including physician profiling, using the claims data that participating providers submit to either US Able or Health Advantage or to any affiliated companies of either. Participating providers must therefore understand and agree, as a term and condition of participation, that claims submitted to Arkansas Blue Cross and Blue Shield, which is the parent organization of US Able Corporation and of Health Advantage, may be subject to review and use in utilization studies or practice profiles of US Able Corporation or Health Advantage, and vice versa. The claim utilization pattern or rate of a participating provider in Arkansas' FirstSource® PPO (or True Blue PPO or Health Advantage HMO) may thus be derived from a combination of the claims data submitted to any of these independent but affiliated companies. Refusal of any participating provider to authorize the release to and use of any claims data for utilization programs, studies or practice profiles of the three affiliated companies shall be grounds for exclusion from the Networks.

XIII. Medical Records/Documentation of Services Provided

Current participation agreements require maintenance of contemporaneous medical records to document the services performed. Providers are further subject, under current credentialing standards, to on-site audit of medical records and claims documentation, using an established set of audit measurements for accuracy, completeness and appropriateness of medical records and documentation of services. While it is long-established practice, not only for Medicare, but also for most private payers, to require that providers submit claims using Current Procedural Terminology codes and related standards, as published by the American Medical Association, and while virtually all providers submitting claims to both government and private payers commonly use such CPT codes and related standards, the network-sponsoring companies wish to make it explicit that where the CPT Manual calls for documentation to support a given code or claim utilizing that code, such documentation standards from the CPT Manual shall constitute the minimal documentation requirements for network participation. The Networks or payers utilizing the Networks may adopt and publish additional or modified standards for medical records and related documentation, but in the absence of such specific standards, participating providers should understand and must agree that the CPT Manual's documentation provisions apply to all claims submitted, and establish the threshold for evaluating adequacy of claim documentation. Audit criteria currently in use for network participation shall continue to apply, but the Networks additionally wish to clarify and make explicit a fact that has been present impliedly all along, i.e., that claims submitted using CPT codes should be supported, at a minimum, by the documentation referenced in the CPT Manual for such codes.

XIV. Hospital Privileges

Hospital privileges are not required as a condition of network participation. However, the hospital privileges status of practitioners will continue to be subject to survey and review, and may, in appropriate cases, form the basis for a network exclusion, termination or restriction decision, depending on the circumstances. For this reason, all practitioners may be required by the network, as a condition of network participation, to provide complete information and any requested documentation concerning the history, background or present status of their hospital privileges.

A. Conditions Leading to Ineligibility

Examples of circumstances in which hospital privileges status can make a substantial difference in network participation decisions include but are not limited to:

1. Any denial, termination, limitation, restriction or suspension of hospital privileges, or any voluntary or involuntary surrender of hospital privileges, particularly if such actions are taken in connection with any disciplinary action, peer review process, patient complaint or other indication of potential questions about the conduct of the practitioner, their competency or fitness, or the quality of the services rendered in any case; and
2. Ineligibility to apply for hospital privileges due to practice history, conduct or misconduct, or questions or issues relating to competency or fitness or the quality of services rendered in any case; and
3. Inability to provide (either directly or by arrangements with other practitioners for equivalent levels of expertise and service) needed services (including but not limited to inpatient treatment) to a network member due to lack of hospital privileges.

It should be noted that while hospital privileges are not a condition of network participation, all participating practitioners who admit any member to a hospital must abide by contracting and network terms and conditions that require referral and admission of members only to network-participating hospitals (absent a bona fide emergency exception). Practitioners who fail to observe the in-network referral-admission requirements, including practitioners who fail to do so due to lack of hospital privileges at an in-network facility, are subject to termination from the network.

As a condition of network participation, and as a provider contract requirement, all participating providers shall notify the appropriate network-sponsoring organization (Arkansas Blue Cross and Blue Shield, USAble Corporation and Health Advantage) or their designated agent such as Provider Network Operations as quickly as possible, and in any event, within three business days following any loss, suspension, denial, restriction, limitation or surrender of hospital privileges, providing a complete explanation of the circumstances involved.

B. Ineligibility Period and Conditions for Re-Application

If a hospital privileges action (whether a denial, termination, limitation, suspension or voluntary or involuntary surrender of privileges) is deemed by the networks as sufficiently egregious or significant to justify network exclusion, that action shall, by itself, render the affected practitioner ineligible for network participation (or consideration for network participation) for a minimum period of four years. After four years have expired from the date of a hospital privileges action, the affected practitioner shall no longer be deemed ineligible for consideration for network participation, based solely on the privileges action, provided the criteria set forth below are met when the affected practitioner's network status or application is reviewed by the networks and their credentialing or appeals committees.

With respect to any practitioner whose network participation is denied or terminated on the basis of a hospital privileges action that occurred less than four years prior to the date of the denial or termination and involved questions of competency or fitness, or the quality of services rendered, such practitioners shall be ineligible to participate or re-apply for participation in the networks for a period of four years from the date of the hospital privileges action. Notwithstanding the preceding sentence, if (i) a past hospital privileges action is renounced or withdrawn in writing by the hospital that took the action under circumstances clearly indicating that the hospital no longer maintains that the practitioner has any competency, fitness or quality deficiency or issue of any kind, or, (ii) if the hospital that took the privileges action reinstates the practitioner to full privileges without restrictions or conditions of any kind under circumstances clearly indicating that the hospital no longer maintains that the practitioner has any competency, fitness or quality deficiency or issue of any kind, or (iii) if a court of competent jurisdiction overturns the hospital privileges action in a final judgment not subject to further challenge/appeal by the hospital, then in such circumstances, the four-year ineligibility period shall expire upon presentation by the practitioner of sufficient documentation of the occurrence of such events. Practitioners claiming early expiration of a four-year ineligibility period on any of the above-referenced grounds must, in order to regain eligibility on such bases, fully respond to all inquiries of the networks regarding such circumstances, including but not limited to, supplying the networks with complete documentation of any court proceedings, hospital peer review process and related records and communications.

Upon expiration of any four-year ineligibility period referenced above, a practitioner to which it applied shall become eligible to be considered by the networks' Credentialing Committee if and only if the following additional conditions are met:

1. No other hospital privileges actions of any kind have been taken against the practitioner during the six-year period immediately prior to the date that application is submitted to the networks (or at any time thereafter up to the date of a final credentialing/appeals decision); and
2. No other hospital privileges actions of any kind not previously known to the networks, and not considered in the original network denial or termination decision, have since been discovered; and
3. The practitioner has not been subject during the six-year period immediately prior to the date that application is submitted to the networks (or at any time thereafter up to the date

of a final credentialing/appeals decision) to any actions or required appearances before the Arkansas State Medical Board or any equivalent licensing or disciplinary board, committee or entity in Arkansas or in any other jurisdiction; and

4. No such Medical Board (or equivalent licensing or disciplinary board or entity) actions or required appearances of any kind not previously known to the networks, and not considered in the original network denial or termination decision, have since been discovered; and
5. No malpractice lawsuits have been filed against the practitioner during the four-year period immediately prior to the date that application is submitted to the networks (or at any time thereafter up to the date of a final credentialing/appeals decision); and
6. No malpractice lawsuits not previously known to the networks, and not considered in the original network denial or termination decision, have since been discovered; and
7. The practitioner must not be disqualified by any other network standard, term or condition, including but not limited to the networks' published credentialing standards, terms and conditions of network participation, or network participation agreements.

Please note that satisfaction of the preceding seven conditions will not automatically qualify the practitioner for network admission, but will render a practitioner formerly ineligible due to a past hospital privileges issue, eligible to be considered by the Credentialing Committee. The Credentialing Committee still must find, based on all the circumstances presented at the time of re-application, that the practitioner is qualified under applicable credentialing standards, and in doing so will consider whether past quality or safety questions or issues, including any hospital privileges issues, have been adequately addressed and resolved. The Credentialing Committee may take into account all factors deemed relevant in this respect by the Committee, which may include but shall not be limited to (i) whether the practitioner has undergone any additional education, training or remediation of any kind; and (ii) whether the practitioner has cooperated with the peer review process or requirements of the hospital that took the adverse privileges action; and (iii) whether the practitioner has unrestricted privileges at any hospital.

With respect to hospital privileges actions not involving questions of competency or fitness of a practitioner, or the quality of any services rendered (e.g., non-habitual tardiness in completing medical records or charts, or willingness to sign up for call rotation), the affected practitioner shall be ineligible to participate in or re-apply for participation in the networks for one year from the date that the hospital privileges action is taken, unless, in the interim, the hospital renounces or withdraws the privileges action, or unless, in the interim, the hospital reinstates the affected practitioner to full hospital privileges without restrictions or conditions of any kind, or unless a court of competent jurisdiction overturns the hospital privileges action.

Special Note on Failure to Notify Networks of Privileges Actions:

Notwithstanding any of the preceding provisions regarding the ineligibility period or conditions for re-application, if a practitioner who is subject to the terms of a network participation agreement is subjected to any hospital privileges action but fails to furnish written notice of the same to the networks within the time frame specified in the network participation agreement(s), such practitioner shall be ineligible to participate in the network or to re-apply for participation in the networks for three years from the date that the networks learn of any such hospital privileges action, dated from the date of the networks' rejection or termination letter citing the hospital privileges action. For avoidance of doubt, the three-year ineligibility period referenced in this paragraph shall apply regardless of whether, in the intervening time between occurrence of the privileges action and its discovery by the networks, privileges have been fully restored without restrictions or conditions (unless privileges are restored based on the hospital renouncing or withdrawing the privileges action under circumstances clearly indicating that the hospital no longer maintains that the practitioner has any competency, fitness or quality deficiency or issue of any kind, or unless a court of competent jurisdiction overturns the hospital privileges action in a final judgment not subject to further challenge/appeal by the hospital).