CHAPTER 2: PROVIDER PARTICIPATION AND RESPONSIBILITIES

UNIT 2: NETWORK CREDENTIALING PROCEDURES

IN THIS UNIT

What Is My Service Area?

The *Highmark Blue Shield Office Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania (PA), Delaware (DE), West Virginia (WV), and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to only two states. **Where no symbol is present, the information is relevant to all states.**

PA ONLY — The PA symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.

DE ONLY — The DE symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.

WV ONLY — The WV symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

2.2 INTRODUCTION TO CREDENTIALING

What Is My Service Area?

Overview

Where the Highmark professional provider networks are utilized to support managed care products, Highmark must credential providers and utilize procedures to comply with National Committee for Quality Assurance (NCQA); the Centers For Medicare & Medicaid Services (CMS); Commonwealth of Pennsylvania Department of Health (DOH) regulations; State of Delaware Regulation 1403 Managed Care Organizations; and State of West Virginia regulations.

Providers are initially credentialed prior to network admission and recredentialed at least every three years. Highmark conducts verification of the practitioners as defined by their policies, state and federal regulations, and in accordance with accrediting standards.

This unit focuses on the credentialing process and presents a general description of Highmark's credentialing criteria and process. This is not intended to be a complete description of all credentialing requirements and procedures.

Note: Throughout this unit, the use of "Highmark" implies the Highmark service areas of Pennsylvania's Western, Central, and Northeastern Regions; Delaware; and West Virginia, unless otherwise noted.

What Is My Service Area?

Purpose

The credentialing and recredentialing processes are performed by Highmark employees who work cooperatively with network practitioners to ensure members have access only to those practitioners who meet Highmark's high standards of professional qualifications.

Online process utilized

Highmark utilizes Proview, the standardized national online credentialing system developed by the Council for Affordable Quality Healthcare (CAQH), as our exclusive provider credentialing system. All Highmark network providers must use the CAQH Proview™ system for credentialing and recredentialing.

Initial credentialing

Highmark staff follows an established process to credential professional providers for the Premier Blue Shield, Western Region managed care, and Medicare Advantage networks in Pennsylvania; the Commercial Exclusive Provider Organization (EPO) and Independent Practice Association (IPA) networks in Delaware; and the Commercial Preferred Provider Organization (PPO) and Point of Service (POS) networks and the Medicare Advantage network in West Virginia. In addition, we have delegated credentialing arrangements with a limited number of institutions that we have audited to assess their compliance with our credentialing standards.

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2.2 INTRODUCTION TO CREDENTIALING, Continued

Initial credentialing (continued)

The initial credentialing process includes, but is not limited to:

- Completion of a CAQH online application
- Signed attestation verifying all information on the application and stating any reasons for inability to perform essential duties, lack of illegal drug use, loss of license/privileges, felony, and disciplinary action
- Primary source verification
- Inquiry to National Practitioner Data Bank for sanction history
- Other verification as needed

To be considered a participating practitioner and support Highmark managed care products, including Medicare Advantage in Pennsylvania and West Virginia, all new practitioners must complete the CAQH online credentialing application, be approved by Highmark through a routine assessment process or by the Highmark Network Quality and Credentials Committee, as applicable, and then sign a contract.

The practitioner's participation and ability to treat Highmark members does not begin until the signed contract is returned and the contract is executed by Highmark. A welcome letter specifying the effective date of participation will be sent along with a copy of the executed contract.

What Is My Service Area?

Recredentialing

Highmark completes the recredentialing process at least once every three years with any applicable physicians and allied health professionals in the Premier Blue Shield, Western Region managed care, and Medicare Advantage networks in Pennsylvania; the Commercial EPO and IPA networks in Delaware; and the PPO and POS networks and the Medicare Advantage network in West Virginia. Our internal policies require recredentialing for the protection of our members. Additionally, Highmark's three year credentialing cycle is consistent with NCQA, CMS, Pennsylvania DOH, State of Delaware, and State of West Virginia standards.

The recredentialing process includes most of the same components as initial credentialing with some added components. At the time of recredentialing, a quality review is conducted. This review includes, when available, member satisfaction, member complaints related to both administrative and quality of care issues, malpractice history, medical record reviews, and office site information. Information regarding clinical quality actions or sanction activity will also be considered for continued network participation.

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2.2 INTRODUCTION TO CREDENTIALING, Continued

Ongoing monitoring

Highmark's Provider Information Management routinely monitors the ongoing compliance of network providers with credentialing/recredentialing criteria. Such monitoring includes, but is not limited to:

- U.S. Department of Health and Human Services, Office of Inspector General (OIG), List of Excluded Individuals/Entities (providers excluded from participation in Medicare, Medicaid, and other federal health programs) (monthly);
- Licensing Board queries (monthly); and
- Medicare Part B Opt Out List (quarterly).

If it is determined or suspected that a provider no longer complies credentialing, recredentialing, or contracting requirements (e.g., revocation or suspension of a license, OIG sanction), the matter will be investigated and presented to the applicable Highmark Network Quality and Credentials Committee (or the medical director in urgent situations) for appropriate action.

Note: Effective November 1, 2015, the ongoing monitoring process applies to practitioners in Highmark Blue Cross Blue Shield's northeastern Pennsylvania service area.

What Is My Service Area?

Network Quality and Credentials Committee

The Highmark Network Quality and Credentials Committee (PA/DE/WV) consists of practitioners from the applicable regions who are practicing physicians of various specialties who participate in Highmark's network in those regions. The Committee meets twice monthly to allow expeditious processing of exception practitioners.

The Committee is chaired by Highmark medical directors (also practicing physicians), who oversee the clinical aspects of the credentialing program. Other Highmark executive staff members serve on the Committee as non-voting members.

The primary responsibilities of the Network Quality and Credentials Committee are:

- Review and make recommendations regarding credentialing/recredentialing exception cases;
- Request additional information if needed to review a provider;
- Review and make recommendations regarding credentialing policies and procedures;
- Recommend corrective action or termination if a provider fails to meet reasonable standards of care or to comply with credentialing or contracting requirements; and
- Consult with appropriate specialists if needed to review a credentialing application or issue.

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2.2 INTRODUCTION TO CREDENTIALING, Continued

Network Quality and Credentials Committee (continued)

Note: The Highmark Network Quality and Credentials Committee is a formally-constituted peer review body, which meets the definition of review organization under West Virginia Code §S30-3C-1. As such, their proceedings and records are confidential and privileged as provided by WV Code §S30-3C-3.

2.2 HIGHMARK NETWORK CREDENTIALING POLICY

Overview

Physicians and any applicable allied health professionals must be credentialed by Highmark to participate in the Premier Blue Shield, Western Region managed care, and Medicare Advantage networks in Pennsylvania; the Commercial EPO and IPA networks in Delaware; and the Commercial PPO and POS networks and the Medicare Advantage network in West Virginia.

What Is My Service Area?

Types of professional providers credentialed

Highmark currently credentials the following types of professional providers:

PHYSICIANS	ALLIED HEALTH PROFESSIONALS
Medical Doctors (MD)	Audiologists
Doctors of Osteopathic Medicine (DO)	Clinical Social Workers
Podiatrists (DPM)	Counselors and Therapists
Doctors of Chiropractic (DC)	Occupational Therapists
Doctors of Dental Surgery/Dental Medicine (DDS/DMD):	Optometrists
	Physical Therapists
• Oral & maxillofacial surgeons	Psychologists
• Oral & maxillofacial radiologists	Registered Dieticians
• Oral and maxillofacial pathologists	Registered Nurse Anesthetists
• Orthodontists	Registered Nurse Midwives
• General dentists who provider covered medical/surgical services	Registered Nurse Practitioners
	Speech Pathologists & Therapists
	Licensed dietitian – nutritionist
	Acupuncturists*
	Massage Therapists*
	Certified Diabetic Educators*
	*Licensed Physician Assistants**

**Highmark West Virginia only*

Why blue italics?

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2.2 HIGHMARK NETWORK CREDENTIALING POLICY, Continued

When are practitioners credentialed?

A practitioner who has never been credentialed by Highmark must be credentialed when:

- Starting a solo practice, or
- Beginning to practice with an established network practice.

In addition, a practitioner who wishes to return to the network(s) will be required to undergo initial credentialing if:

- The practitioner submitted a signed, explicit document stating that he or she no longer wishes to be a participating provider, and there has been a break in service/contract of greater than thirty (30) days.
- The practitioner was terminated by Highmark during the re-credentialing process, and there has been a break in service/contract of greater than thirty (30) days.

Note: A practitioner returning to the network(s) may also be required to execute a new agreement.

If a network(s) credentialed practitioner moves from one network practice to another, no further credentialing is required if the notification from the practitioner is received within thirty (30) days and is ninety (90) days prior to the recredentialing due date.

If the notification from a practitioner is received more than thirty (30) days after the move to another network practice or is not within ninety (90) days of the practitioner's recredentialing date, the practitioner will not be terminated; however, initial credentialing will be required.

When credentialing is not required

An established practitioner who has already been credentialed by Highmark is not required to be credentialed again when:

- Joining another established network practice of the same specialty in a **different** geographic area within six months; or
- Joining another established network practice of the same specialty in the **same** geographic area within six months; or
- Leaving a group practice to begin a solo practice.

However, if a credentialed practitioner joins an existing participating group of the same specialty, Highmark must be notified within thirty (30) days.

NaviNet®-enabled providers can make those changes through the *Provider File Management* function on NaviNet. For those providers not NaviNet-enabled, the Request for Addition/Deletion to an Existing Assignment Account form can be used to notify us. This form is also available on the Provider Resource Center -- select **FORMS**, and then **Provider Information Management Forms**.

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2.2 HIGHMARK NETWORK CREDENTIALING POLICY, Continued

What Is My Service Area?

General credentialing criteria

The following is a general summary of Highmark's credentialing criteria for all practitioners.

- Active state license in each state in which the practitioner provides services;
- Acceptable five-year work history for initial credentialing;
- Professional liability insurance in compliance with regulations in state(s) in which the physician practices (please see the section in this unit on malpractice insurance requirements);
- Acceptable malpractice history;
- Written proof of Medicare eligibility and have not opted out of the Medicare Part B program for the Medicare Advantage network(s) (Pennsylvania and West Virginia); and
- No Medicare or Medicaid sanctions.

In addition, physicians (MDs, DOs, DDSs/DMDs, DPMs, and DCs), *and Physician Assistants for West Virginia only,* must furnish proof of the following:

- Active Drug Enforcement Agency (DEA) certificate in each state in which the practitioner is prescribing controlled substances;
- Privileges at a network or participating Blue Cross Blue Shield hospital, as applicable; and
- Availability to see Highmark members at least twenty (20) hours a week (for primary care practitioners).

Additional criteria for allied health practitioners include:

- Evidence of appropriate education and training (licensure often verifies education);
- Registered nurses (RNs) must have an active advanced practice certification by an entity approved by the state licensing board; and
- Nurse midwives must also provide documentation that describes the scope of services to be provided, as agreed upon by his or her supervising physician (collaborative agreement).
- *Physician Assistants (West Virginia only) must have a collaborating agreement with a physician who is credentialed and contracted in the same network.*

Please see the applicable sections in this unit for criteria specific to Emergency Medicine, Facility-Based, and Behavioral Health providers.

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2.2 HIGHMARK NETWORK CREDENTIALING POLICY, Continued

Physician education and training

All physicians must furnish proof of graduation from an American Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited training program. MDs and DOs may possess current Educational Commission for Foreign Medical Graduation (ECFMG) certification and have passed the Federation Licensing Examination (FLEX) or United States Medical Licensing Exam (USMLE).

Oral and maxillofacial surgeons, general dentists, and orthodontists must have completed training accredited by the Commission on Dental Accreditation (CODA). Podiatrists must have completed an accredited program recognized by the American Board of Podiatric Medicine (ABPM) or the American Board of Foot and Ankle Surgery (ABFAS).

Specialty training and Provider Directory listing

MDs and DOs may be credentialed and listed in the provider directories in a specialty recognized by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) if they have completed an ABMS or AOA accredited residency program in that specialty.

Oral and maxillofacial surgeons may be credentialed and listed in the provider directories in a specialty recognized by the American Board of Oral and Maxillofacial Surgery (ABOMS) if they have completed an accredited residency program in that specialty.

Podiatrists may be credentialed and listed in the provider directories in specialties recognized by either the ABPM or the ABFAS if they have completed an accredited residency program in that specialty. If ABPM or ABFAS boards are not available to the practitioner, the ABMSP will be recognized.

Completion of applications

For practitioners who fail to complete the credentialing or recredentialing process, or fail to supply all required information, this action **will be deemed as a practitioner's intention** to voluntarily withdraw from the applicable network(s) or result in discontinuation of the credentialing process for initial applicants.

The provider will be able to reapply for credentialing once he/she is able to comply with all initial credentialing requirements. For recredentialing practitioners, you will be notified in writing and your members may receive notification that you no longer participate in the network(s).

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2.2 HIGHMARK NETWORK CREDENTIALING POLICY, Continued

Malpractice information

Credentialing representatives may ask detailed questions regarding malpractice cases. If physicians do not submit the requested information, they could be denied or terminated from the network(s). In order to receive an accurate score, please submit the requested information regarding malpractice.

Proof of Medicare eligibility

All new practitioners must supply a Medicare welcome (participation) letter as proof of Medicare eligibility during the credentialing process. Practitioners who have opted out of Medicare are not eligible to see Medicare Advantage members.

Individual proof of Medicare eligibility is not required of physical therapists, speech/language pathologists, and occupational therapists wishing to be part of the Medicare Advantage networks in Pennsylvania and West Virginia if they are contracted with a Medicare approved outpatient physical therapy group.

What Is My Service Area?

24/7 availability requirements

Highmark requires that all credentialed network practitioners provide coverage for members twenty-four (24) hours a day, seven (7) days a week. This can be accomplished either directly or through an on-call arrangement with another Highmark credentialed participating practitioner of the same or similar specialty and of the same network(s).

An answering service, pager, or direct telephone access whereby the practitioner or his designee can be contacted is acceptable. A referral to a crisis line is NOT acceptable unless a prior arrangement has been made with the crisis line whereby the practitioner (or his/her designee) can be contacted directly, if needed.

The following specialties are exempt from this requirement:

- Audiologists
- Dermatopathologists
- Dietitians/nutritionists
- Occupational therapists
- Pathologists (only if working outside of the acute care setting)
- Oral and maxillofacial pathologists (only if working outside of the acute care setting)
- Physical therapists
- Preventive medicine specialists
- Speech/language pathologists

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2.2 HIGHMARK NETWORK CREDENTIALING POLICY, Continued

What Is My Service Area?

Availability for urgent and routine care

At the time of initial credentialing, Primary Care Practitioners (PCPs) not joining an existing group must provide office hours at each practice location accessible to members a minimum of twenty (20) hours a week at each practice site. (Applies to the Keystone Health Plan West [KHPW]* and Premier Blue Shield networks in Pennsylvania, and to the Delaware participating provider network.)

PCP practice sites not meeting this requirement will be subject to an on-site review every three (3) years. In addition, for PCP practices participating in Pennsylvania's KHPW and Premier Blue Shield networks, practice sites not meeting the requirement will be noted in the provider directory as having limited hours.

**Keystone Health Plan West is Highmark's managed care provider network in the 29-county Western Region of Pennsylvania.*

Why blue italics?

Admitting and clinical privilege requirements

Primary care physicians (family practitioners, pediatricians, internists, and general practitioners), *and Primary Care Physician Assistants for West Virginia only,* are required to have admitting privileges in good standing at a network participating hospital**.** Applicable physician specialists, *and Physician Assistant Specialists for West Virginia only,* are required to have clinical privileges in good standing at an in-network hospital. Primary care certified registered nurse practitioners (CRNPs) must have full admitting privileges or a plan of action with a network participating primary care physician.

The hospital clinical privilege requirement is waived for the following specialties:

- Anesthesiology
- Dental anesthesiology
- Emergency medicine
- Nuclear medicine
- General dentistry
- Oral maxillofacial surgery
- Oral maxillofacial pathology
- Oral maxillofacial radiology
- Pathology
- Non-surgical podiatry
- Physiatry/physical medicine
- Psychiatry
- Radiology

Clinical privilege requirements, including admitting, will be waived for all physicians who, on the application, document arrangements that are acceptable to Highmark for adequate coverage through another credentialed in-network practitioner.

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2.2 HIGHMARK NETWORK CREDENTIALING POLICY, Continued

Admitting and clinical privilege requirements (continued)

The practitioner must have privileges at an in-network hospital or belong to a credentialed in-network group of the same specialty. The name(s) of the covering physician(s) must be provided on the application (a co-signed document from the covering physician[s] is not required.)

What Is My Service Area?

First Priority Health network admitting and clinical privilege requirements

Primary care physicians and specialists who are in the First Priority Health (FPH) network in northeastern Pennsylvania must meet the following admitting and clinical privilege requirements:

- Each FPH primary care physician applicant shall have hospital privileges in the specialty for which they are applying at a FPH participating hospital or have an alternative arrangement for admitting a member, approved by the Plan.
- Each FPH specialist applicant shall have hospital privileges in the specialty for which they are applying at a FPH participating hospital or have an alternative arrangement for admitting a member, approved by the Plan.

IMPORTANT!

Highmark practitioners are required to use participating practitioners for all coverage arrangements, including ambulance.

Confidentiality and anti-bias statements

All practitioner information obtained in the credentialing process, except as otherwise provided by law, is kept confidential.

Credentialing and recredentialing decisions will not be based on an applicant's race, religion, ethnic/national identity, gender, age, sexual orientation, or the type of procedures or patients in which the practitioner specializes.

Time frame

Highmark is required to verify all completed application information within one hundred eighty (180) days from the date the practitioner signs the attestation statement.

The Network Quality and Credentialing area will not submit any application for the Network Quality and Credentials Committee's review that is signed and dated more the one hundred eighty (180) days prior to the Committee date for initial or recredentialing providers. These time frames also apply to any primary or secondary source verification information. In such cases, the provider may be asked to re-sign the application and information may need to be re-verified.

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2.2 HIGHMARK NETWORK CREDENTIALING POLICY, Continued

Time frame – Ohio practitioners participating with Highmark West Virginia

Highmark West Virginia's credentialing procedures are designed to facilitate prompt review and decision regarding a provider's completed credentialing application. In accordance with the Ohio Healthcare Simplification Act, all practitioners who participate with Highmark West Virginia and whose primary site of service is located in Ohio are required to be credentialed and notified of their credentialing status within ninety (90) days of Highmark West Virginia receiving a complete or incomplete credentialing application. All other providers will be initially credentialed within one hundred twenty (120) days following the submission of the provider's completed credentialing application, in compliance with W.Va. Code § 30-45-2(11).

What Is My Service Area?

Locum Tenens

Highmark credentials locum tenens physicians based on the length of time the physician will be providing care in Highmark network service areas. Locum tenens physicians who will be providing services for at least six (6) months or longer will be required to undergo initial credentialing and, if applicable, re-credentialing at least every three (3) years.

Please Note: Effective August 22, 2017, locum tenens service time frames may not exceed sixty (60) consecutive days for Medicare Advantage or commercial networks. Locum tenens already in process or those applications received prior to August 22, 2017, will receive the six (6) months of network coverage for commercial lines of business. Please see Chapter 2, Unit 3 for more information on Highmark's locum tenens policy.

2.2 PRACTITIONER CREDENTIALING RIGHTS

Policy

Practitioners who are applying for participation in Highmark's credentialed networks have the right to review information submitted in support of their credentialing application, be notified of information that varies substantially from primary sources, and to correct erroneous information.

Primary sources

Primary sources that may be contacted as part of the credentialing process include, but are not limited to, the following:

- State Licensing Bureau
- Drug Enforcement Agency
- Educational program(s) the practitioner completed
- American Board of Medical Specialties, or American Osteopathic Association, if applicable
- National Practitioner Data Bank
- Office of the Inspector General participation/sanction data
- Federation of Chiropractic Licensing Board, if applicable
- Federation of Podiatric Medical Board, if applicable

Additional sources

Highmark will review and may also take into consideration the following types of information (among others) in credentialing or recredentialing decisions for all provider types:

- Convictions, criminal and civil proceedings;
- Substance abuse impairment;
- Fraud, inappropriate or excessive billing;
- Complaints;
- Non-cooperation/non-compliance with Highmark contract terms, administrative requirement, or health services management programs;
- Completeness, timeliness, and accuracy of credentialing information;
- Quality of care or utilizations issues.

Right to review information

Providers have the opportunity to review information submitted during the credentialing/recredentialing process. This includes information obtained from outside sources except for references, recommendations, or other peer review protected information and any other data that is prohibited from being disclosed by law.

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2.2 PRACTITIONER CREDENTIALING RIGHTS, Continued

Right to review information (continued)

The request for information should be made in writing and directed to:

Highmark Provider Information Management (PIM)
P.O. Box 898842
Camp Hill, PA 17089-8842
or
Fax: 1-800-236-5907

Within thirty (30) calendar days of receipt of the request, the information, except for references, recommendations, or other peer review protected information and any other data that is prohibited from being disclosed by law, will be mailed with a cover letter in an envelope marked "Personal and Confidential."

As documentation of receipt of request, a copy of the communication will be maintained in the provider's credentialing file.

Notification of discrepancy

In the event information from a source varies substantially from that which was submitted by the provider, Provider Information Management (PIM) will initiate notification and communication via phone, fax, email, or certified returned receipt requested letter within thirty (30) calendar days of discovery.

As documentation of receipt of discrepancy notification, a copy of the communication will be provided in the provider's credentialing file.

Right to correct erroneous information

Within thirty (30) calendar days of request to correct information, the provider should submit any corrections in writing to PIM:

Highmark Provider Information Management (PIM)
P.O. Box 898842
Camp Hill, PA 17089-8842
or
Fax: 1-800-236-5907
or
Email address provided by staff assigned

This information is reviewed with the Medical Director to make a decision on a case by case basis. The information received from the provider may be presented to the Network Quality and Credentials Committee, if applicable.

Any differences in demographic information, education, work history, and/or Drug Enforcement Agency (DEA) certificate/license expiration dates may be handled via telephone.

As documentation of receipt of corrections, the communication will be maintained in the provider's credentialing file.

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2.2 PRACTITIONER CREDENTIALING RIGHTS, Continued

Right to be informed of credentialing status

Providers can view network status and effective dates via the Provider File Management selection in NaviNet.® Select **Provider File Management** from the main menu on the left on Highmark's NaviNet Plan Central, and then click on the **Review credentialing status** link at the top of your Provider File Management page.

Through NaviNet's Provider File Management, providers can also complete real-time demographic changes (address updates, phone number changes, site of service selections, upload provider picture to the directory, office hours, new patients information); addition and termination of providers; request credentialing; and view credentialing specialist contact information.

Communication of practitioner rights

Communication regarding provider rights to review, to be notified of and correct erroneous information, and to receive notice of application status is made via inclusion of this information in this manual, the *Highmark Blue Shield Office Manual*. This online manual is available to network participating providers electronically on the Provider Resource Center, which is accessible via NaviNet and also Highmark's regional websites in Pennsylvania, Delaware, and West Virginia.

Annual notifications of the availability of this information in the *Highmark Blue Shield Office Manual* are published in the *Provider News* newsletters, which are published bi-monthly. Providers are notified when *Provider News* is published online via e-Subscribe email notifications. Providers not subscribed to e-Subscribe email notifications receive an annual postcard indicating newsletter publication dates for the calendar year.

What Is My Service Area?

2.2 THE CREDENTIALING PROCESS

Overview

Highmark uses CAQH Proview,™ the standardized national online credentialing system developed by the Council for Affordable Quality Healthcare (CAQH) for initial credentialing because it greatly improves processing times. CAQH Proview eliminates the need for multiple credentialing applications and significantly streamlines the credentialing process. Through this online service, practitioners complete one standard application that meets the needs of Highmark and other participating health plans and health care organizations.

Highmark uses CAQH Proview as the exclusive provider credentialing system for all applicable networks. All Highmark network providers in the Pennsylvania and Delaware service areas must use CAQH for credentialing and recredentialing.

IMPORTANT: Mandated WV Uniform Credentialing Form

To initiate the credentialing process, Highmark West Virginia physicians and allied health practitioners must complete the most recent version of the State of West Virginia Uniform Credentialing Form (application), preferably by entering information into the CAQH database, as long as it is printed on the mandated West Virginia Uniform Credentialing Form (application). Please see the next page for CAQH instructions.

The most current versions of the West Virginia Uniform Credentialing Form and recredentialing forms are also available on the West Virginia Insurance Commissioner's website at www.wvinsurance.gov. All initial credentialing applications for practitioners are to be returned to Highmark's Provider Information Management area for primary source verification **by faxing to 1-800-236-5907**.

Providers without access to a fax machine can mail the application to:

Provider Information Management
Highmark
P.O. Box 898842
Camp Hill, PA 17001-9937

What Is My Service Area?

FOR MORE INFORMATION

For an overview of the Highmark credentialing process, select **CREDENTIALING** from the main menu on the Provider Resource Center, and then click on **Initial Credentialing Set Up**. The process is also explained on the next page.

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2.2 THE CREDENTIALING PROCESS, Continued

If you already have a CAQH ID

If you are already a CAQH participating practitioner with a CAQH ID, please visit https://proview.caqh.org. Log into CAQH Proview to review and re-attest to your CAQH application. Be sure to add Highmark as an authorized plan, or grant global authorization.

In addition, you must complete Highmark's online *Initial Provider Credentialing Request Form*. The form can be found on Highmark's Provider Resource Center via NaviNet® or www.highmark.com* (click on the orange **CONSUMERS/MEMBERS/ PROVIDERS** tab, and then select the link for the Highmark plan in your service area from the options under the **FOR PROVIDERS** heading).

Select **CREDENTIALING** from the main menu of the Provider Resource Center, and then click on the **Initial Credentialing Request Form** link. Complete the required fields on the form, including your CAQH ID, and then click on **Submit**. Highmark will retain an electronic copy of your CAQH Proview profile in its database and send you a confirmation email.

What Is My Service Area?

If you are not yet registered with CAQH

If you have not yet registered with CAQH Proview, you will first need to visit https://proview.caqh.org to obtain a CAQH ID and complete the application. Resources to help you navigate the system are available through links on the login page. Although the initial application may take several hours to complete, the process allows you to save your information and return later to complete the application. **Please be sure to select Highmark as a plan authorized to receive your information.**

Once you have obtained your CAQH ID, please complete Highmark's **Initial Credentialing Request Form**, which is available by selecting **CREDENTIALING** from the main menu on the Provider Resource Center.***** Complete the required fields on the form, including your CAQH ID. After the form is successfully submitted, Highmark will retain an electronic copy of your CAQH ProView profile and will send you a confirmation email.

***** The *Initial Provider Credentialing Request* form is also available on NaviNet Plan Central. To access the form via NaviNet Plan Central, select **Provider File Management**, and then click on the **Request Credentialing** button.

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2.2 THE CREDENTIALING PROCESS, Continued

Check the status of your request

To ensure your application has been received, please visit NaviNet and follow these steps:

- Select **Provider File Management** from the Highmark Plan Central menu (if there is more than one group, select the applicable group from the dropdown, and then click on **Go**).
- Select the **Review credentialing status** link; the **Case Status** field will indicate the progress of the practitioner's credentialing application.
- Click on the arrow before the practitioner's name to view details.

By selecting **Expand All**, you can view credentialing details for all practitioners in the group.

What Is My Service Area?

If you do not have internet access…

If you are not yet registered with CAQH and do not have internet access, please call the toll-free **CAQH Help Desk** at **1-888-599-1771** for other options for completing the CAQH credentialing application. You can then contact Highmark once you receive your CAQH ID.

During initial credentialing, practitioners also participate in the process of contracting with Highmark. The initial credentialing and contracting process is as follows:

STEP	ACTION
1	To begin the process, the practitioner must submit all information requested through CAQH ProView. Highmark will then provide additional information and instructions.
2	The Highmark Credentialing Department representative reviews the application. If the application is incomplete, the representative contacts the practice to request the missing information.
3	The credentialing process will include, but is not limited to, verification or confirmation of the following: • Unrestricted licensing in the state(s) where practicing* • Drug Enforcement Agency (DEA) certificate issued by each state where practicing* • Medical education and training (as applicable)* • Board certification (if applicable)* • History of liability claims • Malpractice coverage amounts • Work history

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2.2 THE CREDENTIALING PROCESS, Continued

Steps in the initial credentialing process (continued)

STEP	ACTION
3 (cont.)	• Medicare participating status • National Practitioner Data Bank (NPDB)* • Office of the Inspector General (OIG) Medicare and Medicaid sanction lists* **Note:** Primary source verification of hospital clinical privileges and medical liability insurance coverage is no longer required. A signed attestation statement is all that is needed. * These elements are verified through primary sources.
4	The Credentialing Department will also review the application for the following: • Ability to enroll new members • Ability to provide urgent/routine care • 24/7 coverage (if applicable) • Office hour availability of at least 20 hours/week (PCP)
5	A Credentialing Department Specialist verifies that all information required for National Committee for Quality Assurance (NCQA) and/or State and Federal Regulatory Agencies is complete. **Note:** If verification cannot be completed within the required 180 days, the applicant will be asked to re-sign and re-date the attestation page of the application and provide valid, current information. Electronic signatures are accepted on the application.
6	If the credentials file elements meet all Highmark credentialing criteria, the Medical Director will review the application and render a decision. If the application does not meet Highmark credentialing criteria, the Highmark Network Quality and Credentials Committee reviews the application. In some instances, the Committee may request additional information before rendering a decision.
7	• Upon approval of the Highmark Network Quality and Credentials Committee or the Medical Director, practitioners will receive written notification. • If denied initial credentialing status, the practitioner will receive written notification within sixty (60) calendar days and will be offered an opportunity to have the decision reconsidered.

Continued on next page

2.2 THE CREDENTIALING PROCESS, Continued

What Is My Service Area?

Steps in the initial credentialing process (continued)

STEP	ACTION
8	• In Pennsylvania, a copy of the executed contract and a welcome letter stating the effective date is mailed to the new practitioner or group, as applicable. The practitioner or authorized representative signs the contract and the original contract is returned to Highmark. A Highmark representative signs the contract for validation. A copy of the executed contract and a welcome letter stating the effective date is then mailed to the new network practitioner or group, as applicable. • In Delaware, a copy of the contract will be mailed to the practitioner for a signature. The practitioner will send the contract back and Highmark Delaware will counter execute it. The practitioner will then receive a fully-executed contract and a welcome letter with the effective date of the new provider or group, as applicable. • In West Virginia, a copy of the executed contract and a welcome letter stating the effective date is mailed to the new practitioner or group. The practitioner or authorized representative signs the contract and the original is returned to Highmark. The contract is signed and validated by a Highmark representative, and then a copy of the executed contract and welcome letter confirming the effective date is mailed to the new practitioner or group, as applicable.

Effective date

The practitioner's participation in Highmark's credentialed networks is effective only upon completion of a Highmark-executed contract. The participation effective date is stated within the welcome letter.

IMPORTANT!

Please note that Highmark strongly discourages the use of Social Security numbers in lieu of business tax identification numbers whenever it requests a provider's tax identification number.

Highmark's use of provider tax identification numbers

In addition to claims processing, Highmark uses a provider's tax identification number to accurately identify providers for other business functions and with outside vendors/partners during the normal course of business operations.

A provider who chooses to submit his or her Social Security Number as a tax identification number hereby acknowledges, understands, and agrees that Highmark will treat the Social Security Number in the same manner in which it handles other providers' business tax identification numbers and shall not be liable to such provider for any intentional or unintentional disclosures of such Social Security Number.

Continued on next page

2.2 THE CREDENTIALING PROCESS, Continued

How to obtain a Federal Employer Identification Number (EIN)

To avoid using your Social Security Number as your Provider Tax Identification Number, you may instead use a federal Employer Identification Number (EIN) issued by the Internal Revenue Service (IRS).

To obtain an EIN, please visit www.irs.gov.

2.2 THE RECREDENTIALING PROCESS

Overview

The process for credentialing new practitioners and recredentialing existing network practitioners is essentially the same. Network practitioners must be recredentialed at least every three (3) years.

Notification to complete online process

Highmark uses the standardized online credentialing system developed by the Council for Affordable Quality Healthcare (CAQH) exclusively for initial credentialing and also for recredentialing of existing network practitioners for applicable networks.

All Highmark network providers must use CAQH ProView™ for recredentialing. Paper applications and NaviNet® functionality for recredentialing have been eliminated.

Several months prior to the end of the three-year credentialing cycle, the practitioner will receive notification that the recredentialing application is due.

- **For Practitioners Registered with CAQH:** Highmark will send a letter to notify the practitioner that it is time for recredentialing. The practitioner will then log into CAQH ProView at https://proview.caqh.org to review and re-attest to their CAQH application.
- **For Practitioners Not Yet Registered with CAQH:** Highmark will send you a notification to log into CAQH ProView at https://proview.caqh.org. Complete the online application. Be sure to add Highmark as an authorized plan, or grant global authorization.
- **For West Virginia Practitioners Not Registered with CAQH:** Generally, six (6) months prior to the recredentialing due date, an application will be mailed to Highmark West Virginia practitioners for completion. Physicians and allied health providers must complete the West Virginia Uniform Recredentialing Form (application), or other state mandated recredentialing application.

What Is My Service Area?

If you do not have Internet access…

If you do not have internet access, please contact the CAQH Help Desk for other options by calling **1-888-599-1771.**

Assessment of clinical quality

During recredentialing, practitioners are evaluated on their professional performance, judgment, and clinical competence. Criteria used may include, but may not be limited to, quality-of-care concerns, malpractice history, sanctioning history, member complaints, participation with quality improvement activities and condition management programs, data completeness, overutilization, and underutilization.

Continued on next page

2.2 THE RECREDENTIALING PROCESS, Continued

Quality Blue clinical quality scores

The Quality Blue clinical quality scores are monitored on an ongoing basis regardless of the practitioner's recredentialing due date. These metrics are available to PCPs on NaviNet even if they do not participate in Quality Blue, Highmark's physician pay-for-value program. In situations where the clinical quality score is below the acceptable threshold, a Highmark Clinical Quality Consultant will contact the practice to work with the practitioner to meet the acceptable scoring requirements.

Office site reviews

For all PCPs, OB/GYNs, and potential high-volume behavioral health practitioners, Quality Management nurses will conduct Practitioner Office/Facility Site Quality and Medical/Treatment Record Evaluations for any practitioner in the network.

These evaluations will be based on the following:

1) Member dissatisfactions received about the quality of any practitioner office where care is delivered that is related to physical accessibility, physical appearance, or adequacy of waiting room and examining/treatment room space; or
2) Annual random sampling with practice sites selected using a statistically valid sampling methodology.
3) Problems that were identified during Risk Adjustment Data Validation (RADV) audits.

The overall evaluation process may include the following:

- Practitioner office site quality evaluation;
- Medical/treatment record evaluation;
- Process improvement evaluation.

The office site evaluations include, but are not limited to, an assessment of the following:

- Physical accessibility;
- Physical appearance;
- Adequacy of waiting and examining room space;
- Member access to services and availability of appointment;
- Policies and procedures;
- Adequacy of equipment;
- Confidentiality of member information;
- Adequacy of medical/treatment record keeping/documentation.

Continued on next page

2.2 THE RECREDENTIALING PROCESS, Continued

Office site reviews (continued)

The on-site review nurse will mail a comprehensive, written report to the practice outlining the results of the evaluation and a corrective action plan if necessary.

Practices not meeting the compliance standards are expected to correct deficiencies and are subject to a re-evaluation six (6) months after the initial visit. Failure to correct deficiencies could impact the practice's credentialing or network status.

For more detailed information on this process, please refer to the applicable section of Chapter 4, Unit 5 of this manual.

Assessment of data completeness

Highmark must include an evaluation of a practitioner's data completeness in the recredentialing process in order to comply with the standards of various accrediting and regulatory entities such as the Centers for Medicare & Medicaid Services (CMS). The Data Completeness Evaluation occurs in concert with the Healthcare Effectiveness Data and Information Set (HEDIS®) and Risk Adjustment Data Validation (RADV) chart audits.

Data Completeness Evaluations are incorporated into the recredentialing process as follows:

- **Year One:** If a Data Completeness deficiency or deficiencies are noted by one of Highmark's Clinical Transformation Consultants during a HEDIS or RADV chart audit, a feedback sheet(s) will be left on each member's medical record detailing the deficiencies found. If the individual practice receives five (5) or more unique feedback sheets in the first year, the practice will be "flagged" in Highmark's database.
- **Year Two:** If five or more feedback sheets are left with the same practice in the subsequent year, the practice will receive a letter that explains that the credentialing decisions for all practitioners in the practice could be impacted if five (5) or more feedback sheets are given to the practice for a third consecutive year.
- **Year Three:** If a practice receives five (5) or more feedback sheets **for three (3*) *consecutive* years**, the practitioners at that office will be evaluated as "exceptions" at the time of their next recredentialing review, which could potentially lead to termination from the network(s).

For the basic elements reviewed during this assessment, please see the measures related to documentation in the Professional/Facility Medical Record Evaluation tables in the Clinical Quality section of Chapter 4, Unit 5 of this manual.

Continued on next page

2.2 THE RECREDENTIALING PROCESS, Continued

Step-by-step process

The recredentialing process is essentially the same as the initial process for credentialing new practitioners.

STEP	ACTION
1	Notification is sent to the practitioner that the recredentialing application is due several months prior to the end of the three-year credentialing period. • CAQH registered practitioners receive a letter from Highmark, and then log into CAQH ProView to review and re-attest to their CAQH application. • Practitioners not yet registered with CAQH ProView will receive a letter from Highmark notifying you to log into CAQH ProView at https://proview.caqh.org. Complete the online application and add Highmark as an authorized plan or grant global authorization.
2	A Credentialing Department representative conducts primary source verification. If additional documents are required, they should be emailed, faxed, or mailed. Highmark is required to verify all completed application information within 180 days from the date the practitioner signs the attestation statement.
3	The Credentials Committee or the Medical Director reviews the practitioner's qualifications and renders a decision.
4	The practitioner is notified of any adverse decision through a letter within sixty (60) calendar days.

2.2 CREDENTIALING REQUIREMENTS FOR FACILITY-BASED PROVIDERS

What Is My Service Area?

Facility-based practitioner credentialing policy

Highmark does not require practitioners to complete the credentialing or recredentialing process for the network(s) if they are strictly facility-based and practice exclusively in a network participating acute care hospital setting. This includes, but is not limited to, the following provider types:

- Pathologists
- Oral maxillofacial pathologists
- Anesthesiologists
- Radiologists
- Oral maxillofacial radiologists
- Emergency medicine specialists

Highmark policy does not require credentialing or recredentialing for the network(s) when the following requirements are met. The practitioner must:

- Provide one hundred (100) percent of his or her services to members exclusively in the acute care or general hospital setting.
- Have a current, valid unrestricted license (i.e., absence of a current Prothonotary report or consent order) to practice in the state(s) where he/she provides care for the organization's members. For participation in the Premier Blue Shield Network in Pennsylvania, a practitioner must have a current, valid, unrestricted license in the Commonwealth of Pennsylvania regardless of the state(s) where the practitioner provides care.
- Have current active malpractice insurance that meets or exceeds Pennsylvania and/or Delaware state requirements.
- Actively participate with Medicare/Medicaid and have never been debarred from or excluded from participation in any Medicare or Medicaid government programs.
- Sign an *Affirmation of Medical Practice Statement* (Form No. 282). (*See PARE Attestation information below*.)

These practitioners, however, must complete the appropriate provider agreements to participate with Highmark's participating provider network(s).

PARE Attestation

The PARE Attestation, or Hospital Based Provider Affirmation Statement form, can be also be accessed from the Provider Resource Center (select **FORMS**, and then **Provider Information Management Forms**).

Continued on next page

2.2 CREDENTIALING REQUIREMENTS FOR FACILITY-BASED PROVIDERS, Continued

IMPORTANT!

If a practitioner begins to provide medical services to members outside of a network-participating acute care facility, the practitioner will be required to complete the initial credentialing and contracting processes.

2.2 EMERGENCY MEDICINE CREDENTIALING REQUIREMENTS

Board certification requirements

Emergency department providers must be board certified in Emergency Medicine, Family Medicine, Internal Medicine, Pediatrics, or General Surgery.

Exception to board certification

Providers who are in the Highmark defined board eligibility period must have completed an approved, applicable residency or fellowship in the specialty in which he/she practices and complete the board certification by December 31 of the sixth (6th) year of completing approved, applicable residency training or a contiguous subsequent fellowship training program in the specialty in which he/she practices. The intent is the provider is to become board certified.

If board certified/eligible in Family Medicine, Internal Medicine, Pediatrics, or General Surgery, the provider must maintain current Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS), and Advanced Trauma Life Support (ATLS) certification.

General Practice Specialist

Effective December 1, 2012, Highmark West Virginia participating physicians practicing in an emergency department can no longer be credentialed as a General Practice Specialist with the exception of those practitioners who are currently credentialed under this specialty who were "grandfathered" in under this specialty listing.

In order to maintain the recredentialing status as a General Practice Specialist, the practitioner must maintain ATLS, ACLS, and PALS certifications and obtain ten (10) Pediatric CMEs (continuing medical education credits) per year (for a total of thirty [30] Pediatric CMEs per credentialing cycle).

What Is My Service Area?

2.2 CREDENTIALING REQUIREMENTS FOR BEHAVIORAL HEALTH

Overview

Behavioral health practitioners considered for participation must provide evidence of a current license in their specialty at the highest level in the state in which they practice. Licensure must be for independent practice, if applicable.

A behavioral health practitioner must carry professional liability insurance in compliance with regulations in the state(s) in which he/she practices. Please see the section in this unit titled "Malpractice Insurance Requirements" for additional information on requirements in Pennsylvania, Delaware, and West Virginia.

Professional organization membership

Membership in a national professional organization that ascribes to a professional code of ethics, such as the American Psychiatric Association or the American Psychological Association, is preferred.

What Is My Service Area?

Psychologist requirements

Psychologists must be licensed as a psychologist in the state(s) in which they practice. PhD level psychologists must meet one of the following criteria:

- Certification from the Council for the National Register of Health Services Providers in Psychology.
- Certification from the American Board of Professional Psychology, Diplomate in Clinical Counseling, Family Psychology, Neuropsychology, or Health Psychology.
- A dissertation for the doctoral degree that is primarily psychological in nature with a specialty in clinical counseling or professional-scientific psychology.
- Graduation from an American Psychological Association (APA) approved internship or successful completion of an APA-equivalency form.

Licensed clinical social worker requirements

Licensed clinical social workers (LCSWs) must hold a master's degree or doctoral degree in social work from a school accredited by the Council on Social Work Education (CSWE). Additionally, they must be licensed at the highest level for independent practice in the state in which they practice.

Clinical nurse specialist requirements

Clinical nurse specialists must be licensed as a registered nurse in the state in which they practice. They must hold a certificate of Clinical Nurse Specialty in psychiatric mental health nursing as issued by the American Nurses' Association (ANA)/American Nurses Credentialing Center (ANCC).

Continued on next page

2.2 CREDENTIALING REQUIREMENTS FOR BEHAVIORAL HEALTH,
Continued

Psychiatric-certified CRNP requirements	Psychiatric certified registered nurse practitioners (CRNPs) must be licensed as a registered nurse and a CRNP in the state in which they practice.
Master's-prepared therapist criteria	Master's-prepared therapists (other than clinical social workers or nurses) must hold licensure or certification in the state in which they practice at an independent practice level in an accepted human services specialty, such as one of the following: • Licensed professional counselor (LPC) • Marriage and family therapists (MPT)

2.2 DUAL CREDENTIALING AND RECREDENTIALING AS BOTH PCP AND SPECIALIST

Physician categories

Highmark contracts with network physicians as either:

- Primary Care Physicians (PCPs) -- family practitioners, general practitioners, internists, and pediatricians; or
- Specialists -- all other MDs or DOs.

An individual practitioner may participate as both PCP and specialist if the practitioner meets network credentialing standards for each category.

Criteria

All practitioners who want to be credentialed as both a PCP and a specialist must:

- Demonstrate that the practice adequately provides primary care services to Highmark members;
- Meet the standards for PCPs; and
- Must be board certified or meet one of the board certification exceptions for each specialty requested. Each specialty not boarded/meets exception will be "Process discontinued".

Recredentialing

Dual-credentialed practitioners will undergo full recredentialing for PCP and specialist participation every three (3) years.

Recredentialing applicants requesting to add dual credentialing must be board certified/meet exception in each additional specialty requested. If not board certified/meets exception in additional specialty requested, the file will be "Process Discontinued" for that specialty only.

Note: Recredentialing applicants without board certification who were approved for dual credentialing prior to August 15, 2016, will be "grandfathered" into the network.

Provider directory

All dual-credentialed physicians will appear in the provider directories as both PCPs and specialists and can receive referrals from other PCPs.

2.2 PRACTITIONER QUALITY AND BOARD CERTIFICATION

Policy

To be credentialed in Highmark networks, primary care practitioners (PCPs) and specialists -- including podiatrists -- are required to be board certified in the specialty in which they practice or meet one of the exceptions to board certification. Our online provider directories will indicate that a physician is board certified if he/she is currently certified in a specialty category.

Note: Effective August 15, 2016, the board certification and exception policy requirements will be applicable to West Virginia practitioners. Board certification is required in each specialty for which the practitioner is requesting to be credentialed. Practitioners in the network prior to August 15, 2016, will be grandfathered and processed as routine. All of these exceptions do not apply to practitioners in emergency departments (see the section of this unit on "Emergency Medicine Credentialing Requirements").

Highmark recognized boards for certification

Highmark recognizes the following boards for certification:

- America Board of Medical Specialties (ABMS)
- American Osteopathic Association (AOA)
- American Board of Podiatric Medicine (ABPM)
- American Board of Foot and Ankle Surgery (ABFAS)
- American Board of Multiple Specialties in Podiatry (ABMSP)*
- American Board of Oral and Maxillofacial Surgery (ABOMS)
- American Academy of Oral and Maxillofacial Radiology (AAOMR)

** If ABPM or ABFAS boards not available to practitioner*

Exceptions to board certification requirements

Effective August 15, 2016, all applicable practitioners who are not board certified and are applying to participate in a Highmark credentialed network must meet one of the following exception criteria to be considered eligible for credentialed network participation:

Exception 1: **Completed training prior to December 31, 1987**

Practitioners must have graduated from an accredited medical osteopathic, or podiatric medical school, or dental school; completed an applicable accredited residency or fellowship acceptable to the Highmark Network Quality and Credentials Committee in the specialty in which the practitioner practices; **and** completed training prior to December 31, 1987.

Exception 2: **Board eligibility period**

Practitioners must have completed an approved, applicable residency or fellowship in the specialty in which he/she practices and complete board certification by December 31 of the sixth year of completing approved, applicable residency training or a contiguous subsequent fellowship training in the specialty in which he/she practices.

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2.2 PRACTITIONER QUALITY AND BOARD CERTIFICATION, Continued

Exceptions to board certification requirements (continued)

Exception 3: Geo Access Deficiency
An annual Geo Access report will be generated and practitioners who are not board certified will be evaluated using network access requirements for specialty and practice location(s). If there is an access deficiency for any location, the practitioner's file will meet the exception. If it is determined that there are no access deficiencies in any location, initial applicants will be "Process Discontinued"; recredentialing applicants will be reviewed by the Medical Director.

Dual credentialing criteria

Initial applicants requesting to be dual credentialed must be board certified or meet one of the board certification exceptions for each specialty requested. Each specialty not boarded or meeting exception will be finalized as "Process Discontinued."

Recredentialing applicants requesting to add dual credentialing after August 15, 2016, must be board certified/meet exception in each additional specialty requested. If not board certified or meets exception in additional specialty requested, the file will be finalized as "Process Discontinued" for that specialty only.

Note: Recredentialing applicants without board certification who were approved for dual credentialing prior to August 15, 2016, will be "grandfathered" into the network.

Northeastern Pennsylvania certification requirements

Effective November 1, 2015, practitioners in Highmark's **northeastern Pennsylvania service region** must meet the following criteria:

- Practitioners must have completed an approved, applicable residency or fellowship in the specialty in which he/she practices and complete the board certification within three (3) years of their initial eligibility.
- Initial applicants will be held to the three-year eligibility period for completion of board certification.
- In-network practitioners who are no longer board eligible will be grandfathered into the network at the time of their next recredentialing cycle.
- In-network practitioners who are still board eligible will be expected to obtain their board certification by November 2018.

2.2 MALPRACTICE INSURANCE REQUIREMENTS

Overview

A provider must carry, at their own expense, the minimum required amount of malpractice insurance at all times to maintain credentialing.

Network malpractice insurance criteria

Providers must carry and maintain at all times liability and professional liability (malpractice) insurance to insure the group provider and each individual practitioner against any claim or claims for damages arising by reason of personal injury or death occasioned, directly or indirectly, in connection with the performance or omission of any provider service. The amount of coverage carried should not be less than the amounts required by any applicable state laws or less than those coverage levels required by Highmark.

Network providers must provide evidence of coverage to the network upon request. Providers must also notify Highmark at least thirty (30) days in advance of any reduction or termination of malpractice coverage.

What Is My Service Area?

Pennsylvania requirements: If you are Mcare Fund eligible

Medical doctors, doctors of osteopathy, podiatrists, and nurse midwives are required by Pennsylvania law to participate in the Pennsylvania Medical Care and Reduction of Error Fund ("Mcare Fund").

By law, these providers must maintain primary medical malpractice insurance with liability limits of $500,000 per medical incident and $1.5 million in the annual aggregate in addition to the limits provided by the Mcare Fund of $500,000 per medical incident and $1.5 million in the annual aggregate (for a combined total of $1 million per incident and $3 million in annual aggregate).

Pennsylvania requirements: If you are not Mcare Fund eligible

All Pennsylvania network practitioners who are not required to participate in the Mcare Fund must carry minimum medical malpractice insurance with liability limits of $500,000 per medical incident and $1.5 million in the annual aggregate.

These practitioners include, but are not limited to, the following:

- Audiologists
- Doctors of chiropractic
- Optometrists
- Oral maxillofacial surgeons
- Physical therapists

Exception: Certified registered nurse practitioners (CRNPs) are required to carry $1 million per incident and $3 million in annual aggregate.

Continued on next page

2.2 MALPRACTICE INSURANCE REQUIREMENTS, Continued

Delaware requirements

All participating practitioners in Delaware are required to carry $1million per medical incident and $3 million in annual aggregate.

What Is My Service Area?

West Virginia requirements

In West Virginia, physicians (MDs, DOs, DDSs/DMDs, DPMs and DCs) *and Physician Assistants (PAs)* are required to carry professional liability insurance in the amount of $1 million per occurrence, $3 million aggregate or compliance with WV Code §55-7B-12.

Allied health practitioners must carry coverage of $500,000 per occurrence, $1.5 million aggregate. The exceptions to this requirement are CRNPs and nurse midwives who are required to maintain $1 million per occurrence, $3 million aggregate in professional liability coverage.

Why blue italics?

2.2 TERMINATION FROM THE NETWORKS

Overview

Decisions to terminate a practitioner may be made by the Highmark Network Quality and Credentials Committee or, in urgent situations, by the Medical Director. A practitioner shall be provided with a written decision to terminate with the specific reason for the decision and any reconsideration/appeal rights.

Final termination decisions will negatively affect the practitioner's reimbursement for services provided to members in the Highmark products serviced by Highmark's credentialed provider networks.

Note: It is recognized that Highmark's provider agreements automatically terminate, or may be terminated immediately or upon specified notice, under certain specified circumstances. Nothing in this Highmark Blue Shield Office Manual shall be deemed to abrogate or modify any such provisions or rights.

Valid reasons for termination

Professional network providers shall be terminated in accordance with the relevant terms of their provider contracts for failure to satisfy the following criteria which includes but is not limited to:

1. Maintain an active license to practice.
2. Maintain an active Drug Enforcement Agency (DEA) certificate, where applicable.
3. Maintain coverage for malpractice insurance in the minimum amounts required and, in Pennsylvania, participate in the Pennsylvania Medical Care and Reduction of Error Fund ("Mcare Fund"), if applicable.
4. Maintain acceptable professional liability claims history.
5. Participate in recredentialing, which requires providing all requested recredentialing information, and be recredentialed for network participation.
6. Provide acceptable clinical quality of care to members.
7. Meet appropriate recredentialing requirements.

Professional network practitioners shall also be terminated if, in the Plan's sole discretion, any of the following occur, or are in imminent danger of occurring:

1. Acts or omissions that jeopardize the health or welfare of a member.
2. Acts or omissions that negatively affect the operation of the network.
3. Acts or omissions which cause the Plan to violate any law or regulation or which negatively impact the Plan under any regulatory or certification requirements.
4. Failure to provide an acceptable level of care.

Continued on next page

2.2 TERMINATION FROM THE NETWORKS, Continued

Invalid reasons for termination

A practitioner may not be terminated for any of the following reasons or actions:

1. Advocating for medically necessary and appropriate health care consistent with the degree of learning and skill possessed by a reputable health care practitioner practicing according to the applicable legal standard of care.
2. Filing a grievance against the Plan in response to a disapproval of payment for requested service, an approval of the requested service at a lower scope or duration, or a disapproval of the requested service but an approval of payment of an alternative service.
3. Protesting a decision, policy, or practice that the practitioner, consistent with the degree of learning and skill ordinarily possessed by a reputable health care practitioner practicing according to the applicable legal standard of care, reasonably believes interferes with the practitioner's ability to provide medically necessary and appropriate health care.
4. The provider has a practice that includes a substantial number of patients with expensive medical conditions.
5. Objection to the provision of or refusal to provide a health care service on moral or religious grounds.
6. Any refusal to refer a patient for health care services when the refusal of the practitioner is based on moral or religious grounds and the practitioner has made adequate information available to the members in the practitioner's practice.
7. Discussing: (a) the process that the Plan uses or proposes to use to deny payment for a health care service; (b) medically necessary and appropriate care with or on behalf of a member, including information regarding the nature of treatment, risks of treatment, alternative treatments, or the availability of alternate therapies, consultations, or tests; or (c) the decision of the Plan to deny payment for a health care service.

Continuation of care throughout a contract termination

In the event of a contract termination by either party, the provider will continue to render necessary care to Highmark Plan member(s) consistent with contractual or legal obligations.

Continuation of care (COC) is a process followed to permit a member to continue an ongoing course of treatment with a primary care physician (PCP), a specialist, or a facility whose contract has been terminated by Highmark for reasons other than for cause, to be provided and paid in accordance with the terms and conditions of the agreement. Continuation of care also covers a member in the second or third trimester of pregnancy; the transition period shall last through post-partum care related to the delivery.

Continued on next page

2.2 TERMINATION FROM THE NETWORKS, Continued

Continuation of care throughout a contract termination (continued)

The provider must notify Highmark that the member is in a continuation of care situation. If Highmark does not take actions to make alternative care available to the member within ninety (90) days after receipt of the provider notice, then for continuation of care services provided after termination Highmark will pay the provider the standard rates paid to non-participating providers for that geographical area.

Notwithstanding the foregoing obligations, Highmark's obligations under this provision do not apply to the extent that other Participating Physicians are not available to replace the terminating participating physician due to:

- Geographic or travel-time barriers; or
- Contractual provisions between the terminating physician and a facility at which Highmark's member receives care that limits or precludes other participating physicians from rendering replacement services to Highmark's members (e.g., an exclusive services agreement between the terminating participating physician and a facility where a Plan member receives services).

Notice to members

Members are issued a written notification when a PCP or specialist has been terminated from the provider networks. Timely notice of these changes is important to the member to allow selection of a new PCP or to make arrangements for future services provided by specialists. Please keep Highmark notified of all changes related to your participation status.

2.2 RECONSIDERATIONS AND APPEALS

What Is My Service Area?

Reconsideration of a Credentials Committee decision

A reconsideration hearing is available to a professional network practitioner in the event that a denial or termination action or a limited or modified decision is made by the Highmark Network Quality and Credentials Committee due to:

1. The lack of required qualifications at the time of recredentialing. (This includes, but is not limited to, loss of an unrestricted state license; loss of Drug Enforcement Agency (DEA)license; failure to obtain or keep appropriate board certification; lack of adequate clinical hospital privileges; and/or insufficient malpractice insurance coverage.)
2. Any reason reportable to the National Practitioner Data Bank (NPDB).

The practitioner must request the reconsideration in writing within thirty (30) days of notice of the termination. The provider shall be given the opportunity to present information to the Highmark Network Quality and Credentials Committee by one or any of the following options:

1. In writing, to the Credentials Committee for consideration, which shall take place during a Credentials Committee meeting.
2. Appearing in person at a Credentials Committee meeting.
3. Participating via a telephone conference call at a Credentials Committee meeting.

Reconsiderations for practitioners who participate in Highmark commercial and Medicare Advantage networks will be presented before the Highmark Network Quality and Credentials Committee.

After the meeting, the provider shall receive written notice of the final decision of the Highmark Network Quality and Credentials Committee which will include the basis for the decision, the appeal process, and the practitioner's right to an appeal to the Medical Review Committee (for Pennsylvania practitioners) or to the Appeals Review Committee (for Delaware and West Virginia practitioners) within thirty (30) days if the decision is upheld. The provider will remain in the network until the Highmark Network Quality and Credentials Committee's final decision to terminate and an effective date of termination is established.

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2.2 RECONSIDERATIONS AND APPEALS, Continued

Appeals of Credentials Committee decisions

An appeal of a Highmark Network Quality and Credentials Committee decision is available to a professional network practitioner if the Credentials Committee upholds a denial or termination action following a reconsideration hearing. The written notice issued following the reconsideration hearing advises the practitioner of the right to appeal as well as the appeal process and states the following:

- The specific time period for submitting the request
- The appointment of a hearing officer or a panel of individuals to review the appeal
- Practitioners are allowed at least thirty (30) calendar days after receipt of the notification to request a hearing
- Practitioners may be represented by an attorney or another person of their choice
- Written notification of the appeal decision will be provided that contains the specific reasons for the decision

In the event of an appeal, the panel of individuals to review the appeal will be the Highmark Medical Review Committee (comprised of professional peers) for Pennsylvania practitioners. The Appeals Review Committee, which is comprised of professional peers including representatives from Delaware and West Virginia, will review appeals for Delaware and West Virginia practitioners. Highmark's Medical Review Committee and Appeals Review Committee decisions are final and not subject to further appeal.

Reporting of actions

When a final determination has been made concerning a proposed corrective action that adversely affects the clinical privileges or network status of a practitioner for a period longer than thirty (30) days, or a final decision notification of termination has been rendered, Highmark shall report such corrective action to the appropriate parties, including the state licensing agency, the National Practitioner Data Bank (NPDB), and/or the Healthcare Integrity and Protection Data Bank (HIPDB) pursuant to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Once a final decision has been issued, a Highmark medical director and the Provider Information Management (Credentialing Compliance) area will review the action and report to appropriate authorities if required.