Dear Peer Reviewer:

Thank you for your interest in the Peer Review Program of KePRO as it signals your commitment to a significant objective – continuing improvement of the quality and utilization of health care services. We fully appreciate the value of your time and earnestly suggest that your participation in the peer review process in today's health care climate is close to an ethical imperative.

KePRO 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, KePRO must have sufficient numbers of qualified peer reviewers who must meet the following criteria:

- **Are doctors of medicine, osteopathy, podiatry, or other allied health care practitioner**
- **Have a current state license**
- **Have a minimum of five (5) years active practice experience**
- **Physicians must be Board Certified in a specialty recognized by the American Board of Medical Specialties or the American Osteopathic Association**

We can then ensure that all quality and utilization determinations completed and follow-up actions taken are the result of true peer review.

KePRO provides liability coverage for peer reviewer activities and the reviewer's name will remain confidential except in instances where identification is required by law or by specific contract.

We provide 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 45 days of receipt of the completed report and invoice.

While we 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.

To become a KePRO peer reviewer, please download, complete and return the application packet, with your current curriculum vitae, copy(ies) of all your Board Certificate(s), and copy(ies) of all of your state licensures to:

KePRO
Medical Affairs Section
777 East Park Drive
PO Box 8310
Harrisburg, PA 17105-8310

Should you have additional questions please contact our Credentialing Department at (717) 564-8288.

We look forward to your participation in the peer review process.

Enclosure(s)

INSTRUCTIONS FOR COMPLETING THE PEER REVIEWER APPLICATION AND CREDENTIALING PROCESS

The Keystone Peer Review Organization (KePRO) and its subsidiary companies contract with various State and Federal government agencies, as well as commercial insurance entities, to perform review. 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 KePRO application packet includes:

1. **Peer Reviewer Application**

   This form collects information about your office, licensure, potential conflicts of interest, and experience.

   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 this policy and complete this Agreement.

4. **Authority to Release Information**

   This Release must be completed by all applicants in order to assure authorized release of confidential credentialing information. To meet the requirements of certain contracts, a copy of this form may need to be submitted to the Medical Staff President (or designee) of the facility in which you primarily practice and maintain staff privileges for confirmation of such privileges.

5. **Peer Reviewer Small Business Form**

   This form helps KePRO comply with Federal Government contracting regulations. Your completion of this form benefits KePRO in its need to comply with contract requirements.

You must submit copies of all the following documents with your application in the enclosed self -addressed large envelope:

- **Current curriculum vitae (preferably in an electronic document format)**
- **All Current Board Certification(s)**
- **All Current State Licensures, including expiration dates**

Thank you for your interest in participating as a peer reviewer.

KEYSTONE PEER REVIEW ORGANIZATION, INC. (KePRO)
PEER REVIEWER APPLICATION

Please print or type – <u>incomplete forms will be returned</u>
The following information is to be completed by all applicants

NAME: **Title:** **(<u>MD, DO, etc.</u>)**

LICENSE #: **EXPIRATION DATE:**

NPI #: **SOCIAL SECURITY/TAX ID #:**

Board Certified Specialty: **Certification #:**

☐ This is a **time-limited** certification & expires:

☐ This is a **life-time** certification

Subspecialty: **Boarded:** ☐**YES** ☐**NO**
If YES: Certification #:
☐ This is a **time-limited** certification & expires: ☐ This is a **life-time** certification

Subspecialty: **Boarded:** ☐**YES** ☐**NO**
If YES: Certification #:
☐ This is a **time-limited** certification & expires: ☐ This is a **life-time** certification

Specialty/Subspecialty case(s) you would like to review

Primary Office Address: **City**

State **Zip Code** **County**

Primary Office: Telephone #: **Fax #:**

Office Email Address

Contact Person: **Title:**

**If more than one office location, please note the address, phone number and contact person on the back of this form.*

Home Address: **City**

State **Zip Code** **County**

Home Telephone #: **Home Fax #:**

Beeper #: **Cell Phone #:**

Home Email Address
Preferred address to receive records? ☐**Office** ☐**Home**

Preferred method of contact? ☐**Office** ☐**Home** ☐ **Cell Phone** ☐**Beeper**

Preferred address to receive recredentialing application? ☐**Office** ☐**Home**

Preferred E-Mail Address:

1. **Have your privileges to practice been abridged or suspended in any way, or is any action now pending?** ☐**Yes** ☐**No** **If *yes*, please explain on a separate page.**

2. **Are you currently involved in active practice or clinical teaching?** ☐ **Yes** ☐ **No**
   If yes, please estimate your average hours per week:
3. **Do you have utilization/quality assurance or peer review experience?** ☐ **Yes** ☐ **No**
   If *yes*, give area of expertise and number of year's experience:
4. **Do you have ABQAURP certification?** ☐ **Yes** ☐ **No** **Date of certification:**
5. **Do you possess basic computer skills?** ☐ **Yes** ☐ **No**
6. **Do have access to high speed internet?** ☐ **Yes** ☐ **No**
7. **Please list ALL of your state medical licensures and their respective expiration dates:**

State	Exp. Date	State	Exp. Date	State	Exp. Date

List current affiliations and type of staff privileges for *all* the following:

- **Hospital (both acute and specialty)**
- **Outpatient Centers**
- **SNF, HMO, CMP, PPO, HHA, and others**

Facility/City	Staff Affiliation	Financial Interest
		☐ **Yes** ☐ **No**
		☐ **Yes** ☐ **No**
		☐ **Yes** ☐ **No**

Federal regulations mandate that a person may not review health care services or make initial denial determinations or changes as a result of DRG validations if they or a member of their family is a governing body member, officer, partner, five percent (5%) or more owner or managing employee in the health care facility where the services were or are to be furnished. The information furnished above will be used to avoid potential conflicts of interest.

Please attach *copies* of the following to your application:

- **Current curriculum vitae (preferable in an electronic document format)**
- **All Current Board Certifications**
- **All Current State Licensures, including expiration dates**

NOTE: *KePRO is contractually required to maintain this information on its peer reviewers.* ***Incomplete applications cannot be processed and will be returned for completion.***

I hereby attest that all information contained in this application and all supporting documentation provided are true and correct to the best of my knowledge. I authorize KePRO to verify the above information and extend immunity to third parties who provide, in good faith, information pursuant to this verification.

____________________________________ ____________________
Signature of Peer Reviewer Applicant Date

Printed Name: ____________________________________

REVIEW AGREEMENT

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

I understand that KePRO 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.

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 KePRO 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 KePRO 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 am willing to provide peer review services as indicated below: (Please indicate with an "X")

YES	NO	List of Services	YES	NO	KePRO and Subsidiaries
☐	☐	UM/Peer Review	☐	☐	Federal/State Contracts (consistent with state licensure)
☐	☐	Independent Medical Exams			
☐	☐	Malpractice Review	☐	☐	Commercial Contracts

YES	NO	
☐	☐	Are you willing to testify?

I agree to notify KePRO promptly of any changes in regard to my credentials or contact information noted within this application. Except to the extent specifically modified by this Agreement, I hereby ratify and affirm all authorizations, applications, consents, and agreements executed by me in connection with my acceptance by KePRO as a reviewer under the Social Security Act and other applicable regulations.

________________________________ ________________

Signature of Peer Reviewer **Date**

HIPAA/CONFIDENTIALITY AGREEMENT -
PEER REVIEWERS

KePRO 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, KePRO is required to ensure that its agents (e.g., peer reviewers) and subcontractors agree to the same restrictions and conditions that apply to KePRO with respect to PHI.

In the course of providing peer review services for KePRO, you may create or receive PHI from or on behalf of KePRO, 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. <u>DEFINITIONS</u>

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. <u>PERMITTED USES AND DISCLOSURES</u>:

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, KePRO and/or Covered Entity as directed by KePRO or in this HIPAA Amendment, provided that such use or disclosure would not violate HIPAA if made by KePRO 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, KePRO 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 KePRO or Covered Entity as permitted by HIPAA.

(B) <u>Restrictions</u>: Peer Reviewer shall not use or disclose PHI for any other purpose not described above.

(C) 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 KePRO 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 KePRO. The information must not be placed in private mailbox for pick-up.

(D) Reporting of Improper Use or Disclosure: Peer Reviewer shall report to KePRO 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.

(E) 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:

(A) 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 KePRO, however, that certain obligations shall survive termination of this HIPAA agreement as set forth in Section III(C).

(B) 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 such material breach to KePRO's satisfaction within thirty (30) days after receipt of written notice from KePRO, KePRO will terminate the services of the Peer Reviewer.

(C) 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, KePRO 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 KePRO 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 KePRO, 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.

V. 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 KePRO'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 KePRO.

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 person for misuse of such information and civil penalties up to $100 per person per violation.

________________________________ ________________

Signature **Date**

Please print your name clearly on the following line:

____

AUTHORITY TO RELEASE INFORMATION

NOTE: *This Release must be completed by all applicants in order to assure authorized release of confidential credentialing information.*

In applying for appointment as a Peer Reviewer or consultant to KePRO and/or its subsidiaries, I

, hereby authorize

(Name of Applicant)

KePRO, or it representatives, to consult with health care 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 KePRO 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 KePRO, or its designees, in good faith and without malice concerning my professional qualifications, clinical competence, credentials, behavior and other qualifications which may be relevant to my appointment as Peer Reviewer, including otherwise privileged or confidential information.

________________________________ ________________

Signature of Applicant **Date**

PEER REVIEWER SMALL BUSINESS FORM

In order to comply with Federal Government Contracting regulations, Keystone Peer Review Organization, Inc. (KePRO) is required to identify those who provide services who have special certifications/classifications. A brief description of each classification is listed below each question to help simplify your response. This information is required for payment processing.

If payment for services will be made directly to you, you are considered to be the business concern, not your group or employer. Average annual receipts include your total income, excluding net capital gains or losses. If this amount is less than $8.5 million, then you are considered to be a small business concern.

Circle as applicable according to the definitions below and on next page.

	Are you:		
1. A small business concern as defined by SBA? A business organized for profit, located in the U.S., and has a 3 year averaged annual gross revenues less than $8.5 million for physician offices and mental health specialists or $6 million for all other health practitioners/offices.	Yes ☐	No ☐	Don't Know ☐

If you have answered "yes" to the above question, please answer questions 2-8. If "no", please sign and date below.

2. A Woman-Owned, Small Business? At least 51% owned by one or more women and whose daily operations are controlled by one or more women.	Yes ☐	No ☐	Don't Know ☐
3. A **certified** HUBZone, Small Business? A business located in a historically underutilized business zone, owned and controlled by one or more U.S. citizen and where at least 35% of its employees reside in a HUBZone.	Yes ☐	No ☐	Don't Know ☐
4. A **certified** small disadvantaged business? At least 51% owned and controlled by an economically and socially disadvantaged individual(s) and an individuals net worth must be less than $750,000 excluding equity in the business and primary residence.	Yes ☐	No ☐	Don't Know ☐
5. A **certified** 8(a), Small Business? Same as above, except an individuals net worth, excluding equity in the business and primary residence may not exceed $250,000.	Yes ☐	No ☐	Don't Know ☐
6. An American-Indian Owned Business? At least 51% owned and controlled by a person eligible for services from the BIA.	Yes ☐	No ☐	Don't Know ☐
7. A Veteran Owned Small Business? At least 51% owned and controlled by a person defined as a veteran (served in active duty) who was discharged or released from under conditions other than dishonorable.	Yes ☐	No ☐	Don't Know ☐
8. Service Disabled Veteran Owned Small Business? Same as above. Service disabled defined as a disability that is service-connected. A spouse may qualify if the veteran has a permanent and severe disability.	Yes ☐	No ☐	Don't Know ☐

Note: Any firm that has misrepresented its status in the above listed categories in order to obtain a subcontract from Keystone Peer Review Organization, Inc., 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.

____
Signature of Peer Reviewer

____
Date

____
Printed Name/Title of Peer Reviewer

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 http://www.sba.gov/certifications/. ***Self-Certification***

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 http://www.sba.gov/GC/indexprograms-cawbo.html. ***Self-Certification***

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% of its employees reside in a HUBZone. For more information, please go to https://eweb1.sba.gov/hubzone/internet/. ***Certification Process***

4. **Small Disadvantaged Business**--A small business must be at least 51% 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 http://www.sba.gov/sdb/indexaboutsdb.html ***Certification Process***

5. **8 (a) Business**—To qualify for the 8(a) Program a firm must: (a) Be a small business, (b) Be unconditionally owned and controlled by one or more socially and economically disadvantaged individuals who are of good character and citizens of the United States; (c) Demonstrate potential for success. Also, the individual's net worth, after excluding the individual's equity in the firm and the equity in the primary residence, may not exceed $250,000. For more information, please go to http://www.sba.gov/8abd/indexfaqs.html.
Certification Process

6. **American-Indian Owned Business**—Refers to any business owner who is a member of any Indian tribe, band, group, pueblo, or community which is recognized by the Federal Government as eligible for services from the Bureau of Indian Affairs (BIA) in accordance with 25 U.S.C. 1452(c) and any "Native" as defined in the Alaska Native Claims Settlement Act (43 U.S.C. 1601). That same person must have 51% or more ownership in the firm, as well as daily control of the firm's management decisions. For more information, please go to http://www.arnet.gov/far/loadmainre.html (Part 26). ***Certification Process***

7. **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 http://www.va.gov/vetbiz/library/faq.htm. ***Self-Certification***

8. **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-disable 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 http://www.va.gov/vetbiz/library/faq.htm.
Self-certification.