Humana®	Policy and Procedure	
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Subject: Provider Quality Review Process		
Original Approved By: Darlene Holzbach	**Original Approval Date: 03/19/2012**	
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Change Summary:	Clarified calendar days, amended definition of provider to include delegates and downstream arrangements, expounded on voluntary resignations	

I. Purpose and Policy:

The purpose of this document is to define the policy and procedure for management of quality issues associated with specific Humana Providers.

It is the policy of Humana:

- To improve the quality and safety of health care services provided to its Members by its Providers through the use of this Provider Quality Review Process and other Humana quality management processes;
- To investigate select episodes of care to determine if intervention is appropriate;
- To intervene as necessary to bring about Provider improvement in care, to protect Members or both;
- To offer an opportunity for a hearing and review when Humana recommends certain actions that may adversely affect a Provider's status for more than 30 days, as more fully described in the procedures below;
- In the event that Humana contemplates action that may adversely affect a Provider's status, it is Humana's policy to take action only:

  (1) in the reasonable belief that the action was in the furtherance of quality health care,

  (2) after a reasonable effort to obtain the facts of the matter,

  (3) after adequate notice and hearing procedures are afforded to the Provider involved or after such other procedures as are fair to the Provider under the circumstances (subject to special rules for suspensions described below), and

  (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3);
- To manage all steps in this process promptly, rationally and fairly;
- To afford maximum immunity protections to Humana committees and participants under federal and state law;
- To treat and manage confidentially all information, documents, records and reports relating to this and other quality management processes.

II. Procedure:

A. Definitions

The following definitions apply throughout this Policy and Procedure:

Actions that **affect adversely** or **adversely affect** a Provider (sometimes referred to as an **adverse action**) mean those that limit, reduce, restrict, suspend, revoke, terminate, deny or fail to renew a Provider's participation in a Humana Health Plan for reasons relating to the competence or professional conduct of the Provider and that adversely affect, or could adversely affect, a patient's health or welfare.

The **Corporate Recommendation Review Committee ("CRRC")** is a subcommittee of the Corporate Quality Improvement Committee vested with the authority to make the final decision on all matters pertaining to participation rights determined under this process. A majority of the CRRC must be physicians (M.D.s or D.O.s).

A **Corrective Action Plan** is a documented plan, either developed in concert with a Provider or imposed by Humana unilaterally, to address Provider quality issues and attempt to improve Provider performance. A Corrective Action Plan may include, among other actions, limitations, restrictions or conditions on participation pending demonstrated improvement; closure of a Provider's panel to new Members; consultation with an administrative management company; compliance with ongoing audits or reviews by the Health Plan; continuing medical education; and monitoring/proctoring. A Corrective Action Plan that adversely affects a Provider's participation rights for more than 30 days must be reported to the National Practitioner Data Bank, subject to hearing and review rights.

All references to **day** or **days** mean calendar days, unless otherwise specified. When counting days, the first day is not counted. The last day is counted. If the last day is a Saturday, Sunday or federal holiday, the prescribed period ends n the very next business day.

A **Health Plan** or simply **Plan** is one or more Humana health maintenance organizations, Humana insurance companies or other managed care organizations.

A **Humana Health Plan Market Medical Director** ("**HMD**") is a physician employed or under contract with Humana or a Health Plan to provide clinical management and support to a Health Plan and its Peer Review Committee in a particular geographic or operating market. Unless otherwise stated, an HMD includes an HMD's designee.

An **Inquiry** is the general collection of information about a Provider's practice or conduct to determine whether an Investigation is necessary. Humana or Plan personnel may and do freely conduct Inquiries to advance mutual Plan/Provider understanding of the quality of Member care. Inquiries may include routine chart audits, conversations and correspondence with the Provider

and tracking and trending of subsequent Provider behavior. An Inquiry becomes an Investigation only in accordance with the specific provisions of this process.

An **Investigation** is the focused and purposeful gathering of information, records and other data respecting the competence, professional conduct or practice patterns of a Provider for the purpose of determining whether to take or recommend an adverse action. An Investigation does not commence until a Peer Review Committee declares that one has begun, except that imposition of a summary or precautionary suspension or a Committee recommendation of Corrective Action Plan or adverse action automatically commences an Investigation. Routine Inquiries about quality and performance between a Provider and an HMD or other Humana representative, Peer Review Committee, QOC or any other Humana or Plan department or committee do not constitute "Investigations."

A **Member** is an individual covered under a health benefits plan underwritten or administered by a Health Plan.

Notice to a person or entity means a writing to a recipient that is either (a) delivered to the recipient in person, via messenger, commercial courier or otherwise or (b) faxed to the recipient or mailed by certified mail return receipt requested, to the recipient's last known home or office address or (c) emailed to the recipient, and the recipient acknowledges receipt by return email. Notice is complete upon delivery, faxing, mailing, or receipt of email acknowledgment.

A **Peer Review Committee** is a Humana committee, composed of physicians, one purpose of which is to conduct review activities to evaluate the quality of care by Providers to Health Plan Members. The committee need not be called a "Peer Review Committee" as long as it performs the functions described.

A **Provider** is an individual health care professional (such as a physician, dentist, physician assistant, nurse practitioner, etc.) or a health care institution or facility (such as a hospital, skilled nursing facility, ambulatory surgery center, home health agency, etc.), whether directly contracted to Humana or granted Provider status via delegation, group contract or other downstream arrangement, that provides/renders health care services to Health Plan Members.

Quality refers to the measure of competence, professional conduct, care and safety that a Provider affords a patient.

The **Quality Operations Compliance Department ("QOC")** refers to the Humana function currently known as the Corporate Quality Operations Compliance and Accreditation Department.

A **Written Instructive Communication ("WIC")** is a letter or memo sent by the HMD to a Provider, that details quality issues that he has identified and his recommendations for improvement.

B. Overview of the Procedure

Humana routinely reviews the quality of its Providers, including both individual practitioners and health care entities. It does this by way of prospective, concurrent and retrospective reviews.

The HMD, with the assistance of the QOC, identifies quality issues that may require attention. Initial Inquiry may include communication with the affected Provider to gather additional information. In many cases, the HMD may propose improvement steps on his own subject to later ratification by the Peer Review Committee.

If the HMD determines to submit a matter to the Peer Review Committee, the submission includes a summary of the case, all relevant communications and a recommendation. The submission is blinded to obscure the Provider's identity.

The Peer Review Committee then meets and determines whether intervention is appropriate. Interventions may take many forms, including corrective action plans, limitations on Provider status, suspensions or termination. If the committee lacks sufficient information to make a decision, it may defer decision to obtain additional information.

All initial efforts to gather information about Providers are deemed "Inquiries" designed to enhance Humana/Provider communications and understanding about incipient problems and to implement improvement strategies without formal intervention. A formal "Investigation" begins only at such time as the Peer Review Committee expressly declares one or takes some affirmative corrective action. Humana must report to the National Practitioner Data bank all individual Providers who resign after an Investigation has begun.

Should the Peer Review Committee decide to recommend an action that adversely affects a Provider's status for more than 30 days, it must offer the Provider an opportunity to request a hearing before a separate hearing panel in accordance with the procedures set forth below. The procedures include specific enumerated rights, including the right to notice and assistance of counsel and a reasoned recommendation from the hearing panel.

At the conclusion of the hearing, the hearing panel transmits its written recommendation and reasoning to the Peer Review Committee for its review and recommendation. The Peer Review Committee then submits its recommendation to the CRRC. The written decision, with reasons, of the CRRC is final.

C. Governing State Law

Throughout the conduct of the review activities described in this policy, Humana intends to comply with the specific laws of the state in which the activity takes place. Similarly, Humana intends to take advantage of all immunities and confidentiality protections available under state law. To the extent that this process is inconsistent with the laws of the state in which review takes place, state law governs.

D. Relationship to Other Documents

Humana intends this Policy and Procedure to be the exclusive means of addressing and resolving quality issues with Providers who are individuals. Humana has developed, and may develop in the future, additional manuals, policies, procedures and other documents to elaborate on this Policy and Procedure. In case of a conflict or inconsistency with such other documents, this Policy and Procedure governs. Use of this process for Providers who are not individuals is at Humana's sole discretion.

E. Specific Procedures

1. Initial Case Identification, Preparation and Submission

a) HMDs are responsible, with the assistance of the QOC, for identifying and managing Provider quality issues. Sources for the initial identification of quality issues include without limitation prospective, concurrent and retrospective file review of cases submitted to the QOC; Member complaints; referrals from other Humana departments and functions such as Legal/Risk Management, Special Investigations Unit, MTC or Quality Improvement Organization; other Humana contracted Providers; and federal, state and local regulatory agencies.

b) Acting on behalf of the Peer Review Committee, the HMD should gather sufficient information on referred quality issues to determine whether intervention is appropriate. Inquiry may include communication directly with the Provider. Personal or telephone inquiries should result in a memorandum to the file. Inquiries may:

(1) Request copies of files or other documents;

(2) Request information, including the Provider's written understanding, explanation or version of events; and

(3) Specify a reasonable time limit for response.

c) Should the Provider fail to respond adequately to a request for information, the HMD may take action or make a recommendation based upon the information available.

d) The HMD, in his sole discretion, may take the following preliminary actions prior to submission to and ratification by the Peer Review Committee:

(1) Track and trend issues of any severity level (issues of Severity Level "0" need not be submitted for ratification);

(2) Send a WIC for issues up to Severity Level B;

(3) Summary suspension of all or part of a Provider's participation rights (only after consultation with the QOC and the Law Department), where the failure to take such an action may result in an imminent danger to the health of any individual;

(4) Imposition of a precautionary suspension of a Provider's participation rights (only after consultation with the QOC and the Law Department) for a period of not longer than 14 days, during which an Investigation is being conducted to determine the need for intervention. A precautionary suspension automatically dissolves after (i) 14 days or (ii) other intervention by the HMD or Peer Review Committee, whichever comes first. Humana may not impose more than one precautionary suspension respecting a given quality issue.

Except for the imposition of a suspension under subsections (3) or (4) above, the information gathering and actions described above do not constitute the commencement of an Investigation.

e) The HMD must compile and submit to the Peer Review Committee a summary of all quality issues for which he believes intervention is appropriate. Communications with the Provider and other relevant records must accompany the summary. The HMD must redact all Provider-identifying information submitted to the Peer Review Committee, such as Provider name and address.

2. Peer Review Committee Evaluation

a) The Peer Review Committee must evaluate and make a recommendation respecting each quality issue the HMD submits to it.

b) To assist its evaluation, the Committee may defer consideration of a matter in order to take one or more of the following preliminary steps:

(1) Request further information from the HMD, including the complete file in the matter;

(2) Request further information from the Provider;

(3) Request by Notice that the Provider attend a Peer Review Committee meeting for an interview. The request must state the date, time and place of the interview; the subject matter of the interview; that it is not a hearing and that counsel may not accompany the Provider; and that the Plan may treat the failure to appear and cooperate as a voluntary resignation from the Plan. If an Investigation of an individual Provider has begun, Humana will report the resignation to the National Practitioner Data Bank as a resignation while under investigation. The Peer Review Committee may take this action (only after consultation with the QOC and Law Department) without prior notice to the Provider.

The foregoing steps do not otherwise constitute the commencement of an Investigation unless the Committee expressly so indicates.

c) At any time, the Committee may commence an Investigation into the conduct at issue and may request the Plan's assistance in gathering further information prior to making a recommendation.

d) The Peer Review Committee may impose a precautionary suspension of a Provider's participation rights (only after consultation with the QOC and the Law Department) for a period of not longer than 14 days, during which an Investigation is being conducted to determine the need for intervention. A precautionary suspension automatically dissolves (i) after 14 days or (ii) other intervention by the Committee, whichever comes first. Humana may not impose more than one precautionary suspension respecting a given quality issue.

e) Where practicable, the Peer Review Committee should make its recommendation within 90 days of the submission of the issue to the QOC, or such shorter time as the law may require. The Committee should promptly (and in no event later than 30 days after imposition) review and ratify, modify or dissolve summary suspensions imposed by the HMD.

3. Interventions

a) Upon completion of its fact gathering and evaluation, the Peer Review Committee must make a written recommendation, with an appropriate summary of its reasons. Actions available include:

(1) A determination that no further action is necessary;

(2) Ratification or modification of an action previously taken by the HMD;

(3) A WIC;

(4) Corrective Action Plan;

(5) Summary suspension of all or part of a Provider's participation rights (only after consultation with the QOC and the Law Department), where the failure to take such an action may result in an imminent danger to the health of any individual;

(6) Restriction or limitation of a Provider's participation;

(7) Termination of Provider status with the Plan.

b) The HMD must promptly communicate by Notice to the Provider each Peer Review Committee recommendation, reconsideration or action. Communication is unnecessary when the Committee ratifies a prior HMD WIC or makes a "track and trend" or "no further action" decision where there has been no prior contact with the Provider on the matter. "Promptly" in this subsection means ordinarily within 15 business days, unless good reason exists to shorten or extend the time.

c) Interventions consisting of or accompanied by requests for additional information must clearly state the nature of the information requested and the place and date by which the Provider must furnish the information. The HMD will assist the Peer Review Committee as directed in the collection of this information. The Committee may revise its proposed intervention based upon information received. The HMD must promptly refer to the Committee for further action failures of the Provider to comply with information requests.

d) Where a recommendation proposes a Corrective Action Plan that does not adversely affect the participation rights of a Provider, the HMD in his sole discretion may involve the Provider in the development of the proposed plan.

e) Where a recommendation proposes an action that adversely affects Provider participation for a period of not more than 30 days, the Provider may request that the Peer Review Committee reconsider the intervention. The Provider must make the request within 10 days of receipt of the recommendation, and must provide the Committee with

reasons why the Committee should alter its recommendation. Failure to make a request within 10 days constitutes a waiver of the right to reconsideration. The Committee must review the request and may adhere to, amend or reverse its original recommendation. The Committee's reconsideration is final.

f) Except as provided below with respect to suspensions, where a recommendation proposes an action that adversely affects Provider participation for more than 30 days, the HMD must (only after consultation with the QOC and the Law Department) offer the Provider a right to request a hearing under the Fair Hearing Plan in accordance with the procedures below. Should the Provider request a hearing, Humana may not implement the recommendation until the Provider has exercised or waived all hearing and review rights. Recommendations of adverse actions lasting more than 30 days and that remain adverse after hearing and review (in the case of individual Providers) will be reported thereafter to the National Practitioner Data Bank.

g) Where the Peer Review Committee has imposed or ratified a summary suspension, the HMD must (only after consultation with the QOC and the Law Department) promptly offer the Provider a right to a hearing under the Fair Hearing Plan in accordance with the procedures below. The terms of the suspension remain in effect pending the hearing, and suspensions that last longer than 30 days (in the case of individual Providers) will be reported after 30 days to the National Practitioner Data Bank.

h) Should a Provider fail or refuse to cooperate (i) in the framing or execution of a Corrective Action Plan; (ii) in the collection of information; or (iii) by failing to appear for a requested interview, the Plan may treat the failure as a voluntary resignation from the Plan. If the Provider is an individual Provider and is under Investigation, Humana will report the resignation to the National Practitioner Data Bank as a resignation while under Investigation. The Peer Review Committee may take this action (only after consultation with the QOC and Law Department) without prior notice to the Provider.

i) Nothing in this Intervention section precludes a Peer Review Committee from reviewing and modifying an intervention at any time, including an increase or decrease in severity, subject to appropriate rights of review or hearing.

4. The Fair Hearing Plan

a) A Provider is entitled to the hearing and review rights under this Fair Hearing Plan if Humana takes or recommends an adverse action against the Provider that lasts for more than 30 days.

b) Humana may take final action under this Fair Hearing Plan only:

(1) In the reasonable belief that the action was in furtherance of quality health care;

(2) After a reasonable effort to obtain the facts of the matter;

(3) After providing the notice and hearing procedures set forth in this Fair Hearing Plan, or such other procedures as may be fair to the Provider under the circumstances; and

(4) In the reasonable belief that the action is warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

c) If a Provider is entitled to a hearing, the HMD, after contacting the QOC and Law Department, must give Notice of the action or proposed action to the Provider. The Notice must contain:

(1) A description of the action taken or proposed;

(2) The reasons for the action;

(3) A statement that the Provider has a right to request a hearing on the action and must do so by Notice to the HMD within 30 days of receipt of the Notice of right to request a hearing;

(4) A statement that if the Provider does not make a timely request for a hearing that the Provider waives all hearing and review rights; and

(5) A statement that the Provider has the rights set forth in this Fair Hearing Plan. A copy of this Fair Hearing Plan must accompany the Notice.

d) Failure of the Provider to make a timely request for a hearing constitutes a waiver of all hearing and review rights, and the action or

recommendation becomes final, subject to ratification by the CRRC. If the recommendation adversely affects the participation of an individual Provider for more than 30 days, the CRRC must, after consultation with the Law Department, direct the HMD to report the recommendation to the National Practitioner Data Bank.

e) If the Provider makes a timely request for a hearing, the HMD must send a Notice of hearing to the Provider setting forth:

(1) The place, time and date of the hearing. The first date of the hearing may not be less than 30 days after the date of the Notice of hearing unless waived by both the Provider and Humana;

(2) A list of witnesses that the Plan expects will testify at the hearing on its behalf; and

(3) A statement that if the Provider fails without good cause to appear at the hearing, the Provider forfeits all hearing and review rights.

f) The Provider must provide to the HMD, not later than seven business days prior to the hearing, a list of witnesses that the Provider expects will testify on the Provider's behalf.

g) A panel of not fewer than three or more than five persons or a hearing officer, appointed by the HMD in consultation with the Law Department, will conduct the hearing. Hearing panel members or the hearing officer must be physicians but need not be Plan Providers. No hearing panel member or hearing officer may be in direct economic competition with the Provider, play any part in presenting the case against the Provider or have participated in investigating or deciding a prior phase of the case. Prior knowledge of the facts is not a disqualifying circumstance.

h) The HMD must designate one of the panel members as chairperson, who presides at the hearing. The chairperson or hearing officer:

(1) must act to assure that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence and that decorum is maintained;

(2) determines the order and procedure during the hearing, makes rulings on admissibility and relevance of evidence and may set reasonable time limits for the hearing; and

(3) may, in his or her sole discretion, hold one or more conferences to simplify or clarify the issues to be heard, resolve disputes, facilitate settlement, specify the timing and order of witnesses, rule on requests for use of Member testimony and address any other matter that may facilitate the just, speedy and inexpensive disposition of the hearing.

i) The hearing panel or officer may select and retain counsel (with the approval of the Law Department and paid by Humana) to assist it in conducting the hearing and in preparing the hearing report and recommendation.

j) Failure of the Provider to appear at the hearing constitutes a waiver of all hearing and review rights, and the action or recommendation becomes final, subject to ratification by the CRRC. If the recommendation adversely affects the participation of an individual Provider for more than 30 days, the CRRC must, after consultation with the Law Department, direct the HMD to report the recommendation to the National Practitioner Data Bank.

k) The HMD represents the Plan at the hearing. Both the Provider and the Plan have the right:

(1) To representation by an attorney or other person of his or her choice;

(2) To have a record made of the proceedings, copies of which may be obtained by the Provider upon payment of any reasonable charges associated with the preparation thereof;

(3) To call, examine and cross-examine witnesses;

(4) To present evidence determined to be relevant by the hearing panel or officer, regardless of its admissibility in a court of law; and

(5) To submit a written statement at the close of the hearing.

l) Hearings are not open for attendance by anyone except the parties, their representatives and witnesses while testifying.

m) Neither party may call a Member to testify at the hearing, except upon an express demonstration of relevance made prior to the hearing and supported by evidence that such testimony is necessary and is unavailable from other sources. A party must make a specific written application to use Member testimony to the hearing panel not later than seven business days prior to the commencement of the hearing. Failure to make an application as provided in this subsection constitutes a waiver. A hearing panel ruling on relevance is final.

n) The Provider bears the burden of proof, including the burden of producing evidence and the burden of persuading the hearing panel or officer, by a preponderance of the evidence, that the action adversely affecting the Provider is arbitrary, capricious, unreasonable or against the weight of the evidence.

o) The hearing panel need not conduct the hearing strictly according to the rules of law relating to the examination of witnesses or the presentation of evidence. The panel may consider facts or issues that arise after the issuance of the original hearing notice.

p) Should the Provider elect not to testify on his, her or its own behalf, the Plan representative may nevertheless call the Provider to testify as if on cross-examination.

q) The hearing panel may, in its sole discretion, recess and reconvene the hearing for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation.

r) Upon conclusion of the presentation of evidence and the submission of written statements, if any, the hearing is closed. The panel, at a time convenient to itself, conducts its deliberations outside the presence of the parties.

s) Within five business days after the hearing closes (or as soon thereafter as is reasonably possible), the hearing panel or officer must make and deliver by Notice to the Provider, HMD and Peer Review Committee a written report and recommendation confirming, modifying or rejecting the adverse recommendation or decision under review. This report must contain the bases for the recommendation. If the report recommends taking an action adversely affecting the

Provider, it must detail the respects in which the recommendation meets the requirements of Section 4(b) of this Procedure.

t) The Peer Review Committee must make a written recommendation to the CRRC within 10 days of receipt of the Notice from the hearing panel or officer. The recommendation may propose adoption, modification or rejection of the hearing panel's or officer's recommendation. Should the Peer Review Committee recommend modification or rejection, it must provide written reasons. If the recommendation directs the taking of an action adversely affecting the Member for more than 30 days, the recommendation must include a proposed report to the National Practitioner Data Bank, drafted in consultation with the Law Department. The Peer Review Committee must also promptly give Notice to the Provider enclosing its recommendation.

u) The CRRC reviews the Peer Review Committee recommendation and makes the final decision for Humana. No member of the CRRC may be in direct economic competition with the Provider or have participated in any earlier investigation or decision of the matter.

v) The CRRC must render a written decision, including the bases for the decision, within 15 days after receipt of the Peer Review Committee's recommendation or as soon thereafter as reasonably possible. The decision of the CRRC may affirm the recommendation of the Peer Review Committee, or it may modify or reverse the recommendation or remand the matter back for the taking of additional evidence if and to the extent that:

(1) the hearing panel or officer failed to follow proper hearing procedures; or

(2) the recommendation under review is arbitrary, capricious, unreasonable or against the weight of the evidence.

The CRRC must deliver a copy of its decision by Notice to the Provider; to the Peer Review Committee; and to the HMD. If the decision directs the taking of an action adversely affecting the Provider, it must state or incorporate by reference the respects in which the decision meets the requirements of Section 4(b).

w) A decision of the CRRC affirming, modifying or reversing the recommendation of the Peer Review Committee is final. If the

decision adversely affects the participation of an individual Provider for more than 30 days, the CRRC must, after consultation with the Law Department, approve or amend, as appropriate, the proposed National Practitioner Data Bank report and direct the HMD to file it with the appropriate authorities. Should the CRRC remand the matter back for the taking of additional evidence, review of the new hearing panel recommendation must follow subsections s) through v) above.

x) Except for the time to request a hearing, the time periods in this Fair Hearing Plan may be extended or shortened by mutual agreement.

y) Except and to the extent that the CRRC remands a matter back for the taking of additional evidence, a Provider is entitled to only one hearing on any matter.

z) Whenever this Process requires the giving of a Notice, Humana and the Provider or their representatives may agree to use any other means of communication instead. Once an attorney formally appears as a party's representative, all Notices and other communications to that party must go to the attorney and not to the party.

5. Immunity and Confidentiality

a) The procedures set forth above are designed to take advantage of, and should be interpreted to be consistent with, the immunities from liability available under the Federal Health Care Quality Improvement Act, 42 U.S.C. § 11111 *et seq*. and comparable state law. Immunity under this procedure extends to:

(1) Humana, each Humana or Plan committee or other body that conducts quality review on its behalf; each person acting as a member or staff of each such body; each person who participates with or assists each such body, whether under a contract or other formal agreement or otherwise; and each person who provides information to any of the foregoing persons or bodies concerning the competence or professional conduct of a Provider, unless such information is false and the person providing it knew that such information was false;

(2) All quality review activities, including reviews, Inquiries, Investigations, interviews, decisions and other activities to determine whether a Provider should continue to hold

participation rights in the Plan, the scope or conditions of such participation; or to change or modify such participation; and

(3) All quality review actions, including suspensions, recommendations and decisions and further including actions that result in the decision to take no action.

b) Providers must exhaust all rights under this procedure, including hearing and review rights under the Fair Hearing Plan, as its exclusive remedy respecting actions taken against a Provider's participation rights.

c) All information, documents, records and reports received or created in the course of quality review activities ("Peer Review Matter") is confidential.

(1) Communications to a Provider should be stamped confidential;

(2) All Peer Review Matter should be handled confidentially and stored securely to assure limited access;

(3) No person, including a Provider, may disclose Peer Review Matter to another person except as contemplated in this procedure in the legitimate pursuit of quality review activity or as may be ordered by a court of competent jurisdiction; and

(4) Humana may notify its Members of each final decision to suspend, limit or terminate a Provider from the Plan, but it may not disclose the reason(s) for such actions.