Peer Review Credentialing Application

Please submit your CV along with you application.

Dear Peer Reviewer Applicant:

Thank you for your interest in the Acentra Health Peer Review Program. It signals your commitment to a significant objective – continuing improvement of the quality and utilization of health care services. Your participation in the peer review process is an ethical imperative. We fully appreciate the value of your time.

Acentra Health is a nationally recognized provider of healthcare management solutions in both state and federal government, as well as commercial clients, providing prior authorization, utilization and specialty review, and case and disease management services.

To accomplish our objectives, Acentra Health must have qualified peer reviewers who meet the following criteria. The peer reviewer:

- Shall have a minimum of five (5) years active practice experience, providing direct clinical care to patients as recent as within the past three (3) years
- Are Doctors of Medicine, Osteopathic Medicine, Dentistry, Podiatry, or other Allied Health Care Practitioners
- Holds an active, unrestricted license or certification to practice medicine or a health profession in a state or territory of the United States
- Must be Board Certified in a specialty recognized by the American Board of Medical Specialties, the Advisory Board of Osteopathic Specialists, the American Dental Association (ADA), the American Board of General Dentistry (ABGD), the American Board of Podiatric Surgery (ABPS), or the American Board of Podiatric Medicine (ABPM)
- Must be located within the United States or one of its territories when conducting an internal appeal or external review

Acentra Health can then ensure that all quality and utilization determinations that are completed and follow-up actions taken are the result of true peer review. Acentra Health provides liability coverage for peer reviewer activities. The reviewer's name will remain confidential, except in instances where identification is required by law or by specific contract. Acentra Health provides compensation for our reviewers based on the type of review or service being requested and/or amount allowed by the individual customer for whom the work is being performed. Compensation of services will be made within 30 days of receipt of the completed report and invoice.

While Acentra Health cannot guarantee any pre-established volume commitments, your approval as a credentialed peer reviewer will present you with opportunities to work with our organization in both the private and public sector. Please contact our Credentialing Department at Acentracredentialing@acentra.com with questions. We look forward to your participation in the peer review process.

~Acentra Health Credentialing

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INSTRUCTIONS FOR COMPLETING THE PEER REVIEWER APPLICATION AND CREDENTIALING PROCESS

Keystone Peer Review Organization, LLC (DBA Acentra Health) and its subsidiaries contract with various state and federal government agencies, as well as commercial insurance entities, to perform utilization reviews and or appeals. Individual contracts have unique requirements for documentation of reviewer credentials. The questions asked and information sought on the forms that follow are either requirements of those contracts and/or will facilitate our staff in contacting you regarding performance of review services. The Acentra Health application packet includes:

1. **Peer Reviewer Application:**
   This form collects information about your office, licensure, potential conflicts of interest, and experience. It includes questions applicable to Peer Reviewer Small Business Administration (SBA) information, which helps Acentra Health comply with federal government contracting requirements. Please complete this portion to allow Acentra Health to comply with contract requirements. *Note: The SBA section of the application requires your signature.*
   ****All applicants must complete this application.****
2. **Review Agreement:**
   This agreement explains the obligations of a peer reviewer and requests each applicant to specify those review types which he/she agrees to perform.
   ****All applicants must complete this Agreement.****
3. **HIPAA/Confidentiality Agreement:**
   This form is to acknowledge the applicant's understanding of confidentiality and disclosure policies.
   ****All applicants must read and complete this Agreement, and attest to their understanding and responsibilities under HIPAA, Code of Conduct, Conflict of Interest (COI), and Ethics.****
4. **Authority to Release Information:**
   To meet the requirements of certain contracts, a copy of this form may need to be submitted to the Medical Staff Director (or designee) of the facility in which you primarily practice and maintain staff privileges for confirmation of such privileges. ****This release must be completed by all applicants to ensure authorized release of confidential information.****
5. **Click the Submit button at the bottom of the last page of this document and attach a copy of your CV with the application.**

ACENTRA HEALTH CREDENTIALING / RE-CREDENTIALING APPLICATION

IDENTIFICATION INFORMATION			
(Click on the *TAB* key to move to next field)			
Date			
Last Name			
First Name			
Middle Initial			
Prefix			
Suffix (Jr., Sr., etc.)			
Title (e.g., MD, RN, MSW)			
SSN #			
NPI #			
Tax ID #			
Is Tax ID business or personal?	Business	Personal	
HOME INFORMATION			
Do you prefer to be contacted at home?	Yes	No	
Preferred Method of Contact (email, cell phone, other phone)			
Address 1			
Address 2			
City	State		Zip Code
County			
Phone			
Fax	Pager		Cell Phone
Email			
OFFICE INFORMATION			
Do you prefer to be contacted at your office?	Yes	No	
Preferred Method of Contact (email, cell phone, other phone)			
Business Name			
Contact Person			
Contact Title			
Email Address			
Address 1			
Address 2			
City	State		Zip Code
Phone		Cell Phone	

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LICENSURE INFORMATION	
o Physician	O Allied Health
License Number **Type** **State** **Expiration Date**	o Expired, not renewing o This is a restricted License
License Number **Type** **State** **Expiration Date**	o Expired, not renewing o This is a restricted License
For additional Licenses, please list information below	
BOARD CERTIFIED SPECIALTIES (MDs and DOs only)	
Specialty **Effective Date**	o This is a time-limited certification that expires: o This is a lifetime certification o I am willing to review this specialty
Subspecialty	o This is a time-limited certification that expires: o This is a lifetime certification
Specialty **Effective Date**	o This is a time-limited certification that expires: o This is a lifetime certification o I am willing to review this specialty
Subspecialty	o This is a time-limited certification that expires: o This is a life-time certification
SPECIAL QUALIFICATIONS: *Please provide a list of your special qualifications*	
For **Allied Health** professionals, please identify your certifications.	
For all applicants, please identify expertise you offer Acentra Health (Examples: languages other than English, expertise with particular settings, experience in specific contracts, such as HRSA or BFCC areas). Type as many as you have, separated by commas.	

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GENERAL QUESTIONS	
Are you currently involved in active practice?	❑ **Yes** ❑ **No** If yes, please estimate your average hours per week:
Are you currently involved in clinical teaching?	❑ **Yes** ❑ **No** If yes, please estimate your average hours per week:
Have you ever provided direct patient care?	❑ **Yes** ❑ **No** If yes, enter the date you started providing direct patient care: *Note: If your direct patient care has had periods of interruption, please enter the date that you most recently started providing direct patient care.*
Do you currently provide direct patient care?	❑ **Yes** ❑ **No** If yes, please estimate your average hours per week: If no, please indicate month and year you stopped providing direct patient care:
Do you have any gaps in work history?	❑ **Yes** ❑ **No** If yes, please explain. Please specify the amount of time that lapsed in work history, if greater than three months:
Have your privileges to practice been abridged or suspended in any way, or is any action now pending?	❑ **Yes** ❑ **No** If yes, please explain:
Do you currently have any charges or sanctions filed against you in a criminal, civil, or administrative proceeding, or do you have reason to believe that such charges or sanctions will be filed?	❑ **Yes** ❑ **No** If yes, please explain:
Have you ever entered a plea of guilty or nolo contendere where the offense involved the use or delivery of a controlled substance? If your conviction has been expunged, please answer No.	❑ **Yes** ❑ **No**
Have you ever been enrolled in any Professional Health Monitoring Program (PHMP)?	❑ **Yes** ❑ **No** If *Yes*, please provide the reason for your participation and the dates in which you were in PHMP. If yes, *h*ave you successfully completed the program? ❑ **Yes** ❑ **No**
Do you have utilization/quality assurance or peer review experience?	❑ **Yes** ❑ **No** If yes, give area of expertise and number of years' experience:
Are you willing to testify?	❑ **Yes** ❑ **No**
Do you have ABQAURP certification?	❑ **Yes** ❑ **No** Date of certification:
Are you willing to complete Expedited Reviews?	❑ **Yes** ❑ **No**

Peer Reviewer Acknowledgement	
I acknowledge that all information provided in this application and disclosure is true, correct, and complete to the best of my knowledge and belief. I will notify Acentra Health within three (3) business days of any material changes to the application. I understand and agree that any material misstatement or omission in this application may constitute grounds for denial or revocation of participation. I acknowledge that I have read this application in its entirety. I further agree that a photocopy of this document may serve as a duplicate original. Facsimile signatures or signatures imprinted in an electronic medium, such as .pdf format, shall be deemed to be original signatures.	
I have reviewed and agree to the Peer Reviewer Acknowledgement as outlined above.	☐ **Yes** ☐ **No**
By typing my name, I acknowledge that I have read and understood this application/document in its entirety and agree to the content of this document.	
Date signed	

Note: *Any firm that has misrepresented its status in the above listed categories in order to obtain a subcontract from Keystone Peer Review Organization, LLC, will be subject to the punishments as defined in 115 U.S.C.645(d) and FAR 52-219-9 (e).*

Signature of this form constitutes certification of compliance with all provisions within this form.

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REVIEW AGREEMENT

My signature at the conclusion of this agreement indicates my willingness to participate as a peer reviewer when requested by Acentra Health or its subsidiaries and to conduct reviews in accordance with the applicable contract, URAC, or state-mandated time frames.

I understand that Acentra Health is relying upon the current accuracy of the information contained in my Peer Reviewer Application and will continue to rely upon its accuracy in deciding whether to request my services as a reviewer.

I further understand that I will be compensated for my peer review services based on the type of review or service and/or amount allowed by the individual contract and that compensation to me as a peer reviewer for any provision of the services required hereunder does not contain direct or indirect incentives to make inappropriate review decisions. I agree to maintain and safeguard the confidentiality of all medical records and data received by me relevant to the performance review activities. I further agree to promptly advise Acentra Health of any issue with respect to a conflict of interest or perceived conflict of interest in connection with review activities.

I also agree to fully cooperate with Acentra Health and client personnel in connection with preparation of all time logs, administrative forms, review reports, depositions, and other oral or written testimony, which may be required in connection with my review activities.

I agree to notify Acentra Health within three (3) business days of any changes regarding my credentials or contact information noted within this application as well as any changes or restrictions to licensure, Drug Enforcement Administration (DEA) registration, and professional board certifications. Except to the extent specifically modified by this Agreement, I hereby ratify and affirm all authorizations, applications, consents, and agreements executed by me in

HIPAA/CONFIDENTIALITY AGREEMENT - PEER REVIEWERS

Acentra Health has entered into a Business Associate Agreement with a Covered Entity subject to the Health Insurance Portability and Accountability Act of 1996 and its implementing simplification regulations (45 CFR §§ 160-164) (HIPAA), which among other restrictions and conditions establish permitted uses and disclosures of Protected Health Information (PHI).

Pursuant to the terms of the Business Associate Agreement, Acentra Health is required to ensure that its agents (e.g., peer reviewers) and subcontractors agree to the same restrictions and conditions that apply to Acentra Health with respect to PHI.

In the course of providing peer review services for Acentra Health, you may create or receive PHI from or on behalf of Acentra Health, or a Covered Entity, or have access to PHI. Therefore, the following restrictions and conditions with respect to PHI apply to you as a peer reviewer:

I. DEFINITIONS

Terms used but not otherwise defined in this HIPAA Agreement shall have the same meaning as those terms in 45 C.F.R. §§ 160.103 and 164.501.

II. PERMITTED USES AND DISCLOSURES

Except as otherwise limited in this HIPAA Agreement, a peer reviewer may use or disclose PHI (1) to perform functions, activities, or services for, or on behalf of, Acentra Health and/or Covered Entity as directed by Acentra Health or in this HIPAA Amendment, provided that such use or disclosure would not violate HIPAA if made by Acentra Health or Covered Entity or (2) as required or permitted by applicable law, rule, regulation, or regulatory agency or by any accrediting or credentialing organization to whom the Covered Entity, Acentra Health, or the peer reviewer is required to disclose such PHI. In addition,

i. Peer reviewer may disclose PHI, if necessary, if the following requirements are met:
    a. The disclosure is required by law; or
    b. Peer reviewer obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies peer reviewer of any instances of which it is aware in which the confidentiality of the PHI has been breached.

ii. Peer reviewer may use PHI to provide Data Aggregation services to Acentra Health or Covered Entity as permitted by HIPAA.
    a. Restrictions: Peer reviewer shall not use or disclose PHI for any other purpose not described above.

b. Appropriate Safeguards: Peer reviewer shall implement appropriate and reasonable safeguards to prevent use or disclosure of PHI other than as permitted in this HIPAA Amendment. When reviews are performed at a location other than the Acentra Health office (i.e., at a reviewer's home or office), confidential information will be transported under reasonable security as follows:

    1. When confidential information is transported offsite, the vehicle will be locked. Confidential information must be placed in a locked trunk whenever possible. If the vehicle does not have a trunk, the information must be kept in a covered container (i.e., a box with a lid). Unattended confidential information will be stored under lock and key.
    2. When using public transportation, confidential information must be carried in a locked briefcase or suitcase or in a covered container.
    3. Any confidential information mailed to or from offsite locations must be properly packaged and deposited in an official United States Post Office receptacle, delivered directly to a post office, or mailed using a mailing service, which has been approved by Acentra Health. The information must not be placed in private mailbox for pick-up.

c. Reporting of Improper Use or Disclosure: Peer reviewer shall report to Acentra Health in writing any use or disclosure of PHI of which he/she becomes aware that is not in compliance with the terms of this HIPAA agreement.

d. Mitigation: Peer reviewer shall mitigate, to the extent practicable, any harmful effect that is known to the peer reviewer of a use or disclosure of PHI in violation of the requirements of this HIPAA agreement.

III. **TERMINATION**

Term: The Term of this HIPAA agreement shall be effective as of the date set forth below and shall terminate when peer reviewer ceases to perform peer review services for Acentra Health, however, certain obligations shall survive termination of this HIPAA agreement as set forth in Section III C.

A. Termination for Cause: In the event that a peer reviewer materially breaches any provision of this HIPAA agreement and fails to cure or take substantial steps to cure Page 14 of 16 such material breach to Acentra Health's satisfaction within thirty (30) days after receipt of written notice from Acentra Health, Acentra Health will terminate the services of the peer reviewer.

B. Return or Destruction of PHI: Upon termination, if feasible, peer reviewer shall return or destroy all PHI received from, or created or received on behalf of, Acentra Health and/or Covered Entity that the peer reviewer still maintains in any form and shall retain no copies of such information. Prior to doing so, peer reviewer further agrees to recover any PHI in the possession of its subcontractors or agents. If it is not feasible to return or destroy PHI, peer reviewer shall provide to Acentra Health notification of the conditions that make return or destruction of PHI infeasible. Peer reviewer shall continue to extend the protections of this HIPAA agreement to such PHI and limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible.

IV. **MISCELLANEOUS**

A. No Third-Party Beneficiaries: Nothing expressed or implied in this HIPAA Agreement is intended to confer, nor shall anything herein confer, upon any person other than Acentra Health, the peer reviewer, and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

B. Governing Law: This HIPAA Agreement shall be governed by and construed in accordance with the substantive law of the Commonwealth of Pennsylvania without regard to conflicts of laws, unless parties mutually agree to change governing law.

III. **INDEMNIFICATION**

The Parties agree to indemnify, defend, and hold harmless each other and each other's respective employees, directors, officers, subcontractors, agents, or other members of each other's workforce (collectively referred to as the "Indemnified Party") against all costs suffered by the Indemnified Party, including but not limited to any and all actual and direct losses, liabilities, fines, penalties, costs, or expenses (including reasonable attorneys' fees) arising from or in connection with a material breach of this HIPAA agreement by the Indemnifying Party. This provision shall survive the expiration or termination of this HIPAA agreement.

1. I have received, read, and understand Acentra Health's restrictions and conditions with respect to PHI, as detailed in this agreement.
2. I will conduct myself in accordance with these restrictions and conditions.
3. I understand that to violate these restrictions and condition will lead to immediate termination of my services by Acentra Health.
4. I also understand that unauthorized disclosures of medical information or PHI may lead to:
    a. a fine of not more than $1,000 and/or imprisonment for not more than six months, under the Social Security Act;
    b. criminal penalties with a maximum fine of $250,000 and up to ten years in prison for misuse of such information and civil penalties up to $100 per person per violation.

AUTHORITY TO RELEASE INFORMATION

In applying for appointment as a peer reviewer or consultant to Acentra Health and/or its subsidiaries, I, hereby authorize Acentra Health, or its representatives, to consult with Name of Applicant healthcare facilities with which I have been associated and with others who may have information bearing on my professional qualifications, clinical competence, credentials, behavior, or any other matters which may be relevant to my appointment as a peer reviewer. I release from any liability
all representatives of Acentra Health for their acts performed in good faith and without malice in connection with evaluating me and my credentials and release from liability all individuals and organizations who provide information to Acentra Health, or its designees, in good faith and without malice concerning my professional qualifications, clinical

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PEER REVIEWER APPLICATION POTENTIAL EXCLUSION

A peer reviewer applicant, at the time of initial credentialing or recredentialing, may be declined participation for the following:

1. Evidence of incompetence, meaning the gross or repeated deviation from the standard of care by failing to conform to minimal standards of acceptable and prevailing medical practice or failure to maintain appropriate professional boundaries.
2. Evidence that the applicant has engaged in any unethical conduct, including actions likely to deceive, defraud, or harm patients or the public.
3. Evidence that the applicant has been sanctioned or has sanctions pending by federal, state, or local government programs.
4. Evidence that the applicant has personally engaged in or otherwise contributed to the submission of claims for payment that were false, negligently incorrect, intentionally duplicated, or indicated other abusive billing practices.
5. Evidence that the applicant has engaged in any conduct resulting in a felony or gross misdemeanor conviction. For purposes of this provision, a plea of guilty or a plea of no contest to a felony or gross misdemeanor charge constitutes a conviction.
6. Evidence that the applicant has engaged in any sexual misconduct or in any behavior toward a patient that could be reasonably interpreted by the patient as physical, emotional, or sexual abuse or harassment.
7. Evidence of using or prescribing for self or self-administration of any controlled substance, dangerous drug (as specified in law), or alcoholic beverages, which are dangerous or injurious to the applicant, any other person public, or that the practitioner's ability to practice safely is impaired by that use.
8. Evidence of repeated acts of clearly excessive prescribing, furnishing, administering of controlled substances, repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and the medical reason for prescribing (note that in no event shall a physician or surgeon who is lawfully treating intractable pain be reported for excessive prescribing).
9. Evidence that the applicant has had hospital privileges suspended or revoked for other than the failure to sign medical records.
10. Evidence that the applicant does not hold an active, unrestricted license or certification to practice medicine or a health profession in a state or territory of the United States. Thank you for your interest in participating as a peer reviewer.

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FEDERAL CONTRACTING DESIGNATION DEFINITIONS

1. **Small Business Concern –** A business concern eligible for assistance from SBA as a small business is one that is organized for profit with a place of business located in the United States. It must operate primarily within the United States or make a significant contribution to the U.S. economy through payment of taxes or use of American products, materials, or labor. Together with its affiliates, it must meet the numerical size standards as defined in the Small Business Size Regulations, 13 CFR 121. For more information, please go to Size standards (sba.gov)
2. **Woman-Owned Small Business -** A business that meets the following criteria: (a) Is at least 51 percent owned by one or more women; or, in the case of any publicly owned business, at least 51 percent of the stock of which is owned by one or more women; and (b) Whose management and daily business operations are controlled by one or more women." For more information, please go to Women-Owned Small Business Federal Contracting Program (sba.gov)
3. **HUBZone** – Historically Underutilized Business Zone. To qualify as a HUBZone small business concern, the firm must be: (a) Small; (b) Located in a "historically underutilized business zone" (HUBZone); (c) Owned and controlled by one or more U.S. Citizens; and (d) One that at least 35 percent of its employees reside in a HUBZone. For more information, please go to HUBZone program (sba.gov)
4. **Self-Certified Business** - A small business must be at least 51 percent owned and controlled by a socially and economically disadvantaged individual or individuals. African Americans, Hispanic Americans, Asian Pacific Americans, Subcontinent Asian Americans, and Native Americans are presumed to qualify. Other individuals can qualify if they show by a preponderance of evidence that they are disadvantaged. All individuals must have a net worth of less than $750,000, excluding the equity of the business and primary residence. Successful applicants must also meet applicable size standards for small businesses in their industry. For more information, please go to Size standards (sba.gov).
5. **Veteran-Owned Small Business** - A small business concern where: (A) Not less than 51 percent of which is owned by one or more veterans (as defined at 38 U.S.C. 101(2)) or, in the case of any publicly owned business, not less than 51 percent of the stock of which is owned by one or more veterans; and (B) The management and daily business operations of which are controlled by one or more veterans. According to 38 U.S.C. 101 (2), veteran is defined as “a person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable.” For more information, please go to Veteran-owned businesses (sba.gov).
6. **Service-Disabled Veteran-Owned Small Business** - A small business concern where:(A) Not less than 51 percent of which is owned by one or more service-disabled veterans or, in the case of any publicly owned business, not less than 51 percent of the stock of which is owned by one or more service-disabled veterans; and (B) The management and daily business operations of which are controlled by one or more service-disabled veterans or in the case of a veteran with permanent and severe disability, the spouse or permanent caregiver of such veteran. A service-disabled veteran means a veteran, as defined in 38 U.S.C. 101(2), with a disability that is service-connected, as defined in 38 U.S.C. 101(16). From U.S.C. 101 (16), the phrase service connected (in terms of service disabled) means: “with respect to disability or death, that such disability was incurred or aggravated, or that the death resulted from a disability incurred or aggravated, in line of duty in the active military, naval, or air service.” For more information, please go to Veteran-owned businesses (sba.gov).

Save a copy for your personal record.

Email this application along with your CV to Acentracredentialing@acentra.com.