univera HEALTHCARE

SUBJECT: MALPRACTICE REVIEW SECTION: CREDENTIALING POLICY NUMBER: CR-17	EFFECTIVE DATE: 1/01
Applies to all products administered by the Plan except when changed by contract	

Policy Statement: For those practitioners who have been named in a malpractice claim, the Plan's policy assures a fair and unbiased review by an independent reviewer. The purpose of the review is to evaluate the practitioner's history for problematic trends, potential risk to the Plan members, and possible educational opportunities for the practitioner, if needed to establish remediation as a condition of continued participation.

Process:
All new and recredentialed practitioners will have source verification of all malpractice claims. Each practitioner is required to submit sufficient clinical background on each case for the Plan Medical Director and the Credentialing Committee ("Committee") to appropriately review the circumstances surrounding such claim(s).

1. Medical Director Review

The relevant and/or requested information is forwarded to a Plan Medical Director who reviews each case based on the practitioner's feedback and information received from various sources.

A Plan Medical Director reviews each case to determine whether:

a. Additional information is required from the practitioner.
If additional information is required, Plan Credentialing Staff will contact the practitioner.

b. If the case(s) warrant no concern**,** (e.g. no patterns) a Plan Medical Director will note "no issues" on the review form. This information is shared with the Credentialing Committee.

c. When a practitioner in the specialty of OB/Gyn, Orthopedic, Neurosurgery and Thoracic Surgery has five (5) cases or other physician specialties or non-physician practitioners, have three (3) cases, the practitioner is referred to the Credentialing Committee for discussion.

d. There is a pattern of adverse determinations extending back over time, in which case the practitioner is referred to the Credentialing Committee for discussion.

e. There are settlements in the current credentialing/ recredentialing cycle for aggregated amounts of $3,000,000 for all specialties.

If a Plan Medical Director requests Committee review, Plan Credentialing Staff will include all pertinent data into the Committee agenda.

2. Credentialing Committee Review

The Credentialing Committee will review the malpractice history of each practitioner applying for credentialing/re-credentialing and each case(s) referred by a Plan Medical Director based on information provided by the Plan Credentialing Staff. The following recommendations may be made by the Committee, including but not limited to:

a. Approval for up to the three-year time period,
b. Approval for a limited time frame to monitor the performance more closely,
c. Denial of the practitioner's application,
d. An Independent Reviewer reviews each malpractice case with additional information (sufficient records to be provided by the practitioner under review or when records unavailable, a summary consistent with applicable codes regarding release of information), and/or
e. An independent review of additional cases

If "d" or "e" above is invoked, the following actions will occur to coordinate an independent review:

1. A Plan Medical Director determines who the independent reviewer will be.
2. Credentialing Staff contacts the reviewer to complete the reviews.
3. Credentialing Staff will issue a letter to the practitioner under review advising them of the Plan's decision to have an independent review performed. The letter must also require the practitioner to send in the records that pertain to the case(s) identified. Failure of the practitioner to participate in this review will result in the denial of their current credentialing status or their application.
4. The review would be completed within 30 days of the reviewer's receipt of the requested records.
5. The findings of the independent review will be reported to the Plan Medical Director. The Plan reserves the right to request a second independent review.
6. The Plan Medical Director will make a recommendation to the Credentialing Committee based on the results of the independent reviewer(s).
7. The Credentialing Committee will consider the Plan Medical Director's recommendation and make a final decision regarding the applicant's application.
8. Credentialing Staff will be responsible for coordinating the communication of the final decision from the Committee to the practitioner.

All applicable practitioners whose application for credentialing/re-credentialing was denied on the basis of their malpractice claims will be offered a hearing in accordance with the Plan's fair hearing and appeal process.

Cross Reference:
Adopted from BlueCross BlueShield of the Rochester Area MCO Policy and Procedure #CR-17 Dated 12/99

Committee Approvals:
Corporate Credentialing Committee 12/15/03, 8/31/05, 7/25/07, 7/16/08, 6/16/10, 6/20/2012, 6/18/14, revised 8/20/14; 6/22/16; rev 6/20/2018; renewed 6/17/2020; revised 6/15/2022; renewed 4/17/2024

Excellus Credentialing Committee: 12/17/01
MCOCC 11/13/00
HCBMC 12/7/00
Revision 10/01

Original Source: Adopted from BlueCross BlueShield of the Rochester Area MCO Policy and Procedure #CR-17