

Criteria for Provider Denial or Termination

The FCH PPO Credentialing Committee shall approve or deny network participation. Denial or termination based upon quality of care is a reportable action.

All providers must meet credentialing and recredentialing requirements of FCH PPO. Failure to meet established standards or guidelines can result in the denial or termination of a provider.

- Termination of a provider contract must comply with the specific terms of the provider's contract.
- A participating provider may be terminated without cause with 90 days written notice. Criteria considered by FCH PPO in making the decision to terminate without cause include but are not limited to administrative reasons.
- A participating provider may be terminated immediately with cause when charges are serious enough to warrant urgent action and/or members are at immediate risk of harm or imminent danger.

Criteria considered by FCH PPO in making the decision to deny or terminate network participation include, but are not limited to the following criteria:

- Lack of network and/or membership needs.
- Inability of FCH PPO to complete credentialing/rec credentialing due to the applicant's failure to provide relevant information or the necessary release.
- Submission of inaccurate or misleading information on the application, or failure to disclose relevant information.
- Voluntary relinquishment, withdrawal or failure to proceed with an application in order to avoid an adverse action, or to preclude an investigation, or while under investigation relating to professional competence or conduct.
- Failure to notify FCH PPO of any changes in clinical privileges, hospital staff privileges, practice scope; sanctions/restrictions or of any medical or mental health problems that could affect the care of patients.
- Lack of local hospital admitting privileges or an inpatient coverage plan (if applicable).
- History of restrictions on hospital privileges or scope of practice.
- Inadequate inpatient coverage plan (if applicable).
- Current or previous loss of, or restrictions to, hospital, clinic, facility, surgical center, network or other healthcare privileges.
- Refusal, revocation, suspension or restrictions of hospital staff privileges at any hospital.
- Failure to become Board certified in practice speciality, when applicable.

- Failure to become Board certified in practice specialty within five years of completion of residency (if applicable).
- Failure to maintain Board certification for specialties that require periodic recertification.
- Loss of Board certification status based on a adverse event.
- Current or previous loss of or insufficient/inadequate malpractice insurance coverage.
- History of malpractice claims judged excessive by the Credentialing Committee.
Professional liability claims history is defined as cases that are settled and have resulted in an adverse judgement against the provider.
- Current or previous sanctions by Medicare/Medicaid (including censure or exclusion).
- Current or previous quality issues as reported by National Practitioner Data Bank (NPDB)/ Healthcare Integrity Data Bank (HIPDB), licensing boards or prior work/training sites.
- Current or previous loss of, restriction to or sanctions on professional licensure, certification/registration or authorization to practice, including, but not limited to, probationary status, chaperone or related requirements (i.e., monitoring, open doors, etc.), or prescribing limitations, required supervision, or restricted hospital privileges.
- History of practicing without valid license, registration/certification or authorization.
- History of significant patient complaints documented by licensing authority, healthcare facility, health plan, or network administrator.
- Current or previous revocation or loss of, or restrictions to, DEA registration.
- History of concerns about quality of care or evidence of compromised quality of care.
- Current or history of chemical dependency/substance abuse.
- Current physical or mental health problem(s) which significantly impair practitioner's ability to perform within the scope of his/her professional duties.
- Physical or mental health condition that may impair the provider's's ability to practice within the full scope of licensure and qualifications or may impose a risk of harm to patients.
- Notification from a confidential program for chemically impaired providers (i.e., Washington Physicians Health Program) documenting that they can no longer provide advocacy for the provider because of instability in his/her recovery and/or for non-compliance with the Program/Contract.
- History of providing patient care outside of the scope of license, registration/certification or authorization.
- Practice inconsistent with professional standards of care.
- Criminal record affecting professional practice.
- Current or history of a felony conviction.
- Unethical conduct, or history of unethical conduct, in violation of laws or standards governing the practice of health care.
- Acts of, or history of, fraud, deceit, dishonesty or moral turpitude.

- Practice trends, or history of, practice trends that raise concerns regarding provider's ethics, quality of care and/or practice standards.
- Current or history of inadequate medical record practices or inappropriate billing practices (i.e., upcoding, failure of adequate chart documentation to support submitted claims, etc).
- Submission of erroneous, improper, or incomplete claims.
- Failure to comply with procedures implemented in connection with the administration of utilization review or failure to cooperate with the quality management activities.
- Non-compliance with or history of non-compliance with FCH PPO Provider Contract.