CHAPTER 4: PROVIDER PARTICIPATION AND RESPONSIBILITIES

UNIT 2: HEALTH OPTIONS CREDENTIALING AND RECREDENTIALING

IN THIS UNIT

4.2 INTRODUCTION TO CREDENTIALING

Overview

Where the Health Options professional provider networks are utilized to support managed care products, Health Options must credential providers and utilize procedures to comply with National Committee for Quality Assurance (NCQA); the Centers For Medicare & Medicaid Services (CMS); and State of Delaware Regulation 1403 Managed Care Organizations. Providers are initially credentialed prior to network admission and recredentialed every three years. This unit focuses on the credentialing process.

Purpose

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

Online process utilized

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

Initial credentialing

Health Options has delegated credentialing responsibilities to its parent company, Highmark Inc. ("Highmark"). Highmark credentialing staff follows an established process to credential professional providers for the Health Options network. In addition, there are delegated credentialing arrangements with a limited number of institutions that we have audited to assess their compliance with our credentialing standards.

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
- Verification of Disclosure Form on file with the State of Delaware
- Other verification as needed

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4.2 INTRODUCTION TO CREDENTIALING, Continued

Initial credentialing (continued)

To be considered a participating practitioner and support Health Options, 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 Credentialing Committee, as applicable, and then sign a contract.

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

Recredentialing

The recredentialing process is completed at least once every three years with any applicable physicians and allied health professionals in the Health Options network. Our internal policies require recredentialing for the protection of our members. Additionally, Health Options' three year credentialing cycle is consistent with the NCQA, CMS, and State of Delaware 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, member grievance and appeals 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.

4.2 HEALTH OPTIONS NETWORK CREDENTIALING POLICY

Overview

Physicians and any applicable allied health professionals must be credentialed by Highmark Inc. ("Highmark") on behalf of Health Options to participate in the Health Options network in Delaware.

When are practitioners credentialed?

A practitioner who has never been credentialed by Health Options 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 Health Options during the recredentialing 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 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.

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4.2 HEALTH OPTIONS NETWORK CREDENTIALING POLICY, Continued

When credentialing is not required

An established practitioner who has already been credentialed by Health Options 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, Health Options 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 Highmark Blue Cross Blue Shield Delaware ("Highmark Delaware") Provider Resource Center -- select *Provider Forms*, and then click on *Provider Information Forms*.

The Provider Resource Center can be accessed at www.highmark.com – click on the orange *CONSUMERS/MEMBERS/PROVIDERS* button, and then select the link for Highmark Blue Cross Blue Shield Delaware from the options under *FOR PROVIDERS*.

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. For recredentialing practitioners, your members may receive notification that you no longer participate in the network(s).

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.

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4.2 HEALTH OPTIONS NETWORK CREDENTIALING POLICY, Continued

24/7 availability requirements

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

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
- Dieticians/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

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.

PCP practice sites not meeting this requirement will be subject to an on-site review every three (3) years.

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4.2 HEALTH OPTIONS NETWORK CREDENTIALING POLICY, Continued

Admitting and clinical privilege requirements

Primary care physicians (family practitioners, pediatricians, internists, geriatricians, and general practitioners) are required to have admitting privileges in good standing at a network participating hospital. Applicable physician specialists 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 collaborative agreement 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 Health Options for adequate coverage through another credentialed in-network practitioner.

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.)

IMPORTANT!

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

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4.2 HEALTH OPTIONS NETWORK CREDENTIALING POLICY, Continued

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

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

If verification cannot be completed within the 180-day time frame, the applicant will be asked to re-sign and re-date the attestation statement.

4.2 PRACTITIONERS' CREDENTIALING RIGHTS

Policy

Practitioners who are applying for participation in Health Options' credentialed network 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
- Delaware Department of Health and Social Services (DHHS) Provider Disclosure List

How practices can review information

If the practitioner would like to review information Health Options receives from outside sources, the practitioner must specify which information he or she would like to review and fax the request to Provider Information Management at fax# 1-800-236-5907.

Right to revise inaccurate information

A credentialing department representative will contact the practitioner in writing or by telephone in cases where information received from other sources varies substantially from that provided by the practitioner to the extent that it would jeopardize the practitioner's admission to the network.

When notifying the practitioner about the conflicting information, the representative will include instructions on how to revise the information.

4.2 THE CREDENTIALING PROCESS

Overview

Health Options has delegated credentialing responsibilities to its parent company, Highmark Inc. ("Highmark"). Highmark uses the standardized national online credentialing system developed by the Council for Affordable Quality Healthcare (CAQH) for initial credentialing because it greatly improves processing times. Universal Provider Datasource® 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 Health Options and other participating health plans and health care organizations.

Highmark uses CAQH Universal Provider Datasource as the exclusive provider credentialing system for all applicable networks in Delaware. All Health Options network providers must use CAQH for credentialing and recredentialing.

If you already have a CAQH ID

If you are already a CAQH participating practitioner with a CAQH ID, please visit www.caqh.org. Log in to Universal Provider Datasource to review and re-attest to your CAQH application. Be sure to add **Highmark** as an authorized plan, or grant global authorization. (Note**:** As stated above, Health Options has delegated credentialing responsibility to Highmark.)

In addition, please notify Health Options of your intention by completing the *Initial Provider Credentialing Request Form*. It can be found on the Highmark Blue Cross Blue Shield Delaware ("Highmark Delaware") Provider Resource Center by selecting *Provider Forms*, and then *Provider Applications*. A link to the form is available within the text under the first bullet.*

Complete the form, including your CAQH ID, and click on *Submit*. You will receive a printable confirmation that your request has been received. In approximately ten (10) business days, you will receive an email at the Credentialing Contact Email address supplied on your request. The email will provide additional information and instructions for completing the credentialing process with Health Options. (In certain instances, the communication may be sent via postal mail to the Credentialing Mailing Address supplied on your request.)

* The *Initial Provider Credentialing Request* form is also available on NaviNet's Highmark Delaware 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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4.2 THE CREDENTIALING PROCESS, Continued

If you are not yet registered with CAQH

If you have not yet registered with CAQH, you will need a CAQH ID for access to the CAQH credentialing application. The *CAQH ID Request* form is available on Highmark Delaware's Provider Resource Center. Select *CAQH ID Request* from the main menu to access the link to the *Initial Provider Credentialing Request Form*.

Complete the required fields on the *Initial Provider Credentialing Request Form*, and then submit. Once the form is successfully submitted, you will receive a confirmation email that will contain your CAQH ID. Your request for a CAQH ID serves as notification to Highmark of your intention to participate in Health Options' credentialed network(s).

Once you receive your CAQH ID, you must then complete the credentialing process via www.caqh.org. Log in to Universal Provider Datasource using your CAQH ID to complete the credentialing application. Be sure to add **Highmark** as an authorized plan, or grant global authorization. Following completion of the CAQH application, you will receive additional information and instructions from Health Options.

If you do not have internet access…

If you are not yet registered with CAQH and do not have internet access, please call Highmark at **1-866-763-3224, Option 4** to obtain a CAQH ID.

Once you receive your CAQH ID from Health Options, call the toll-free **CAQH Help Desk** at **1-888-599-1771** for other options for completing the CAQH credentialing application.

Steps in the initial credentialing process

During initial credentialing, practitioners in Delaware also participate in the process of contracting with Health Options. 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. Health Options will then provide additional information and instructions.
2	The Credentialing Department representative reviews the application. If the application is incomplete, the representative contacts the practice to request the missing information.

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4.2 THE CREDENTIALING PROCESS, Continued

Steps in the initial credentialing process (continued)

STEP	ACTION
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 • Medicare participating status • National Practitioner Data Bank (NPDB)* • Office of the Inspector General (OIG) Medicare and Medicaid sanction lists* • Delaware Department of Health and Social Services (DHHS) Provider Disclosure List **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 Health Options credentialing criteria, the Medical Director will review the application and render a decision. If the application does not meet Health Options credentialing criteria, the Highmark Network Quality and Credentialing Committee reviews the application. In some instances, the Committee may request additional information before rendering a decision.

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4.2 THE CREDENTIALING PROCESS, Continued

Steps in the initial credentialing process (continued)

STEP	ACTION
7	• Upon approval of the Highmark Network Quality and Credentialing 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.
8	A copy of the contract will be mailed to the practitioner for a signature. The practitioner will send the contract back and Health Options 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.

Application status

If you have any questions regarding your application, you can contact a Health Options contracting representative, toll-free, at **1-866-763-3224, Option 4.**

IMPORTANT!

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

4.2 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

Health Options 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 in Delaware.

All Health Options network providers must use CAQH's Universal Provider Datasource® 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:** Credentialing staff will send a letter to notify the practitioner that it is time for recredentialing. The practitioner will then log in to Universal Provider Datasource at www.caqh.org to review and re-attest to their CAQH application.
- **For Practitioners Not Yet Registered With CAQH:** Credentialing staff will provide you with a CAQH ID to log in to Universal Provider Datasource at www.caqh.org. Complete the CAQH online credentialing application. Be sure to add **Highmark** as an authorized plan, or grant global authorization.

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, member grievances and appeals, participation with quality improvement activities and condition management programs, data completeness, overutilization, and underutilization.

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4.2 THE RECREDENTIALING PROCESS, Continued

Assessment of data completeness

Health Options 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 the Clinical Quality 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 Health Options' 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 Chapter 5, Unit 4 of this manual.

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4.2 THE RECREDENTIALING PROCESS, Continued

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.

For more detailed information on this process, please see Chapter 5, Unit 4 of this manual.

Step-by-step process

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

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 credentialing staff, and then log in to Universal Provider Datasource to review and re-attest to their CAQH application. • Practitioners not yet registered with CAQH will receive a letter from credentialing staff with a CAQH ID for you to log in to Universal Provider Datasource at www.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. Health Options is required to verify all completed application information within 180 days from the date the practitioner signs the attestation statement.
3	The Credentialing 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.

4.2 CREDENTIALING REQUIREMENTS FOR FACILITY-BASED PROVIDERS

Facility-based practitioner credentialing policy

Health Options 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

Health Options 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.
- Have current active malpractice insurance that meets or exceeds 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 Health Options' participating provider network(s).

PARE Attestation

The PARE Attestation*, or Affirmation of Medical Practice Statement* form, can be obtained and printed from the Highmark Delaware Provider Resource Center. Select the *Provider Forms* link, and then click on *Provider Information Management Forms.*

If you are unable to access the form online, please call **1-866-763-3224** to obtain the form.

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4.2 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.

4.2 CREDENTIALING REQUIREMENTS FOR BEHAVIORAL HEALTH CARE PROVIDERS

Behavioral health practitioner requirements	Behavioral health practitioners considered for participation must provide evidence of the following as applicable: • 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. • All practitioners in Delaware are required to carry $1million per medical incident and $3 million in annual aggregate.
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.
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).

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4.2 CREDENTIALING REQUIREMENTS FOR BEHAVIORAL HEALTH CARE PROVIDERS, 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. A CRNP with a secondary license type in mental health must have a collaborative agreement with a network participating psychiatrist.
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)

4.2 DUAL CREDENTIALING AND RECREDENTIALING AS BOTH PCP AND SPECIALIST

Physician categories

Health Options 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 Health Options members;
- Meet the standards for PCPs; and
- Provide documentation of an average of fifty (50) CME hours per year for the preceding three (3) years (this requirement is waived if board certified in both specialties).

Recredentialing

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

Provider directory

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

4.2 PRACTITIONER QUALITY AND BOARD CERTIFICATION

Policy

To be credentialed in the network(s), primary care practitioners (PCPs) and specialists -- including podiatrists -- are required to be board certified in the specialty in which they practice.

Health Options recognized boards for certification

Health Options recognizes the following boards for certification:

- America Board of Medical Specialties
- American Osteopathic Association Board
- American Board of Podiatric Orthopedics and Primary Podiatric Medicine
- American Board of Podiatric Surgery
- American Board of Oral and Maxillofacial Pathology
- American Board of Oral and Maxillofacial Surgery
- American Academy of Oral and Maxillofacial Radiology

Exceptions to board certification requirements

The following are exceptions to the policy requiring board certification:

- Practitioners who have completed an approved applicable residency or fellowship in the specialty of practice; graduated from an accredited medical, osteopathic, dental, or podiatric school; and finished their training prior to December 31, 1987.
- Practitioners who have not practiced for a sufficient length of time to complete board certification. (Practitioners must complete the board certification within two (2) years of meeting the eligibility requirement.)
- At the time of the practitioner's credentialing or recredentialing, fifty (50) percent or more of the existing practice's credentialed associates (including the practitioner who is undergoing the credentialing/recredentialing process) are already board certified in the specialty being requested, and the practitioner has completed an approved applicable residency or fellowship in the specialty of practice.
- Rural practitioners who have greater than five (5) years of experience in the specialty in which they practice and have completed an approved applicable residency or fellowship in the specialty of practice.

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4.2 PRACTITIONER QUALITY AND BOARD CERTIFICATION, Continued

Emergency medicine requirements

The exceptions for non-board certified practitioners do not apply to Emergency Medicine practitioners; they must be board certified or within the board eligibility period.

Physicians in a Health Options network who practice in an emergency department, and all physicians identified as working in a network credentialed urgent care center, will be credentialed in Emergency Medicine if they meet one of the following criteria:

1. Have current board certification in Emergency Medicine.
2. Have current board certification(s) in Pediatrics, General Surgery, Internal Medicine, or Family Practice **and** have current certification in Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS), and Advanced Trauma Life Support (ATLS).
3. Practitioner is in board eligibility period for Emergency Medicine.
4. Practitioner is in the board eligibility period for Pediatrics, General Surgery, Internal Medicine, or Family Practice **and** has current certification in Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS), and Advanced Trauma Life Support (ATLS).

4.2 MALPRACTICE INSURANCE REQUIREMENT

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

4.2 TERMINATION FROM THE NETWORKS

Overview

Decisions to terminate a practitioner may be made by the Medical Director(s) of Quality Management in urgent situations or by the Highmark Network Quality and Credentialing Committee. A practitioner shall be provided with a written decision to terminate with the specific reason for the decision and nay reconsideration/appeal rights.

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

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.
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.

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4.2 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 treatment, or the availability of alternate therapies, consultations, or tests; or (c) the decision of the plan to deny payment for a health care service.

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4.2 TERMINATION FROM THE NETWORKS, Continued

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 Health Options 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 Health Options 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.

The provider must notify Health Options that the member is in a continuation of care situation. If Health Options 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 Health Options will pay the provider the standard rates paid to non-participating providers for that geographical area.

Notwithstanding the foregoing obligations, Health Options' 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 Health Options member receives care that limits or precludes other participating physicians from rendering replacement services to Health Options members (e.g., an exclusive services agreement between the terminating participating physician and a facility where a Plan member receives services).

4.2 RECONSIDERATIONS AND APPEALS

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 Credentialing 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 Credentialing 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 Credential Committee meeting.
3. Participating via telephone conference call at a Credentials Committee meeting.

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

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4.2 RECONSIDERATIONS AND APPEALS, Continued

Appeals of a Credentials Committee decision

An appeal of a Highmark Network Quality and Credentialing 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 Quality Improvement Committee (comprised of professional peers, including representatives from Delaware) for Delaware practitioners. The Quality Improvement Committee decisions are final and not subject to further appeal.

When the 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, the Director of Quality Management or his/her designee shall report such corrective action to the appropriate parties, including the state licensing agency and/or the National Practitioner Data Bank (NPDB)., pursuant to the requirements of the Health Insurance Portability and Accountability Act(HIPAA) of 1996.