eq·Health solutions

PHYSICIAN REVIEWER APPLICATION

Name	Credentials (MD, DO, MBA, MPH, etc)	SSN#

OFFICE	HOME
Address	Address
Phone	Phone
Fax	Fax
Date available to begin review:	Please give both an office and a home address, but indicate which you prefer as your mailing address for review documents. ☐ **Office** ☐ **Home**
Pager	Assistant's Name
Cell Phone	Assistant's Phone
Email	
IL License #	

Other State Licensures:			
State:	Number:	State:	Number:

Board Certified? ☐ **Yes** List certified specialty(ies) and **sub**specialty(ies):

Board Eligible? (Residency completed) ☐ **Yes** Residency specialty(ies):

Additional Training:

Primary Practice Setting:

Number of hours per week in clinical practice:

Hospital(s) where you have admitting privileges:

Do you currently serve as a faculty member of a medical school or teaching facility? ☐ **Yes** ☐ **No**		
List any professional organizations to which you belong:		
Do you routinely treat Medicaid recipients? ☐ **Yes** ☐ **No**	Is your practice predominately: ☐ **MSA** *(medically served area)* ☐ **Non MSA** *(rural)*	**Medicaid Number**

Are you willing to discuss cases with attending physicians? ☐ **Yes** ☐ **No**	Are you willing to participate in criteria development and/or specialty committees? ☐ **Yes** ☐ **No**	Are you willing to participate in quality review panels? ☐ **Yes** ☐ **No**

PLEASE READ THE FOLLOWING CAREFULLY: A physician may not review health care services or make initial denial determinations and determinations regarding the quality of care if he/she is subject to any license restrictions, current sanctions and/or fraud and abuse issues from the Illinois Department of Healthcare and Family Services, the Illinois Department of Professional Regulation, Office of the Inspector General, and/or the Center for Medicare and Medicaid Services.

Do any of the above circumstances apply to you? ☐ **Yes** ☐ **No**

If yes, please explain:

I hereby certify that all information provided is accurate and true. I have read and understand the above information and give my permission to eQHealth Solutions to contact any of the above facilities/organizations to verify this information.

Signature: **Date:**

Please INCLUDE COPIES of the following documents to support information given on this application:	**Please also sign, date and attach the following forms included in this packet:**
☐ CV	☐ Licensure Attestation Statement
☐ Illinois Medical License	☐ Conflict of Interest Attestation
☐ Other State Medical Licenses	☐ Contract
☐ Degree (MD, DO)	☐ Physician Reviewer Job Description
☐ Board Certifications or residency completions	☐ Physician Reviewer or Associate Medical Director Attestation Sheet
☐ Hospital Admitting Privileges from at least one facility (form letter included)	☐ Physician Data Form
	☐ Sub-Business Associated Agreement

Please return this completed form with ALL REQUIRED DOCUMENTATION (refer to checklists directly above). Until all necessary documentation is received, your application cannot be processed.

Mark the envelope “CONFIDENTIAL” and return your information to: eQHealth Solutions NFP
ATTN: Physician Credentialing2050-10 Finley Road
Lombard, IL 60148

HOSPITAL ADMITTING PRIVILEGE VERIFICATION

Date:	
Hospital Name:	
Address:	
Fax:	

Dear Sir or Madam:

eQHealth Solutions conducts utilization review and peer review services for the Department of Healthcare and Family Services. As part of our credentialing and recredentialing procedure, eQHealth Solutions requires verification of admitting privileges for contract physicians. We are requesting your assistance at this time in this verification process. Please check below to indicate whether the following physician(s) have admitting privileges at the above named facility.

Please complete and fax back to **(630) 317-5202**, Attn: Angela Perry, Medical Director. Your prompt assistance is appreciated.

	Admitting Privilege		**Comments**
Dr. ______________________________	☐ **YES**	☐ **NO**	_________________
Dr. ______________________________	☐ **YES**	☐ **NO**	_________________

Facility Representative
Please print Name and Title

____

Signature_______________________________________

Date____

Sincerely,
Angela Perry MD
Medical Director
eQHealth Solutions NFP

eQ·Health solutions

CONFLICT OF INTEREST ATTESTATION STATEMENT

CONFLICT OF INTEREST

Conflict of Interest: *No Physician Reviewer and/or Consultant shall review any case in which he or she has a conflict of interest. A conflict of interest is defined as follows:*

(1) Any case in which the Physician Reviewer and/or Consultant rendered medical care, either directly or indirectly, or

(2) Any case from a facility, physician, and/or patient with whom the Physician Reviewer and/or patient with whom the Physician Reviewer and/or Consultant has a financial interest, or

(3) Any case in which the Physician Reviewer and/or Consultant requests refusal of review because objectivity may be at risk for personal or professional reasons.

Federal (42 CFR §476.98):
PHYSICIANS EXCLUDED FROM REVIEW
A physician may not review health care services or make initial denial determinations and determinations regarding the quality of care if he or she has, or is perceived to have, a conflict of interest such as:

- *Participation in developing or executing the participant's treatment plan,*
- *Being a member of the participant's family,*
- *Being a governing body member, officer, partner, five percent or more owner or managing employee of facility where the services were/are to be furnished,*

or

- *Any license restrictions, current sanctions and/or fraud and abuse issues from the Illinois Department of Public Aid, Office of the Inspector General, Illinois Department of Professional Regulations, or the Center for Medicare and Medicaid Services.*

I understand and will abide by the above protections against a conflict of interest affecting the peer review process.

SIGNED: ____

PRINTED NAME: _________________________________

DATE:____

Change in Professional Licensure Status
Attestation Statement

To Whom It May Concern:

As a licensed physician conducting utilization review activities for eQHealth Solutions $_{\text{NFP}}$, I hereby state that I understand it is my obligation to report to my immediate supervisor any change in the status of my professional licensure. I agree to report any change as soon as I become aware of such information.

Furthermore, I have reviewed, read, and understand the eQHealth Solutions Credentialing/Recredentialing Policy and Procedures and agree to follow proper procedure in the event of a change in my professional licensure status. I also agree to allow verification of my professional licensure status as outlined in the policy or any time deemed necessary by eQHealth Solutions.

I understand that changes in licensure status may be grounds for disciplinary action per eQHealth Solutions policy up to and including dismissal.

SIGNED: ____

PRINTED NAME: ____________________________________

DATE:____

Physician Reviewer or Associate Medical Director Attestation Statement

In order for eQHealth Solutions $_{NFP}$ to adhere to company standards for Physician Reviewer or Associate Medical Director credentialing, I hereby give permission to eQHealth Solutions to verify required information regarding my professional credentials and qualifications from educational facilities, the chief(s) of the clinical department(s) of the hospital(s) in which I currently have or formerly have had staff privileges, professional certification boards, state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities, and present and past employers.

I hereby authorize the educational facilities, the chief(s) of the clinical department(s) of the hospital(s) in which I currently have or formerly have had staff privileges, professional certification boards, state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities, and present and past employers to submit information requested by eQHealth Solutions including otherwise privileged or confidential material relative to my professional qualifications, credentials, past and present malpractice coverage, claims and suit information, clinical and/or professional competence, character, ethics, or any other matter having bearing on the credentialing procedure. I hereby further release all such entities, their representatives, employees and agents from any and all liability for any damages which may result from providing this information as long as such release of information is done in good faith and without malice.

I agree that a photocopy of this document with my signature may be accepted by any entity from which such information is sought, with the same authority as the original, and I specifically waive written notice from any such entities or individuals which may provide information based upon this authorized request.

I represent that information provided in or attached to this application is accurate and complete. I understand that a condition of this application is that any misrepresentation, misstatement or omission from this application, whether intentional or not, is cause for automatic and immediate rejection of this application by eQHealth Solutions. I agree to inform eQHealth Solutions in writing within 15 days if there is any change in the information provided on the application as a result of developments subsequent to my signing this application.

SIGNED: ____

PRINTED NAME: ____________________________________

DATE: ____

CONTRACT FOR SERVICE AGREEMENT
Physician Reviewer

AGREEMENT BETWEEN:

NAME:	
ILLINOIS MEDICAL LICENSE:	

And eQHealth Solutions $_{NFP}$.

Purpose: The purpose of the Agreement is to outline the responsibilities of the above named Physician Reviewer and/or Consultant and eQHealth Solutions.

Nature of Services: The Physician Reviewer and/or Consultant agrees to review the medical data submitted to him/her by eQHealth Solutions and to prepare and/or provide eQHealth Solutions, in legible written form, the details qualifying the conclusions and results of all review determinations made by the Physician Reviewer and/or Consultant. The physician reviewer shall, where possible, make a determination of medical necessity, quality of care, appropriateness of treatment, and/or appropriate level of care as defined by the Illinois Department of Healthcare and Family Services (HFS), using his/her best medical judgment. The Physician Reviewer and/or Consultant will submit the completed materials to eQHealth Solutions in such form and fashion as required by eQHealth Solutions.

Site of Review: The site of review will be either the Physician Reviewer's and/or Consultant's office, eQHealth Solutions offices, or at other such locations as may be mutually acceptable to both parties.

Compensation for Services: eQHealth Solutions shall compensate for the review work according to the Board of Director's policy, prorated at the rate of **$75.00**. eQHealth Solutions shall not be obligated to pay for reviews not completed or which are not in compliance with current requirements.

Meetings of the various committees and subcommittees of eQHealth Solutions shall be compensated at the rate of **$75.00** for actual meeting time, excluding travel time.

Eligibility: The Physician Reviewer and/or Consultant certifies that he or she meets the requirements for a physician reviewer as outlined below:

1. Must be licensed in Illinois.
2. In active practice in the Illinois Medical Assistance Program service area.
3. It is desirable to treat Medicaid Participants on a routine basis.
4. Staff privileges in at least one (1) health care facility (e.g., hospital) in Illinois. Active staff privileges means that a physician is authorized on a regular basis to order an admission to a facility, perform diagnostic services in a facility, or care for and treat patients in a facility.
5. Board Certified (or "Board Eligible") in their specialty.
6. Good standing with the Illinois Department of Professional Regulation and the Medicaid program.

Confidentiality: The Physician Reviewer and/or Consultant understands and agrees that any information, privileged or non-privileged by definition, to which he or she has access as a Physician Reviewer and/or Consultant of eQHealth Solutions, is to be treated in a confidential manner and shall not be discussed with anyone except as necessary to carry out his/her responsibilities, nor shall it be released to anyone without the express approval of the Project Director. The Physician Reviewer and/or Consultant has been advised and understands the penalties which may be imposed for any breach of confidentiality.

CONTRACT FOR SERVICE AGREEMENT
Physician Reviewer

NAME:	

Conflict of Interest: No Physician Reviewer and/or Consultant shall review any case in which he or she has a conflict of interest. Conflict of Interest is defined below.

A. Federal (42 CFR §476.98):

(d) Persons excluded from review.

(1) A person may not review health care services or make initial denial determinations or changes as a result of DRG validations if he or she, or a member of his or her family—

(i) Participated in developing or executing the beneficiary's treatment plan;

(ii) Is a member of the beneficiary's family; or

(iii) Is a governing body member, officer, partner, 5 percent or more owner, or managing employee in the health care facility where the services were or are to be furnished.

(2) A member of a reviewer's family is a spouse (other than a spouse who is legally separated under a decree of divorce or separate maintenance), child (including a legally adopted child), grandchild, parent, or grandparent. **AND**

B. A conflict of interest is also defined for purposes of this Agreement as follows:

1. Any case in which the Physician Reviewer and/or Consultant rendered medical care, either directly or indirectly, or
2. Any case from a facility, physician, and/or patient with whom the Physician Reviewer and/or patient with whom the Physician Reviewer and/or Consultant has a financial interest, or
3. Any case in which the Physician Reviewer and/or Consultant requests refusal of review because objectivity may be at risk for personal or professional reasons.

Liability: eQHealth Solutions does carry professional liability insurance for peer review, which provides Indemnification against claims arising from work performed as Physician Reviewer and/or Consultant, subject to the conditions and limitations of the policy.

Other Obligations: The Physician Reviewer and/or Consultant shall keep his/her state license or certificate current and will notify eQHealth Solutions within ten (10) working days of any factors that would render him or her ineligible to practice or to maintain a license or certificate. eQHealth Solutions shall also be notified within ten (10) working days of any denial or renewal, lapse, suspension, probation, conditional approval, termination of any state license or certificate governing his/her right to practice medicine, change in clinical practice, or change in specialty Board Certification.

Non-Participation: This agreement shall not require eQHealth Solutions to provide the Physician Reviewer and/or Consultant with any specified number of cases for review or that HSI must maintain the Physician Reviewer and/or Consultant on the list of eligible Physician Reviewers and/or Consultants. The Physician Reviewer and/or Consultant shall notify eQHealth Solutions if he or she no longer desires to participate and will return all case materials not yet completed or reviewed to eQHealth Solutions.

Period of Agreement: The Agreement shall be in effect the date indicated below unless amended or cancelled by eQHealth Solutions or until the Physician Reviewer and/or Consultant submits a written intention to withdraw from the eQHealth Solutions Agreement. I understand and accept the terms of this Agreement.

______________________________ ____________________

Physician Reviewer Date

______________________________ ____________________

Medical Director Date

JOB DESCRIPTION

Position: Physician Reviewer (PR)
Reports to: Medical Director

Qualifications and Requirements:

- Must have a current Illinois unrestricted license to practice medicine in all its branches.
- Must be board certified or board eligible by a specialty board approved by the American Board of Medical Specialties (MD's); or the Advisory Board of Osteopathic Medicine.
- Must be in active practice, and have admitting privileges to one or more Illinois healthcare facilities.
- Must be in good standing with the Department of Healthcare and Family Services (HFS) and with the Office of the Inspector General (OIG).
- Must have strong verbal and written communication skills.
- Required to maintain professional behavior in dealing with colleagues and nurse staff.
- Maintain CME credits for proper credentialing process of license.
- Actively participate in quality improvement activities.
- Assure availability during scheduled time.
- Be able to apply sound medical judgment during the review process.

I have read and understand the above job description.

SIGNED: ____

PRINTED NAME: _____________________________________

DATE:____

SUB BUSINESS ASSOCIATE AGREEMENT

This Sub Business Associate Agreement is made and entered into on this _____ day of __________________, 20__ by and between eQHealth Solutions (hereinafter referred to as "Business Associate") and _______________________________ (hereinafter referred to as "Sub Business Associate").

BACKGROUND

WHEREAS, the Business Associate has been engaged by the Illinois Department of Health care and Family Services (the "Program") to provide certain services as described herein on behalf of the Program;

WHEREAS, the Program may disclose or require health care providers to disclose Protected Health Information as defined by the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. part 160 and part 164, subparts A and E of the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA Privacy Rule") for the performance of these services on behalf of the Program;

WHEREAS, the Business Associate has entered into a business agreement with the Program whereby the Business Associate has agreed to require any agent, such as Sub Business Associate, to whom it provides Protected Health Information received from or on behalf of the Program, to agree to the same restrictions and conditions that apply to the Business Associate through a business associate agreement between the Business Associate and the Program;

WHEREAS, the Business Associate and Sub Business Associate desire to enter into an agreement that defines the obligations of the two parties with respect to the Protected Health Information provided to the Sub Business Associate to provide the services described herein;

THEREFORE, in consideration of the foregoing, the Parties agree to the following:

1. Definitions. The following terms shall have the meanings noted below for purposes of this Business Associate Agreement:

(a) Individual. "Individual" means the person who is the subject of Protected Health Information and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

(b) Protected Health Information. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 C.F.R. § 164.501, and is limited to the information created or received by the Sub Business Associate from or on behalf of the Business Associate.

(c) Required By Law. "Required By Law" means a mandate contained in law that compels an entity to make a use or disclosure of Protected Health Information and that is enforceable in a court of law. Examples of "required by law" includes, but is not limited to, court orders and court-ordered warranties; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; and statutes or regulations that require the production of information.

(d) Secretary. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.

2. Obligations of the Sub Business Associate. The Sub Business Associate agrees to the following:

(a) Sub Business Associate agrees to not use or disclose Protected Health Information received from, or on behalf of, the Business Associate other than to perform the services described in this Agreement or as Required By Law.

(b) Sub Business Associate agrees to use appropriate safeguards to prevent any use or disclosure of Protected Health Information received from or on behalf of Business Associate other than to perform the services described in this Agreement.

(c) Sub Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Sub Business Associate of a use or disclosure of Protected Health Information by Sub Business Associate in violation of the requirements of this Agreement or the HIPAA Privacy Rule.

(d) Sub Business Associate agrees to report to the Business Associate any use or disclosure of Protected Health Information not provided for by this Agreement of which the Sub Business Associate becomes aware.

(e) Sub Business Associate agrees to provide the Business Associate access at any time to Protected Health Information to enable the Business Associate to comply with the requirements of the HIPAA Privacy Rule that provide an individual with the right to access their Protected Health Information provided in 45 C.F.R. § 164.524.

(f) Sub Business Associate agrees to include any amendment(s) to Protected Health Information provided by the Business Associate to comply with the requirements of the HIPAA Privacy Rule that provide an individual with the right to request an amendment to their Protected Health Information provided in 45 CFR § 164.526.

(g) Sub Business Associate agrees to make its internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by the Sub Business Associate on behalf of, the Business Associate available to the Business Associate, or to the Secretary or designated by the Secretary, for purposes of the Secretary determining the Business Associate's compliance with any business associate agreement between the Business Associate and other persons or entities.

(h) Sub Business Associate agrees to make available to Business Associate in response a request from an individual, information required for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528. Sub Business Associate shall provide such information necessary to provide an accounting within thirty (30) days of the Business Associate's request.

3. Permitted Uses and Disclosures by Sub Business Associate.

(a) Except as otherwise provided in this Agreement, the Sub Business Associate may use or disclose Protected Health Information received on behalf of the Business Associate to perform health care utilization review and quality review, as well as any other consultation or project which requires the presentation of protected health information from the Business Associate to the Sub Business Associate.

(b) Except as otherwise limited in this Business Associate Agreement, Sub Business Associate may use Protected Health Information for the proper management and administration of the Sub Business Associate or to carry out the legal responsibilities of the Sub Business Associate.

4. Provisions for Business Associate to Inform the Sub Business Associate of Privacy Practices and Restrictions. The Business Associate shall make the following notifications to the Sub Business Associate, if applicable:

(a) Business Associate shall notify the Sub Business Associate of any restriction or limitation(s) that may affect the use or disclosure of Protected Health Information by the Sub Business Associate.

(b) Business Associate shall notify Sub Business Associate of any changes in, or revocation of, permission by any Individual to use or disclose Protected Health Information, to the extent that such changes may affect the Sub Business Associate's use or disclosure of Protected Health Information.

5. Term and Termination

(a) Term. The Term of this Agreement shall be effective as of _______________, and shall remain in effect until terminated in accordance with the terms of this Agreement.

(b) Termination Without Cause. The Business Associate may terminate this Agreement for any reason upon thirty (30) days written notice of such failure to the Sub Business Associate.

(c) Termination for Breach. The Business Associate, at its sole discretion, may immediately terminate this Agreement and shall have no further obligations to the Sub Business Associate hereunder if any of the following events shall have occurred:

(1) Sub Business Associate shall fail to observe or perform any material covenant or agreement contained in this Agreement for ten (10) days after written notice has been given to the Sub Business Associate by the Business Associate; or

(2) A violation by the Sub Business Associate of any provision of the HIPAA Privacy Rule or any other state or federal law.

(c) Effect of Termination.

Upon termination of this Agreement, for any reason, Sub Business Associate shall return or destroy all Protected Health Information received from the Business Associate, or created or received by Sub Business Associate on behalf of the Business Associate. The Business Associate shall not retain any copies of Protected Health Information received from the Business Associate, or created or received by Sub Business Associate on behalf of the Business Associate.

8. Miscellaneous.

(a) Regulatory References. A reference in this Agreement to a section in the HIPAA Privacy Rule means the section as in effect or as amended.

(b) Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for compliance with the requirements of the HIPAA Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-19 1. The Parties further agree that this Agreement may only be amended upon written consent by both Parties.

(c) Survival. The respective rights and obligations of Business Associate under this Agreement shall survive the termination of this Agreement.

(d) Interpretation. Any ambiguity in this Agreement shall be resolved to permit the parties to comply with the HIPAA Privacy Rule.

(e) Indemnification. Sub Business Associate will indemnify, defend and hold Business Associate and its officers, directors, employees, agents, successors and assigns harmless, from and against any and all losses, liabilities, damages, costs and expenses (including reasonable attorney's fees) arising out of or related to any third-party claim based upon any breach of this Agreement by Sub Business Associate .

(The remainder of this page has been intentionally left blank.)

IN WITNESS WHEREOF, the parties have executed this Sub Business Associate Agreement on the date first set above.

Sub Business Associate

By: ______________________________________
Title: ______________________________________
Date: ______________________________________

Business Associate

By: ______________________________________
Title: ______________________________________
Date: ______________________________________