

Memorial Hermann Physician Network

NETWORK PARTICIPATION CRITERIA & POLICIES

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NETWORK PARTICIPATION CRITERIA & POLICIES

- I. POLICY OBJECTIVES** - Memorial Hermann Physician Network (**MHMD**) is an organization developed and designed to promote the delivery of quality and operationally and economically efficient health care services. **MHMD** markets structured health plans ("**Plans**") to employers or other associations who provide health care services to enrollees. The Network Participation Criteria & Policies are intended to establish guidelines for granting qualified Doctors of Medicine, Doctors of Osteopathy, Dentists, and Podiatrists, (**Network Providers**) initial and continued participation in **MHMD**. The objectives of the criteria and policies are as follows:
- A. To determine eligibility of Doctors of Medicine, Doctors of Osteopathy, Dentists, and Podiatrists for **MHMD** participation.
 - B. To evaluate the **Network Providers'** practice profiles in the areas of medical training, malpractice history, patient satisfaction, clinical practice of medicine, and cost effectiveness in treatment planning.
 - C. To develop a balanced network which satisfies a geographic and specialty need of **MHMD** as determined by the **Board**.
 - D. To structure programs of utilization review, quality assurance and other medical peer review for **Network Providers**.
 - E. To clarify the relationship of individual members of **MHMD** and **Memorial Hermann Healthcare System (MHHS)** hospitals as well as hospitals and/or facilities who have affiliated with **MHHS** or have entered into joint ventures with **MHHS ("Plan Hospitals")** to minimize risk of liability to the organization.
- II. NETWORK PARTICIPATION CRITERIA - Provider Applicants and Network Providers** will be reviewed and considered for membership on a physician-by-physician basis according to the physician's qualifications, practice history in the community, network geographic and specialty need. In order to be considered for and to maintain membership in **MHMD**, **Provider Applicants** and **Network Providers** must meet the following minimum requirements as determined by the **Board**:
- A. **Medical Staff Membership Requirements:**
 - 1. **Provider Applicants** and **Network Providers** with clinical privileges* at an **MHMD**-participating facility must practice within the scope of those privileges as delineated by the **MHMD**-participating facility.
 - 2. **Provider Applicants** and **Network Providers** in the "recognized non-admitting" specialties of: Primary Care, Allergy/Immunology, Dermatology, Ophthalmology, Psychiatry and Rheumatology with non-clinical staff membership** at a Memorial Hermann Hospital may qualify for **MHMD** membership and must provide the names and contact information for the **MHMD** physician(s) who will provide in-patient services for their patients and the Memorial Hermann Hospital at which those services will be provided.
 - *Types of Clinical Privileges - Active, Active Network, Active Teaching, Active Clinical Courtesy, Provisional and Senior
 - **Non-Clinical staff membership - Affiliate, Consulting, Refer and Follow
 - 3. **Provider Applicants** and **Network Providers** in the "recognized non-admitting" specialties of: Primary Care, Allergy/Immunology, Dermatology, Ophthalmology, Psychiatry and Rheumatology with no staff membership at any hospital with in the MHHS service areas, may qualify for **MHMD** membership and must provide the names and contact information for the **MHMD** physician(s) who will provide in-patient services for their patients and the MHHS facilities at which those services will be provided.
 - B. **Board Certification Requirements - MHMD** recognizes only Board Certifications, sub-certifications and "Added Qualifications" of the American Board of Medical Specialties, the American Board of Podiatric Surgery, the American Board of Maxillofacial Surgery and the American Osteopathic Association. A foreign board may be recognized when the **Provider Applicant or Network Provider** supplies from the equivalent American Specialty Board documentation of equivalency between the Foreign and American Specialty Boards.

NETWORK PARTICIPATION CRITERIA & POLICIES

II. NETWORK PARTICIPATION CRITERIA - Board Certification Requirements – Continued

1. **Network Providers** must be and remain Board Certified in their primary practice specialty.
2. **Provider Applicants** or **Network Providers** must attain and maintain Board Certification by their practice specialty and/or sub-specialty board within five years after completion of their practice specialty or sub-specialty training.
 - a. Failure to attain Board Certification within said five (5) year grace period, or failure to maintain required Board Certification, will be deemed a voluntary relinquishment of **MHMD** membership and forfeiture of all **Contracted Plan** participation.
 - b. If at the time of membership reapplication (re-credentialing) a **Network Provider**, whose practice specialty board certification has expired, provides verification of a recertification exam or registration to take the recertification exam, may, at the **Board's** discretion be given up to 180 days from **Board** approval to provide verification of practice specialty recertification. Should the **Network Provider** fail to do so, he/she will be deemed to have voluntarily relinquished **MHMD** membership and forfeiture of all **Contracted Plan** participation.
3. **Board Certification Exceptions;**
 - a. The **Board** may grant a Specialty Board Certification exception for Primary Care physicians who completed training prior to 1978, and have demonstrated to the **Board's** satisfaction equivalent practice specialty competence and history in the community.
 - b. In July 1999 the **Board** granted a one-time Practice Specialty Board Certification exception for **Network Providers** who were active participating **Network Providers** prior to the approval of the July 1999 **MHMD** Membership Policies and Procedures.
 - c. The **Board** may grant at its discretion a Board Certification exception to Physicians joining **MHMD** due to hospital or organization acquisition, merger or affiliation. These **Provider Applicants** will be reviewed according to the **Provider Applicant's** qualifications, practice history in the community, geographic and specialty network need. This Exception may be granted under the following conditions:
 1. The application to **MHMD** must be made within 180 days of Medical Staff notification of the **MHHS** acquisition, merger or affiliation;
 2. The **Provider Applicant** must have successfully completed the provisional year of staff membership and have admitting privileges in good standing at the hospital; and
 3. Each **Provider Applicant** seeking a Board Certification exception must be reviewed individually by the Credentials Committee.

NOTE: Any **Provider Applicant** who completed a residency or fellowship training program in his/her primary specialty within the five year period prior to the acquisition, merger, or affiliation is not be eligible for the Section II (G) (4) Board Certification exception, and must become Board Certified in their practice specialty within five years after completion of their primary specialty training program.

- C. **Providers Participating through Group NPA's**– The criteria for **MHMD** membership participation provider groups are:
 - a. The group will be contracted as a group with **MHMD**.
 - b. Providers must bill under the same group tax id/NPI number.
 - c. More than 90% of the group's providers must meet the **MHMD** practice specialty board certification criteria.
 - d. Providers will be credentialed individually.

NETWORK PARTICIPATION CRITERIA & POLICIES

II. NETWORK PARTICIPATION CRITERIA- Continued

- D. **Professional ethics and standards - Provider Applicants and Network Providers shall** have an absence of professional disciplinary actions and agree to strictly abide by the ethics and standards of his/her profession. Must be licensed to practice medicine, dentistry or podiatry in the state of Texas and be without sanction, restriction, probation or other limitations, possess unrestricted Drug Enforcement Administration ("DEA") registration, (if applicable), possess unrestricted Texas State Department of Safety Controlled Substance Certificate ("DPS") (if applicable).
- E. **Network Providers** must have an absence of adverse actions taken against them by any other health care hospital, HMO, PPO, professional society, state or federal licensing agency or other health care entity and; be able to document to the satisfaction of the **Board** his/her background, experience, training, competency, physical and mental health, and adherence to the ethics of his/her profession with sufficient adequacy to enable the **Board** to determine that patients treated by him/her will be given appropriate and necessary health care in accordance with the **MHMD** objectives of quality, operational and economic efficiency.
- F. **Malpractice Liability - Provider Applicants and Network Providers** must have an absence of a history of denial or cancellation of professional liability insurance. Have a satisfactory malpractice claims and/or settlement history as determined by the **Board**. Provide evidence of required, continuous professional liability insurance (\$200,000/\$600,000 minimum) coverage and requested information on professional liability claims history and experience, including the name of carriers.
- F. **Practice Location - Provider Applicants and Network Providers** must document the location of patient accessible practice locations within the Network service area and the names and addresses of other **Providers** with whom he/she is associated so as to assure that services and coverage arrangements are available 24 hours per day, seven days per week.
- G. **References** - A Letter of reference, recommendation, or evaluation from the Director of the applicant's residency or fellowship program will be required from **Provider Applicants** who have been out of residency or specialty fellowship training programs for less than five years. The Committee at its discretion may request additional Peer References be provided by the active **Network Providers** who are not practicing partners of the applicant.
- H. **Policy Compliance** - In order to perform the functions, duties and obligations required of the **MHMD** By-laws, the Network Participation Criteria & Policies and the Network Participation Agreement and to maximize the delivery of quality, operationally and economically efficient patient care and the smooth operation of **MHMD, Network, Providers** must satisfy the **Board** with their ability and willingness to work cooperatively and in a supportive manner with others including but not limited to; patients, physicians, other healthcare professionals, **Contracted Plans, MHMD** and the staffs of **Plan Hospitals**.
- I. **Conviction/Indictment - Provider Applicants and Network Providers** may not have been convicted of a misdemeanor involving moral turpitude, and must not have at any time a criminal conviction or indictment. (A "conviction" includes a plea or verdict of guilty or a conviction following a plea of nolo contendere).

III. APPLICATION PROCESS - Upon receipt of a completed application on the prescribed form, the information in the application shall be verified, using National Committee Quality Assurance (**NCQA**), Utilization Review Accreditation Commission (**URAC**), Texas Department of Insurance (**TDI**) and **MHMD** processing criteria.

- A. **Incomplete Application - MHMD** shall notify the **Provider Applicant/Network Provider** if his/her application is not complete or if verification cannot be obtained and shall have no obligation to review or consider the application until the application and its verification have been completed. The burden of supplying or obtaining **Provider Applicant/Network Provider** requested information should rest with the **Provider Applicant/Network Provider**. The **Provider Applicant/Network Provider** must supply requested information to **MHMD** within 10 business days of notification. When the **Provider Applicant/Network Provider** fails to provide the requested information within said ten (10) business day period, the **Provider Applicant/Network Provider** will be deemed to have withdrawn his/her initial application or application for membership renewal.

NETWORK PARTICIPATION CRITERIA & POLICIES

III. APPLICATION PROCESS - Continued

- B. **Allied Health Professionals - Provider Applicants/Network Provider** who employ Allied Health Professionals such as, Physician Assistants, Advanced Practice Nurses, or Registered Nurse First Assistants, must provide the Allied Health Professionals, name, professional designation and state license number (Requested in the practice information section of the Texas Standardize Credentialing Application) and sign an addendum which states the following:
If you employ Physician Assistants, Advanced Practice Nurses, or Registered Nurse First Assistants, do you have written policies, which are implemented and enforced and describe the duties of all such providers in accordance with the statutory requirements for licensure and supervision as appropriate?" Options are "Yes" or "No".
- C. **Provider Rights & Notification: Provider Applicants and Network Providers** have the right to be notified of the following;
1. **Application Status** - Provider Applicants/Network Providers upon request shall be informed of the status of their credentialing and/or re-credentialing application.
 2. **Right to Review Information – Provider Applicants/Network Providers** who have applied or reapplied to MHMD have the right to review information submitted in support of their membership or membership renewal application.
 3. **Provider Notification of Differing Information - Provider Applicants/Network Providers** must be notified when information obtained during the credentialing process differs from self-reported information.
Note: The **Provider Applicant/Network Provider** may only review information obtained from any outside primary source such as; malpractice insurance carriers, state licensing boards or specialty boards. The **Provider Applicant/Network Provider** may not review references or recommendations or other information that is peer review protected.
- D. **Provisional Credentialing - MHMD** is an Independent Physician Association (IPA) whose members are credentialed and approved as individual providers by the **MHMD Board**. Once approved by the **Board - Network Providers** participate in the **MHMD** contracted plans as individuals.
- E. **MHMD Provider Applicants** do not meet the criteria for Provisional Credentialing of providers joining existing groups outlined in Texas Bill 1594.
- F. **Medical Director Review**- The completed application shall then be forwarded to the Medical Director for review and recommendation to the Credentials Committee. The Credentials Committee will review the application and shall make a recommendation to either approve, to defer a decision pending receipt of additional information or forward the application to the Board for additional review. Any recommendation to reject the application shall be accompanied by a statement of the reasons, and forwarded to the **Board** for further action in accordance with Section VII.
- G. **Denial of Application** - Denial of membership may be based on criteria related to the prompt, courteous, quality and operationally and economically efficient delivery of patient care in a **Plan Hospital**, to professional ability, judgment and conduct, or to the geographic and specialty needs of **MHMD**, the community or the patients served. Any **Provider Applicant/Network Provider** who fails to document to the **Board's** satisfaction compliance with the **MHMD** membership criteria and qualifications shall have his/her application denied.
1. Any misrepresentation, misstatement or omission in the initial or renewal application or any subsequent information provided for or during membership will constitute grounds for denial of the application or for termination of **MHMD** membership.
 2. **Providers** shall not be denied membership on the basis of gender, age, race, creed, color, ethnic/national origin, sexual orientation, types of procedures or types of patients the Provider Applicant specializes in or any other basis prohibited by law.
 3. **MHMD** will not discriminate in the selection or retention of **Network Providers** who serve high-risk populations or specialize in the treatment of costly conditions.
 4. The Provider **Applicant/Network Provider** will be notified via mail within 10 business days of the **Board's** decision

- IV. **INITIAL MEMBERSHIP** - After successfully completing the initial credentialing process the **Provider Applicant** will be offered a membership in **MHMD**. The **Provider Applicant** will be notified via mail within 10 business days of the **Board's** decision and will be provided with a copy of the **MHMD** Bylaws, the Network Participation Criteria & Policies and a Network Participation Agreement. The Network Participation Agreement must be signed and returned to **MHMD** in order for the **Provider Applicant** to be considered a **Network Provider**. It is the responsibility of the Network Provider to familiarize himself/herself with the contents of the Bylaws, the Network Participation Criteria & Policies and Network Participation Agreement.

NETWORK PARTICIPATION CRITERIA & POLICIES

- V. MEMBERSHIP RENEWAL** - Prior to completion of the Initial membership, the **Network-Provider** shall be required to seek renewal of his/her membership in **MHMD**.
- A. The **Network Provider** must renew his/her **MHMD** membership through re-credentialing every two (2) years from the date of full **MHMD** membership acceptance.
- B. The **Network Provider's** failure to renew **MHMD** membership prior to term expiration will be deemed to be a voluntary relinquishment of **MHMD** membership and forfeiture of **Contracted Plan** participation.
- C. Only those **Network Providers** who provide information regarding or otherwise document compliance with the following shall be eligible for renewal of membership;
1. Executed Network Participation Agreement
 2. Attest to current physical and mental health status
 3. Provide the name of each hospital, health care facility or practice setting where the **Network Provider** provides or provided patient services during the preceding membership period
 4. Provide the **Network Provider's** level of staff membership (active, courtesy, provisional, consulting, etc.) and percentage or usage at each hospital and healthcare facility he/she provides patient services
 5. Authorize **MHMD** to obtain requested information from each hospital, healthcare facility, medical society, professional medical organization, professional liability insurance carrier, and/or other individual or entity
 6. Disclose any sanctions, reprimands, investigations, complaints, or proceedings, of any kind which have been imposed or instigated by any hospital, health care facility, professional health care organization, professional society or licensing authority
 7. Current malpractice liability coverage
 8. Provide a complete medical narrative regarding each professional liability insurance claim, litigation, judgment, or settlement since the **Network Provider's** last credentialing or re-credentialing
 9. Demonstrated a satisfactory attitude toward his/her patients, **MHMD**, **Plans**, and **Plan** members, and the staff(s) of the **Plan Hospital(s)**
 10. Demonstrated compliance with all applicable **MHMD** Bylaws, the Network Participation Agreement, the Network Participation Criteria & Policies, and all other policies and rules promulgated by the **Board**
- D. After successfully completing the membership renewal/re-credentialing process at the end of the **Initial** term the **Network Provider** will be granted a full two year **MHMD** membership. The **Network Provider** will be notified via mail within 10 business days of the **Board's** decision. The fifteen month Network Participation Agreement will automatically renew every two years at the conclusion of each **MHNP** membership re-credentialing. It is the responsibility of the **Network Provider** to familiarize himself/herself with the contents of the Bylaws, and the Network Participation Criteria & Policies and Network Participation Agreement.

NOTE: Requests for renewal of membership shall be processed in the same manner as initial applications, or as may otherwise be required by the **Board**. In addition, the **Network Provider's** patterns of care including utilization, procedures performed in the **Plan Hospitals** as well as in the office, as demonstrated in the findings of the utilization review, quality assurance and other medical peer review activities, will be reviewed by the **Board** in connection with the renewal process.

- VI. ACCEPTANCE OF MEMBERSHIP** - In accepting membership each **Network Provider** shall be required to comply with the **MHMD** Bylaws, Network Participation Criteria & Policies and the Network Participation Agreement.
- A. **Notification - Network Provider** agrees to notify the **Board** within 5 (five) business days of any occurrence or change which may affect or relate to his/her compliance with the Network Participation Criteria & Policies including but not limited to; denials, revocations, non-renewals, restrictions, suspensions, imposition of probation, sanctions, reprimands, investigations, disciplinary action, fines or penalties, complaints or proceedings of any kind that have been threatened or imposed, and/or any change, whether voluntary or involuntary, to licensure membership and/or clinical privileges with regards to;
1. Professional medical, dental or podiatric license in Texas or any other state;
 2. DEA, DPS, or any other narcotic license or certificate;
 3. Hospital, academic institution and/or other healthcare organization staff membership, appointment or privileges;
 4. Medicare, Medicaid or other governmental program participation;

NETWORK PARTICIPATION CRITERIA & POLICIES

VI. ACCEPTANCE OF MEMBERSHIP – Notification Continued

5. Membership or fellowship in any professional medical society, medical organization, board organization, or peer review organization; or

6. Participation in any HMO, PPO, or prepaid health plan.

- B. **Directories - Network Providers** will be listed in **Contracted Plan** directories according to their board certified primary practice specialty and/or board certified or recognized sub-specialties or “Added Qualifications” and verified training approved by the **Board**. Where no ABMS recognized specialty board exists, **Network Providers** practice specialty listings will be consistent with all recognized training programs and the **MHMD Contracted Plans**.
- D. **Provider Cooperation** - Each **Network Providers** agrees to fully cooperate with all re-credentialing activities, and must meet all deadlines for providing requested information. A **Network Provider** who fails to comply with requests for information within the prescribed time period will receive a notification of non-compliance by certified mail return receipt requested and given thirty (30) calendar days from the **Network Provider’s** receipt of the notice of non-compliance to provide all outstanding requested information. Where the **Network Providers** fails to provide the requested information within said thirty (30) day period, the **Network Providers** will be deemed to have voluntarily relinquished his/her **MHMD** membership and forfeited **Contracted Plan** participation.
- E. **Membership Fees - Network Providers** shall be required to comply with the reapplication fee requirements of the **Board**. **Network Providers** shall be notified in writing by certified mail return receipt requested of nonpayment of fees and shall be given ten (10) business days from the **Network Provider’s** receipt of said notice to pay the fees. Where the **Network Provider** fails to pay the fee within said ten (10) business days the **Network Provider** will be deemed to have voluntarily relinquished his/her **MHMD** membership and forfeited **Contracted Plan** participation.
- F. **Confidentiality of Network Information - Network Providers** may from time to time receive proprietary information from **MHMD**. **Network Providers Member** agrees that such information shall be kept confidential and unless otherwise required by law, shall not be disclosed to any person except as authorized in writing by **MHMD**.
- G. **Contracted Plan Participation** - Availability to **MHMD**, as well as **Plans** who contract with **MHMD**, for a quality group of **Network Providers** is essential to the business of **MHMD** and each **Network Provider** of **MHMD**. Therefore, each individual **Network Provider** agrees to participate in a reasonable number of those **Contracted Plans** offered to the **Network Provider** as a condition of continued participation in **MHMD**.

VII. RESIGNATION - A **Network Provider** may officially resign from **MHMD** by submitting written notice to the **Board**. Resignation shall not relieve the resigning **Network Provider** from the **Network Provider’s** obligation to pay any dues or other charges accrued and unpaid. The **Network Provider** also agrees to cooperate with **MHMD** in arranging for the continuing care of any patients who may be affected by the **Network Provider’s** resignation.

VIII. TERMINATION, SUSPENSION, PROBATION OF MEMBERSHIP - Termination of membership is solely within the discretion of the **Board**. Prior to terminating membership, if appropriate, the **Board** may issue an oral or written warning or reprimand, or place the **Network Provider** on suspension or probation for a limited period of time.

- A. **Grounds for Suspension, Probation or Termination** - The grounds for suspension, probation or termination of membership apply whether concerns or complaints regarding a **Network Provider** are raised during the membership period or identified through the renewal process. The following may be grounds for suspension, probation or termination of membership;
1. The loss, restriction, probation, sanction, reprimand, fine or penalty assessed against the **Network Provider’s** professional medical license, DEA or DPS registrations, or by any other governmental agency.
 2. Reliable information that patients or prospective patients of the **Network Provider** may face imminent harm under his/her care
 3. Involuntary loss of a **Network Provider’s** membership or clinical privileges at a hospital, healthcare facility, professional health care organization or contracted health plan (excluding termination for medical record non-completion or for failure to satisfy meeting attendance requirements).
 4. Failure to timely notify the **Board** of any occurrence or change affecting or relating to the Network Participation Criteria & Policies or the Network Participation Agreement.

NETWORK PARTICIPATION CRITERIA & POLICIES

IX. TERMINATION, SUSPENSION, PROBATION OF MEMBERSHIP – Continued

5. Failure to comply with any of the **MHMD** Bylaws, Network Participation Criteria & Policies, Network Participation Agreement or breach of any condition or requirement which is necessary for **MHMD** to promote the delivery of quality and operationally and economically efficient patient care by its members.
6. Failure to cooperate or comply with quality assurance, utilization review, and other medical peer review activities.

IX. RIGHT OF REVIEW - Any **Provider Applicant** or **Network Provider** whose application for membership or membership renewal to **MHMD** has been denied or whose Network Participation has been suspended, placed on probation or terminated and who desires to appeal such decision is entitled to be provided a due process opportunity for review. This process does not apply to **Network Providers** who fail to complete the application for membership renewal or re-credentialing.

- A. **Initial Notice** - If the **Board**, has suspended, placed on probation, denied or terminated membership the affected **Provider Applicant** or **Network Provider** shall be notified in writing by the **Medical Director** prior to the suspension, probation or termination of the **Network Providers** Network Participation Agreement and/or contracted plan participation. The notice shall state the following:
1. The reason for the suspension, probation, denial or termination.
 2. The effective date and the length of the suspension or probation.
 3. The effective date of termination will be 90 days from the date of the notice; unless the termination should be immediate due to:
 - a. Providers loss of medical licensure
 - b. Conviction of a crime or
 - c. Section 7.2.b.i-iv of the Network Participation Agreement
 4. The fact that it is an “administrative decision”. The fact that the suspension, probation or termination is not reportable to the Texas Medical Board or National Practitioner’s Data Bank.
 5. That the **Provider Applicant** or the **Network Provider** has a right to file a written request for review within thirty (30) calendar days following receipt of the notice of suspension, probation, denial or termination either by hand delivery or by certified mail, return receipt requested, at the address specified in the notice of denial or termination. Delivery of the request for review will be deemed effective upon receipt if delivered in person and when postmarked if sent by certified mail, return receipt requested.
 6. If the **Provider Applicant** or **Network Provider** requests a review, the **Provider Applicant** or **Network Provider** must provide at the time such a request is made a detailed written rebuttal for the Special Review Committee to review that supports his or her request for review.
 7. That a **Provider Applicant** or **Network Provider** who either fails to request a review or fails to submit the reasons that support his or her review within the time and in the manner specified above waives all rights to any review to which he or she might otherwise have been entitled.
- B. **Review process for Board recommended suspensions, probation terminations or denials** Upon receipt of a proper written request for review from the affected **Provider Applicant** or **Network Provider** within the required time period and in the manner specified above, the Medical Director and the Chairman of the Special Review Committee shall appoint a Special Review Committee to conduct the review.
1. Composition of Special Review Committee - The Special Review Committee shall be composed of the Chairman of the Special Review Committee and no fewer than three (3) nor more than five (5) members of **MHMD**, who are experienced in the peer review process including a representative (as a non-voting member of the Special Review Committee) of the Credentials Committee.
 2. The **Provider Applicant** or the **Network Provider** is entitled to a review by an Special Review Committee that includes a representative of the **Provider Applicant’s** or the **Network Provider’s** specialty or similar area.
 - a. The Special Review Committee member in the same specialty as the affected **Provider Applicant** or **Network Provider** shall not have a conflict of interest with the **Provider Applicant** or the **Network Provider**.
 3. The review by the Special Review Committee must be conducted within 60 calendar days of the **Provider Applicant’s** or **Network Provider’s** request for appeal.
 4. The Special Review Committee may consider and make its decision on the basis of only the written materials before it; or

NETWORK PARTICIPATION CRITERIA & POLICIES

IX. RIGHT OF REVIEW - Continued

5. **May** at their discretion allow the **Provider Applicant** or **Network Provider** to make a personal appearance or interview by telephone conference before the Special Review Committee and conduct an informal hearing of the review/appeal.
6. In the event of a **Review Hearing** - the Medical Director shall send the **Provider Applicant** or **Network Provider** written notice including;
 - a. The time, place and date of the review hearing;
 - b. A list of members serving on the Special Review Committee and
 - c. The rules and process to be followed at the review hearing.
7. **Review Hearing Procedures** - In the event that the **Provider Applicant** or **Network Provider** is permitted to make a personal appearance before the Special Review Committee, the following procedures shall be applicable;
 - a. Any **Provider Applicant** or **Network Provider** who fails to appear at the hearing or fails to submit any information requested by the Special Review Committee shall be deemed to have waived any opportunity for any review, which he or she might otherwise have been entitled.
 - b. During the review hearing the Special Review Committee may allow the **Provider Applicant** or **Network Provider** to;
 1. Make an oral statement, introduce exhibits, present any documentary evidence determined to be relevant by the Chair of the Special Review Committee;
 2. Rebut any evidence, and submit an additional written statement at the close of the review hearing.
 3. The Special Review Committee shall establish any limitations on the time allowed for the **Provider Applicant's** or **Network Provider's** presentation, **MHMD's** presentation, and any rebuttal or question and answer period, and all other procedural issues.
 4. **MHMD** and the **Provider Applicant** or **Network Provider** may consult with legal counsel or other persons (whose attendance must be previously approved by the Special Review Committee), during the review hearing.
 - c. The review/appeal hearing shall be informal and not be conducted according to judicial rules of evidence and procedure. Regardless of the admissibility of the evidence in a court of law, any relevant evidence, including hearsay, shall be reviewed if it is the type of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs. At its discretion, the Special Review Committee may request or permit both sides to file additional written statements.
 - d. The Special Review Committee may recess and reconvene the review hearing without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or for further consultation.
 - e. Upon conclusion of the presentation of all evidence, the review hearing shall be adjourned. Then, at a convenient time, the Special Review Committee shall deliberate outside the presence of the parties. Upon conclusion of these deliberations, the review hearing shall be declared closed.
 - f. After completion of its review, the Special Review Committee shall render a recommendation accompanied by a written report, which shall be delivered to the **Board**.
- C. **Decision of the Board** - The **Board** shall review the recommendation of the Special Review Committee and render a decision, which may affirm, modify, or reverse the recommendation of the Special Review Committee or return the matter to the Special Review Committee with instructions for further action. The **Board** then shall notify the **Provider Applicant** or **Network Provider** of its decision. A notice of the recommendation shall be forwarded to the **Provider Applicant** or **Network Provider** within five (5) business days of the **Board's** decision. The decision of the **Board** to affirm, modify or reverse a recommendation of the Special Review Committee is final.
- D. **Right to One Review** - No **Provider Applicant** or **Network Provider** shall be entitled to more than one review of any matter that was the subject of an Adverse Recommendation
- E. **Reapplication** - Following termination of his or her **MHMD** Network Participation Agreement, the **Network Provider** shall not be permitted to contract with **MHMD** for a period of two (2) years from the date of the final decision of the **Board**, unless an exception is granted by the **Board**. **Network Providers** whose memberships were terminated for reasons other than failure to meet **MHMD** criteria must have Board approval prior to reapplication.

NETWORK PARTICIPATION CRITERIA & POLICIES

X. RIGHT OF REVIEW - Continued

F. **Release from Liability** - Each **Provider Applicant** or **Network Provider** agrees to release and hold harmless from liability all **MHMD** employees, agents, officers, directors and other representatives for any actions taken pursuant to this policy in connection with the resolution and final decision of any such Adverse Recommendation.

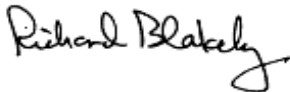
G. **Exhaustion of Remedies** - Each **Provider Applicant** or **Network Provider** agrees to be bound by all of the terms and conditions of this policy with respect to any Adverse Recommendation (and final decision) that may be made against such the **Provider Applicant** or **Network Provider**. Each **Provider Applicant** or **Network Provider** agrees to exhaust all available remedies under this policy before taking any further legal action in connection with the resolution of any such Adverse Recommendation (and final decision).

X. **AMENDMENT OF POLICY** The Network Participation Criteria & Policies will be reviewed annually or sooner as may be as required to maintain compliance with NCQA, URAQ or TDI other legal, Health plans or accreditation requirements, or and may be amended or repealed in whole or in part by one of the following mechanisms: resolution of the Credentials Committee, recommended to and adopted by the **Board**; or action by the **Board** on its own initiative, after notice to the Credentials Committee of its intent, such notice to include a reasonable period of time for response.

A. In the event that there is any inconsistency between any provisions of the Network Participation Criteria & Policies and any provisions of the Network Participation Agreement, the provisions of the Network Participation Agreement shall prevail and control.

B. The **Board** may at its discretion may make an exception to or waive any requirement, criterion, or provision of the Network Participation Criteria & Policies if it determines that to do so is reasonable and appropriate under the circumstances and consistent with the mission and purpose of **MHMD**. **MHMD** will notify the **Contracted Health plans** of **Provider Member** exceptions according to each Contracted Health plan's delegation policy.

Memorial Hermann Physician Network



Richard Blakely, M.D.
Chief Medical Officer

7/20/2012
Date