

## How to become a Network Provider

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## A step-by-step outline

This section outlines the steps a health care provider should take to:

- Obtain a provider number – necessary for any provider to receive reimbursement from Highmark Blue Shield.
- Apply to join Highmark Blue Shield’s Participating network – Highmark Blue Shield’s largest network that supports its traditional, indemnity products.
- Apply to become a member of PremierBlue Shield, Highmark Blue Shield’s statewide selectively contracted preferred provider network.
- Establish an assignment account, Highmark Blue Shield’s term for a group practice.
- Maintain up-to-date information on his or her practice in Highmark Blue Shield’s provider file.

## How to obtain a provider number

Highmark Blue Shield pays claims for services performed by eligible health service providers, as defined by state law. These providers include:

- Doctors of medicine;
- Doctors of osteopathy;
- Dentists;
- Podiatrists;
- Optometrists;
- Doctors of chiropractic;
- Nurse midwives;
- Physical therapists;
- Independent clinical laboratories;
- Licensed psychologists;
- Certain certified registered nurses;
- Audiologists;
- Licensed speech pathologists; and
- Teachers of the hearing impaired

All providers must obtain an individual provider identification number from Highmark Blue Shield prior to submitting claims. No payments can be made to you, or your patient, for eligible services you provide until you have secured a provider identification number.

To obtain an individual provider identification number from Highmark Blue Shield you must complete a Provider Application, form PIK000.

Certified registered nurses also must complete a supplemental questionnaire, form MA513, in order to receive a provider identification number.

Please see Section 13, “Claims Submission and Billing Information,” for instructions on how to order these forms.

Submit completed form(s) to:

Highmark Blue Shield  
Provider Data Services  
PO Box 898842  
Camp Hill, PA 17089-8842

After reviewing and approving your application, we will establish a provider identification number for your practice and notify you of that number in writing.

## **Participating Providers**

Highmark Blue Shield has agreements with more than 44,000 Participating Providers – eight out of ten in the state – representing every major discipline.

Please see Section 5, “Products and Related Networks,” for more information about the Participating network.

### **How to become a Participating Provider**

Complete a Participating Provider agreement, form 815. Send the agreement and a copy of your current Pennsylvania license to:

Highmark Blue Shield  
Provider Data Services  
PO Box 898842  
Camp Hill, PA 17089-8842

Samples of this agreement and the Regulations for Participating Providers, form 346, are included in this section. See Section 13, “Claims Submission and Billing Information,” for information on how to order these forms.

We will notify you in writing of the effective date of your participation and send a participant’s decal that you may display in your office.

For more information about how to become a participating provider, please contact your Provider Relations representative.

Central Region: 1-866-731-2045

Eastern Region: 1-866-362-6116

To resign from participation with Highmark Blue Shield, send a signed, written request to Highmark Blue Shield’s Provider Data Services department. You may submit a resignation at any time. It is effective 30 days after receipt by Provider Data Services. A letter will be sent to you advising you of the effective date of your resignation.

## **PremierBlue Shield**

PremierBlue Shield is Highmark Blue Shield’s statewide, selectively contracted preferred provider network that was implemented in January 1994. The network services Highmark Blue Shield’s PPOBlue, DirectBlue and SelectBlue plans, as well as the national BlueCard program.

Please see Section 5, “Products and Related Networks,” for more information about the PremierBlue Shield network.

### **How to become a PremierBlue Shield provider**

Complete a Provider Application, form PIK000, and either a PremierBlue Shield Preferred Provider Agreement (specialists), form PB4, or a PremierBlue Shield Preferred Provider Agreement for Primary Care Physicians in Managed Care Programs (PCPs), form PB5.

The PremierBlue Shield selection criteria includes:

- Verification of Pennsylvania license.
- Board certification in respective specialties. In some cases, appropriate CME credits may be accepted in lieu of board certification.
- Active staff privileges at one or more hospitals for PCPs; privileges at one or more hospitals for specialists.
- An investigation that yields no history of criminal activities or active substance abuse.
- Verification of malpractice history and adequate malpractice coverage.
- Acceptable practice characteristics, including such items as utilization review and referral patterns.

After careful review of your application, Highmark Blue Shield will advise you in writing of your acceptance into or rejection from the PremierBlue Shield network. A formal appeals process is available to any provider whose application is not accepted.

For more information about the application process or for an application package, please contact your Provider Relations representative.

Generally, in order for a professional provider to resign from this network, Highmark Blue Shield must receive a 60-day written notice.

### **Assignment accounts**

An assignment account (AA) is established by Highmark Blue Shield to permit group practices of one or more individual providers to direct Highmark Blue Shield payments to an entity other than the individual provider.

The status of the AA is based on the individual provider’s network participation status, for example, participating with Highmark Blue Shield. All members of the AA must be participating in the network in order for the AA to be recognized as participating. Any AA member not participating in the network must complete the proper agreement with Highmark Blue Shield in order to be added to an existing AA.

An individual provider can only have one provider identification number and participating status, regardless of where the provider practices.

### How to form an assignment account

To form an assignment account, you must meet the following conditions:

1. The billing entity must be arranged in one of these manners:
  - **Incorporated solo practitioner** – An incorporated solo practitioner who desires to have the corporation recognized as the entity or to use a tax identification number (TIN) to receive payment from Highmark Blue Shield.
  - **Group practice** – Two or more providers practicing as a group may establish an assignment account to have the group recognized as a single entity for purposes of billing and payment. Examples of a typical group practice arrangement are:
    - Two or more providers practice as a partnership;
    - A group of providers form a professional corporation and the corporation becomes the employer of the providers;
    - A provider employs one or more other providers as associates in his or her practice.
  - **Health care facility** – Providers with an employment or other contractual relationship with a health care facility, duly licensed by the Pennsylvania Department of Health pursuant to the Health Care Facilities Act (35 P.S. 448.101-448.904), may establish an assignment account for the purpose of having Highmark Blue Shield pay fees directly to the health care facility.
2. All members of the group must be professional providers of the same degree.
3. All members of the group must be either participating or non-participating in a Highmark Blue Shield private business program.

### AA forms available through Provider Data Services or Provider Relations

To establish an assignment account, obtain the appropriate forms from Provider Data Services or your Provider Relations representative. A sample form (No. 3975) for establishing an assignment account is included in this section.

Return completed forms for processing to:

Highmark Blue Shield  
Provider Data Services  
PO Box 898842  
Camp Hill, PA 17089-0089

If you need assistance call your Provider Relations representative:

Central Region: 1-866-731-2045  
Eastern Region: 1-866-362-6116

Assignment Account guidelines, appendix C to the Regulations for Participating Providers, may be found on Page 3.28 of this section.

To establish a Medicare assignment account, call HGSAdministrators Provider Enrollment Services at 1-866-488-0549.

**Please keep assignment account information up to date**

Please inform Highmark Blue Shield of any changes to your assignment account. Failure to keep this data current may lead to missed mailings or checks, and, possibly, incorrect payments.

When any of the following information changes, please notify Highmark Blue Shield immediately:

- Practice address (physical location);
- Mailing address if different from practice address;
- Specialty (needs signatures of AA members if you are changing their individual specialties as well);
- Tax identification number (TIN);
- Additions/deletions of AA members;
- Telephone number, including area code.

Send notification of changes in writing to Provider Data Services.

**What to do when a member leaves – or joins an assignment account**

You should notify Highmark Blue Shield when an existing member leaves your assignment account or when a new member joins the account. Use form 9106 to report the change (see example on Pages 3.15 and 3.16).

Highmark Blue Shield will send written notification to the members of the assignment account who are leaving, to advise them of the transfer of profiles to their individual provider number. Please be sure to notify Highmark Blue Shield of a departing member's new address and tax identification number – an employer identification number or Social Security number, as appropriate. If you notify us that there are no members left in the account, we will send you written notification of the cancellation date of the entire account.

**Non-network provider payment guidelines**

Non-network providers do not sign an agreement with Highmark Blue Shield. Therefore, they have no contractual obligation to accept Highmark Blue Shield's allowances as payment-in-full. However, non-network providers are required to accurately report services performed and fees charged.

Highmark Blue Shield sends payment for covered services performed by non-network providers directly to the member who is responsible for reimbursing the non-network provider. Non-network providers do not receive Explanation of Benefits (EOB) statements.



**Dear Health Care Professional:**

The enclosed forms are provided to process your request for an Assignment Account number with Highmark Blue Shield. An Assignment Account is Highmark Blue Shield's term for a single provider or group of providers who wish to bill as a single entity under one tax identification number.

All providers who wish to be enrolled in the Assignment Account must have a Highmark Blue Shield provider number. If any provider does not have a number, they must complete the Provider Application to be enumerated on our file and cross-referenced to the group.

**Participating Status of Assignment Account**

The participating status of the Assignment Account is based on the individual provider's participating/non-participating status with Highmark Blue Shield. **Mixed Assignment Accounts of participating and non-participating providers will not be approved.** Providers, who are not already participating with Highmark Blue Shield, must complete a **Participating Provider's Agreement**. The provider must be licensed in Pennsylvania in order to qualify for participation. An individual provider is allowed to have only one participating status regardless of where the provider practices.

If the Assignment Account is to be used for the Keystone Health Plan West (KHPW) Programs, the account will not be effective until the appropriate KHPW Agreement(s) have been executed. After you have signed and returned the Agreement(s), you will receive a welcome letter from KHPW that will advise you of the effective date.

If you have any questions, please contact your Provider Relations Representative or your appropriate Regional Office at:

For <b>Vision:</b>	(717) 972-0498
For <b>Medical-Surgical:</b>	
Central Region	1-866-731-2045
Eastern Region	1-866-362-6116
Western Region	1-800-547-3627 Option 4

Please return the completed application to:

Highmark Blue Shield  
 Provider Data Services  
 P.O. Box 898842  
 Camp Hill, PA 17089-8842

***You may not bill under the assignment account name until you receive an approval letter specifying your assignment account number and its effective date.***





## **Assignment Account Guidelines**

### **I. Introduction**

An assignment account is an account established by Highmark Blue Shield to permit one or more individual providers, practicing together, to direct Highmark Blue Shield payments to an entity other than the individual providers. An assignment account will be permitted only if the provider(s), as well as the entity to which payment is being directed, meet, and continue to comply with, the guidelines set forth below.

The guidelines set forth below apply exclusively to payments under Highmark Blue Shield's private business programs. These guidelines were developed to accommodate the needs of groups of providers practicing together while, at the same time, addressing Highmark Blue Shield's concerns regarding appropriate, efficient utilization of services and appropriate application of payment limitations for ineligible providers.

### **II. Eligible Entities**

For the purpose of these guidelines, a provider will be considered to be a duly licensed health service doctor eligible for payment by Highmark Blue Shield.

Upon acceptable completion of the assignment account application forms, Highmark Blue Shield will permit an assignment account to be established for the following types of entities:

**A. Group Practice** — Two or more providers practicing together as a group in the same location may establish an assignment account to permit the group to be recognized as a single entity for purposes of billing and payment. Acceptable types of group practice arrangements are:

**1.** Two or more providers practice as a partnership;

One or more provider(s) form a professional corporation in accordance with the Professional Corporation Law (15 P.S. SS2901, et seq.) and the corporation becomes the employer of the provider(s). This would include solo practitioners who incorporate their practices; or

**2.** One or more provider(s) form a professional corporation in accordance with the Professional Corporation Law (15 P.S. SS2901, et seq.) and the corporation becomes the employer of the provider(s). This would include solo practitioners who incorporate their practices; or

**3.** A provider employs one or more other provider(s) as associates in his or her practice.

In each type of group practice, the providers will be required to provide documentation that they are a group practice eligible to establish an assignment account. For example, in the case of an employer-employee relationship, Highmark Blue Shield will require proof that a bona fide employment relationship exists, including copies of W-2 forms and other relevant documents.

Existence of a professional partnership may be demonstrated by a signed copy of the partnership agreement. The agreement should demonstrate that only eligible providers are partners.

- B. Limited Partnership** — In cases in which the general partner of a limited partnership is an eligible entity in accordance with these guidelines, an account may be established in the name of the general partner. Limited partners may not be included. For example, if the general partner of a limited partnership is a professional corporation, then the general partner may establish an assignment account in the name of the professional corporation. The limited partners would not be members of the assignment account.
- C. Non-profit Corporation** - A non-profit corporation, established for the purpose of providing health services, through duly licensed health service doctors, which is not being reimbursed by any Blue Cross Plan for the same service, may establish an assignment account at the discretion of Highmark Blue Shield. The non-profit corporation, and all members of the proposed assignment account who are licensed health service doctors, will be required to execute an agreement, agreeing to be jointly and severally liable for overpayments and misreporting by the account.
- D. Business Corporation** - A business corporation, sometimes also referred to as a for-profit corporation, established for the purpose of providing health services, through duly licensed health service doctors, which is not being reimbursed by any Blue Cross Plan for the same services, may establish an assignment account at the discretion of Highmark Blue Shield. The business corporation, and all members of the proposed assignment account who are licensed health service doctors, will be required to execute an agreement, agreeing to be jointly and severally liable for overpayments and misreporting by the account.
- E. Health Care Facility** - Providers who are employed by a health care facility or an affiliate of such a facility, for which Highmark Blue Shield has payment responsibility, may establish an assignment account at the discretion of Highmark Blue Shield for the purpose of having fees for services paid by Highmark Blue Shield directed to the health care facility or its affiliate. It should be noted that such assignment accounts are solely for the purpose of directing professional fees which are otherwise payable under the subscription agreements and master contracts to the appropriate entity. For purposes of this Section, an affiliate of a health care facility is a corporation which either controls, or is controlled by, the health care facility.

### III. Ineligible Entities

The following entities are not eligible to establish an assignment account with Highmark Blue Shield:

- A. Business Corporation as defined in the Business Corporation Law (15 P.S. §§1001, et seq.)**  
Highmark Blue Shield has concluded that it will not permit an assignment account to be established in order to direct payment(s) to a business corporation, except as stipulated in Section II.D.
- B. Mixed Participating/Non-participating Provider Assignment Accounts** — Non-participating providers may not be included in a Highmark Blue Shield assignment account which also contains participating providers.
- C. Groups Seeking Solely to Purchase Services** — An assignment account will not be permitted in a

situation which would effectively evade Highmark Blue Shield's purchased services requirement. Highmark Blue Shield will not permit an assignment account to be formed in which the account intends solely to purchase professional services from independent contractors.

- D. Groups Established Solely as Investment Vehicles** — Assignment accounts are established for the purpose of permitting providers who practice together to bill under a single provider identification number. They will not be established in situations in which the apparent purpose of including members in the assignment account is to provide an investment vehicle for those members. In a situation in which there is a question as to whether the account is being established for investment purposes, the proposed providers will be required to certify their intent to provide professional services on behalf of the assignment account.
- E. Groups Providing Non-covered Services** — Assignment accounts will not be permitted in situations where it is apparent that the majority of services to be provided will not be covered under Highmark Blue Shield contracts.
- F. Group Practices with Outstanding Utilization Review Problems** — Highmark Blue Shield will not permit an assignment account to be established in any situation in which any proposed member(s) of the assignment account has a pending utilization review problem with Highmark Blue Shield. Furthermore, Highmark Blue Shield will not permit the addition or deletion of members in any situation in which either the members or the existing assignment account have a pending utilization review problem with Highmark Blue Shield.
- G. Groups Seeking Multiple Assignment Accounts** — Highmark Blue Shield reserves the right to refuse duplicate assignment accounts. Multiple accounts composed of the same providers, with the same tax identification number, in the same locale will be refused.
- H. Mixed License Assignment Accounts** - Limited license providers may not be included in a Highmark Blue Shield assignment account which also contains doctors of medicine and/or doctors of osteopathy. Highmark Blue Shield has concluded that it will not permit such an assignment account, since it would eliminate the ability to determine that a limited license provider reporting services is operating within the scope of his or her license.

#### **IV. Application Process**

A group of providers desiring to establish an assignment account must complete and submit an application form provided by Highmark Blue Shield. The application form and accompanying paperwork can be obtained from the providers' local Provider Relations representative. The following requirements apply to the application process (Additional instructions are included with the form itself.):

- A.** Each member of the group must provide his or her name and Highmark Blue Shield individual provider number.
- B.** The assignment account must provide its proposed tax identification number. If a tax identification number of an entity other than the group making the application is to be used, the group must identify the entity whose number is being used.

- C. The group must provide a statement signed by each member which certifies that each member is billing fee-for-service and agrees to assign his or her fees to the group account.
- D. The group must agree to inform Highmark Blue Shield of any changes in the group's contractual arrangements that would necessitate Highmark Blue Shield payments being made to some entity other than that designated in the assignment account application.
- E. The group must agree that every claim submitted to Highmark Blue Shield will bear the name of the individual provider who actually performed the service(s).
- F. The group must agree to notify Highmark Blue Shield in writing of any subsequent changes in the membership of the assignment account **prior to the effective date of each change.**
- G. Each member of the group must sign a statement agreeing that the entity sponsoring the assignment account and each individual member will be jointly and severally liable for any overpayment that the account receives.

#### **V. Termination**

Highmark Blue Shield reserves the right to dissolve any assignment account which is determined by Highmark Blue Shield not to meet the requirements set forth in these guidelines. The assignment account and its member providers shall be given written notice of a decision by Highmark Blue Shield to dissolve the account. Dissolution of an assignment account will not affect the right of the individual providers to submit claims under their individual provider numbers.

#### **VI. Appeals**

Because it is impossible to address all possible billing and business arrangements in these guidelines, providers shall have the right to appeal Highmark Blue Shield's decision to deny an assignment account in any situation in which there is a question whether the group qualifies for the assignment account.

Such appeals must be in writing. Proposed assignment accounts that do not strictly meet the eligibility criteria stated in these guidelines may be approved if it is established to the satisfaction of Highmark Blue Shield that creation of the assignment account will significantly increase the delivery of high quality, cost effective health care to Highmark Blue Shield members. Such exceptions will only be granted in extraordinary circumstances; they are not a matter of course. Highmark Blue Shield reserves the right to deny any proposed assignment account that does not comply with all of the criteria set forth in these guidelines.

Highmark Blue Shield will maintain records of decisions on all written appeals of denials of assignment accounts which are filed in accordance with these guidelines, to assure consistency and fairness in the granting of such accounts.



## Request for Assignment Account

Name of Account \_\_\_\_\_ Specialty \_\_\_\_\_

IRS# \_\_\_\_\_ (Provide copy of Federal IRS Notification. W-9 is **NOT** acceptable.)

Legal Relationship of the Group Practice - Please Check One:

- Providers in an Employment Relationship
- Professional Corporation
- Partnership of 2 or more providers
- Group billing under a hospital Tax ID
- Solo Practitioner
- Non-profit Corporation (With federal and state non-profit status established to provide health care services)
- Business Corporation (For Profit Corp. incorporated to provide health care services)

**Main Practice Address** Primary physical practice location (P.O. Box Numbers are **NOT** acceptable.)

\_\_\_\_\_

Telephone number (\_\_\_\_) \_\_\_\_\_ Fax number (\_\_\_\_) \_\_\_\_\_

Is this location in a hospital or hospital owned building? Yes  No

**Mailing Address** where administrative work is done, if different than Main Practice and Check

**Check Address** where checks are sent

\_\_\_\_\_

Telephone number (\_\_\_\_) \_\_\_\_\_ Telephone number (\_\_\_\_) \_\_\_\_\_

Fax number (\_\_\_\_) \_\_\_\_\_ Fax number (\_\_\_\_) \_\_\_\_\_

Is this a lockbox? Yes  No

Does the group employ CRNAs? Yes  No  If Yes, complete CRNA Employment Status (Attachment I).

Name(s) of Providers in Assignment Account (type or print)				
Provider Name	Highmark Provider #	Social Security #	Specialty	Signature*
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**Each provider must sign to be enrolled in the group**

\*By my signature, I, as a member of this account, agree to fully abide by the Assignment Account Agreements listed on the reverse side of this form.



**Assignment Account Agreement**

1. We hereby agree to only bill those services performed by providers in our account.
2. We certify that each member agrees to assign his/her fee to the group account.
3. We agree that every 1500 claim form submitted to Highmark Blue Shield will include the provider number of the individual provider who actually performed the service. (Place in Block **24K** of the claim form.)
4. We agree that the account and each individual member will be jointly and severally liable for any overpayment that the account receives.
5. We agree to notify Highmark Blue Shield in writing of any subsequent changes in the composition of the account prior to the effective date of each change.
6. We agree to inform Highmark Blue Shield of any change in the group's contractual arrangements that would necessitate Highmark Blue Shield payments to be made to some entity other than that designated in this assignment account application.
7. We certify that we will not bill for any professional services that are reimbursed through a Blue Cross Plan. All claims for these services will be submitted on the 1500 claim form for all appropriate Blue lines of business patients.
8. We understand that for certain networks all individual providers in the group must be fully credentialed in order for the group to be able to bill for that network.
9. We have carefully reviewed the forms and applications associated with the establishment of this Assignment Account, and each member has verified the accuracy and completeness of all information provided.

On behalf of the group, I verify that all providers have reviewed the Assignment Account Requirements, agree upon their responsibility, and recognize that as the authorized representative, I have the authority to bind the individual providers and sign on their behalf.

---

Signature of Authorized Representative of Group Date

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Title (     )  
Telephone Number with Area Code



## **CRNA Employment Status**

Only health care professionals who have supplied the CRNA employment documentation and verified the employment relationship receive 100 percent of the approved allowance for covered services from Highmark Blue Shield when they medically direct (supervise) their employee. If this information is not on file with Highmark Blue Shield, reimbursement will be 50 percent of the approved allowance, in accordance with our existing policy.

Health care professionals who employ CRNAs must provide sufficient documentation to establish an employer-employee relationship. This documentation can be in the form of the CRNA's W-2 Form and/or a copy of the contract between the health care professional and the CRNA, and a letter from the hospital administrator attesting to the billing arrangement. If you intend to submit claims for the services of CRNAs that you employ, please review the following criteria and respond as required:

An employment relationship is established between the health care professional and nurse anesthetist if the following criteria are sufficiently documented:

1. The health care professional has the power to hire and fire the nurse anesthetist.
2. The health care professional has the power to direct the work performed by the nurse anesthetist and has ultimate responsibility for the manner of its performance.
3. The health care professional has the duty to pay wages, fringe benefits, and establish the level of compensation of the nurse anesthetist.
4. The health care professional is personally responsible for withholding federal income tax and social security contributions for the nurse anesthetist's compensation and is personally responsible for making contributions for the nurse anesthetist under the Pennsylvania Unemployment Compensation Act (43 P.S. § 751 et. seq.) and is personally responsible for ensuring the nurse anesthetist's liability under the Pennsylvania Workmen's Compensation Act (77 P.S. § 1 et. seq.).
5. No hospital receives any compensation whatsoever for the services of the nurse anesthetist during the period the nurse anesthetist is employed by the health care professional.

***Please hold all claims for services for CRNAs you employ until advised by Highmark Blue Shield to start claim submissions.***

***CRNA Employment documentation will need to be reverified on an annual basis. Failure to respond to a reverification request will result in reduced payments for anesthesia services.***

If the above criteria is met, please complete the form on the reverse and return it with the Assignment Account paperwork. Failure to respond will result in reduced payments for anesthesia services.

### CRNA Employment Status

Please complete and return this form with the CRNA employment documentation:

Attached is the following documentation for review:

W-2 Form(s) \_\_\_\_\_

Contract \_\_\_\_\_

Letter \_\_\_\_\_

Other \_\_\_\_\_

Listed below are the names and starting dates of employment for all CRNA employees. (If additional space is needed, please attach the additional names and dates.)

Name	License #	Starting Date of Employment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

At what hospital(s) do you currently perform anesthesia services [name(s) and address(s)]?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you perform anesthesia services at a freestanding facility? Yes  No

If Yes, who employs the CRNAs at the facility?

\_\_\_\_\_

\_\_\_\_\_

Please complete the name(s) of the provider(s) and/or Assignment Account(s) and Highmark Blue Shield/provider number(s) you currently use to submit claims.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of Authorized Representative of the Assignment Account \_\_\_\_\_ Date \_\_\_\_\_

Title \_\_\_\_\_ Telephone Number with Area Code \_\_\_\_\_





### Request for Addition / Deletion to Existing Assignment Account

Name of account \_\_\_\_\_ Group Account number \_\_\_\_\_

IRS number \_\_\_\_\_ Effective date of change \_\_\_\_\_

Practice address \_\_\_\_\_ Specialty \_\_\_\_\_

Change current specialty

Note: For address changes, please complete the PDS Change of Address form (9111).

Provider name (Typed or printed)	Provider number	Social Security number	Provider signature (Required for additions)	Applicable to: All Highmark Blue Shield networks	Indicate Add (1) Delete (2)
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

① By my signature, I, as a member of this account, fully agree to abide by the requirements listed on the reverse side of this form.

② Deletions - Please provide the following information for providers being deleted from the assignment account:

Provider name (Typed or printed)	Provider number	New address	New telephone number
_____	_____	_____	( )
_____	_____	_____	( )

Mail to: Provider Data Services      Fax to: (866) 731-2896  
 PO Box 898842  
 Camp Hill, PA 17089-8842  
 (Please read and sign on the reverse side)

### Assignment Account Requirements

1. We hereby agree to only bill those services performed by providers in our account as called for in our written contractual arrangement with Highmark Blue Shield and its subsidiaries.
2. We certify that each member agrees to assign his or her fee to the group account.
3. We agree that every claim submitted to Highmark Blue Shield will include the provider number of the individual provider who actually performed the service. (Place in Block 24K of the claim form.)
4. We agree that the account and each individual member will be jointly and severally liable for any overpayment that the account receives.
5. We agree to notify Highmark Blue Shield, in writing, of any subsequent changes in the membership of the account prior to the effective date of each change.
6. We agree to inform Highmark Blue Shield of any change in the group's contractual arrangements that would necessitate Highmark Blue Shield payments to be made to some entity other than that designated in this assignment account application.
7. We have carefully reviewed the forms and applications associated with the establishment of this assignment account, and each member has verified the accuracy and completeness of all information provided.
8. We understand that for certain networks all individual providers in the group must have the same network status to be added to the groups. Providers may not be added to a group if they have not completed the credentialing process.

On behalf of the group, I verify that all members have reviewed and agree to all assignment account requirements, all applicable network contracts and regulations.

\_\_\_\_\_  
Signature of authorized representative of group

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title

(        )  
Telephone number

**PARTICIPATING PROVIDER AGREEMENT  
WITH HIGHMARK BLUE SHIELD**

(AGRPBS)

Under the applicable laws of the Commonwealth of Pennsylvania, I am duly authorized to engage in the practice of \_\_\_\_\_ . In consideration of being registered by Highmark Inc. d/b/a Highmark Blue Shield, an independent licensee of the Blue Cross and Blue Shield Association (hereinafter termed "Blue Shield"), as a participating provider, I do hereby agree as follows:

I will perform services for Blue Shield members, make reports to Blue Shield concerning such services and accept compensation therefore, as provided for in the Blue Shield Regulatory Act, as heretofore or hereafter reenacted or amended, and the Bylaws, the applicable Regulations, the applicable Subscription Agreements and Master Contracts, all as heretofore or hereafter adopted or entered into by Blue Shield under authority of said Regulatory Act, with any required governmental approval.

Copies of the Blue Shield Regulatory Act, and the Bylaws, Regulations, Subscription Agreements and Master Contracts referred to in this Agreement shall be available for examination by me during regular business hours at the principal office of Blue Shield. A copy of the Regulations shall be provided to me upon execution of this Agreement and thereafter upon my request.

I understand that this Agreement constitutes a contract between Blue Shield and me, that Blue Shield is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting Blue Shield to use the service mark in the Commonwealth of Pennsylvania, and that Blue Shield is not contracting as the agent of the Association. I further understand and agree that I have not entered into this Agreement based upon representations by any person other than Blue Shield and that no person, entity or organization other than Blue Shield shall be held accountable or liable to me for any of Blue Shield's obligations created under this Agreement.

This Agreement shall continue in effect until terminated by me giving thirty (30) days prior written notice to Blue Shield, unless the Regulations provide otherwise; or until terminated by Blue Shield with the approval of the Pennsylvania Department of Health.

_____	<b>Main practice address*</b> (primary physical practice location)
Signed _____	Street _____
_____	City _____ State _____ ZIP code _____
Name - <i>Please print</i> _____	( _____ ) _____
_____	Telephone number _____
Date _____	<b>Mailing address</b> (if different from above)* (where administrative work is done)
Specialty _____	Street _____
_____	City _____ State _____ ZIP code _____
Social Security number _____	<b>Previous main practice address</b> (if at current address less than two years)
_____	Street _____
Pennsylvania license number** _____	City _____ State _____ ZIP code _____
Attach a copy of your current Pennsylvania license.	<b>Check address*</b> (address to which checks are sent)
_____	Street _____
Accepted by _____	City _____ State _____ ZIP code _____
_____	_____
Date _____	<b>Mail To:</b>
_____	PROVIDER DATA SERVICES
Highmark Blue Shield provider number _____	POST OFFICE BOX 898842
_____	CAMP HILL, PA 17089-8842
_____	Is this a lockbox? <input type="checkbox"/> Yes <input type="checkbox"/> No

\* YOUR PROVIDER RECORD WILL BE UPDATED BASED ON THE INFORMATION REPORTED ON THIS AGREEMENT.  
815 R 5/03 \*\* ACTIVE PENNSYLVANIA LICENSE IS REQUIRED TO BECOME PARTICIPATING.

## HIGHMARK BLUE SHIELD REGULATIONS FOR PARTICIPATING PROVIDERS

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### A. REGISTRATION OF PARTICIPATING PROVIDERS

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1. Any health service doctor or ancillary provider duly authorized to practice as such under the applicable laws of the Commonwealth of Pennsylvania is entitled to register with Highmark Inc. d/b/a Highmark Blue Shield, (hereafter referred to as "Blue Shield"), as a participating provider and to continue participation, upon maintaining a current license and upon complying with these Regulations as amended from time to time with approval of the Pennsylvania Department of Health. Any such amendments will be reproduced in their entirety in Blue Shield's professional publications within the calendar quarter immediately following their approval or in any other manner approved by the Department of Health, and will become effective 30 days after their publication.
2. Applications for registration as a participating provider shall be submitted to Blue Shield on forms provided by it for such purpose, such form to be signed by the provider making application and to contain such information as the form may indicate.
3. The registration of any provider as a participating provider shall be conditioned upon his or her execution and delivery to Blue Shield of the Participating Provider's Agreement in effect at the time.
4. Blue Shield may, for proper cause, refuse to place the name of any provider upon its register of participating providers with the approval of the Pennsylvania Department of Health.
5. The registration of any provider as a participating provider shall be effective immediately upon acceptance by Blue Shield of the provider's application, and Blue Shield shall promptly supply to the provider an appropriate sign or certificate to display in his or her professional office evidencing the provider's registration as a participating provider.
6. A provider's registration with Blue Shield as a participating provider shall continue until such time as the provider's resignation becomes effective by giving written notice to Blue Shield and such resignation shall become effective 30 days after receipt by Blue Shield of such written notice.
7. Blue Shield may suspend or terminate the registration of a participating provider for proper cause, but only with the approval of the Pennsylvania Department of Health. Action may not be taken by Blue Shield to terminate or suspend the registration of any participating provider until the provider has been afforded an opportunity to be heard and be represented by counsel at a hearing held by Blue Shield in the manner provided by Article IX of the Bylaws of Highmark Inc., which is reproduced as Appendix A, and the Review Committee Guidelines, which are reproduced as Appendix B.
8. Every participating provider of Blue Shield whether heretofore or hereafter registered as such, shall when requested by Blue Shield, execute and deliver to Blue Shield a revised Participating Provider's Agreement reflecting changes in the law applicable to Blue Shield or duly approved changes in its mode of operation, if such revised Participating Provider's Agreement has been approved by the Department of Health.
9. Only individual providers may be registered as participating providers of Blue Shield. A participating provider may assign his or her rights to payment for covered services performed for Blue Shield members only in accordance with such procedure as Blue Shield may prescribe in the Assignment Account Guidelines, which are reproduced as Appendix C.

10. Each participating provider shall promptly advise Blue Shield of any change in the address of his or her professional office or place of practice.

## **B. GENERAL REGULATIONS**

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1. Participating providers of Blue Shield must participate in all Blue Shield programs under which they provide covered services except those programs which have been determined by the Department of Health to require their own unique participation agreements.
2. The Subscription Agreements and Master Contracts may be changed or supplemented from time to time when deemed advisable by Blue Shield in order to reflect changing conditions, provided that such changes or supplements are approved by the Pennsylvania Insurance Department.
3. Participating providers shall submit all claims for payment for services performed for Blue Shield members upon the claim form provided by Blue Shield. The utilization of a format other than this claim form must receive prior approval from Blue Shield. The information required by the form shall be set forth and the form shall be signed or verified by the provider in such manner as Blue Shield may prescribe.
4. To the greatest extent possible, participating providers shall report services in terms of the procedure codes listed in the Blue Shield **Procedure Terminology Manual**. In unusual cases, a description of service, a copy of the hospital records or other appropriate documentation should be submitted.
5. All claim forms for covered services performed for Blue Shield members shall be submitted as soon as possible, but in no event later than one year after the date of performance of the services involved, unless an extension of this period is granted by Blue Shield at the request of the participating provider. Charges for services rejected as being over the time limit shall not be collected from the member.
6. A participating provider performing covered services for a Blue Shield member shall be fully and completely responsible for all statements made on any claim form submitted to Blue Shield with respect to such services, regardless of the mode of execution or verification of such report which may be accepted by Blue Shield. A participating provider who misreports services to Blue Shield shall be responsible for reimbursing Blue Shield for all payments which were caused by such misreporting.
7. A participating provider shall not bill or collect from a member, or from Blue Shield, charges itemized and distinguished from the professional services provided. Such charges include, but are not limited to, malpractice surcharges, overhead fees or facility fees, or fees for completing claim forms or submitting additional information to Blue Shield.
8. A participating provider performing covered services for Blue Shield members is not an employee of Blue Shield and Blue Shield shall do nothing to interfere with the customary provider-patient relationship in such cases. Blue Shield shall not be liable or responsible to anyone or any person whatsoever as a result of any negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any participating provider performing services for Blue Shield members.
9. The determination as to whether any covered service meets accepted standards of practice in the community shall be made by Blue Shield in consultation with providers engaged in active clinical practice. Fees for covered services deemed not to meet accepted standards of practice shall not be collected from the member.

10. A participating provider shall render covered services in the most cost effective manner and in the least costly setting required for the appropriate treatment of the member. A participating provider shall bill Blue Shield for covered services performed for Blue Shield members only if such services are medically necessary. The determination as to whether any covered service is medically necessary shall be made by Blue Shield in consultation with providers engaged in active clinical practice. Whenever payment criteria related to cost effectiveness or medical necessity are developed, they will be made available to participating providers in Blue Shield's professional publications. Fees for covered services deemed not medically necessary shall not be collected from the member, unless the member requests the service(s), and the participating provider informs the member of his or her financial liability and the member chooses to receive the service(s). The participating provider should document such notification to the member in the provider's records.
11. Blue Shield will not interfere with a member's choice of a provider to perform covered services after that choice has been made. Any participating provider shall have the right to refuse to perform services for any Blue Shield member for cause satisfactory to the provider, provided that such refusal is not merely because the patient is a Blue Shield member.
12. A participating provider may, at all times, bill a Blue Shield member for non-covered services.
13. The determination as to whether any services performed by a participating provider for a Blue Shield member are covered by a Blue Shield Agreement and the amount of payment for such services shall be made by Blue Shield.
14. All covered services provided for Blue Shield members by participating providers shall be performed by such providers either personally or under their direct personal supervision. Direct personal supervision requires that a provider be in the immediate vicinity to perform or to manage the procedure personally, if necessary.
15. Each participating provider shall permit Blue Shield representatives to make reasonable examination of the provider's clinical records, including X-rays, relating to any covered service performed for Blue Shield members, when such examination is necessary to resolve any question concerning such services.
16. Upon prior request by Blue Shield, participating providers agree to take pre- and/or post-operative X-rays and submit tissue for examination by a pathologist. Such procedures shall be performed in accordance with accepted standards of practice in the medical and dental communities.
17. Each participating provider shall cooperate with utilization committees, or other similar committees, established by the provider's state society, and sub-division thereof, or by Blue Shield.
18. A participating provider is prohibited from paying or receiving a fee, rebate or any other consideration in return for referring a Blue Shield member to another provider, or in return for furnishing services to a member referred to him or her by another provider.
19. In the event any participating provider has received either from Blue Shield or from the member, an amount in excess of the amount determined by Blue Shield to be payable to the provider with respect to services performed for the member, such excess amount shall be returned promptly to Blue Shield, or to the member, as the case may be.

20. All matters, disputes or controversies relating to the services performed by participating providers or any questions involving professional ethics shall be considered, acted upon, disposed of and determined only by providers in the manner provided by Article IX of the Bylaws of Highmark Inc., which is reproduced as Appendix A, and the Review Committee Guidelines, which are reproduced as Appendix B. If such disputes involve overpayments which have not been returned to Blue Shield within thirty (30) calendar days of notification of a Review Committee determination, claim payments otherwise due the participating provider will be subject to withholding and the assessment of interest on the unpaid balance. The rate of interest shall be determined in the manner provided in the Review Committee Guidelines, which are reproduced as Appendix B. If a participating provider resigns while an overpayment is being disputed, claim payments otherwise due the participating provider for services rendered prior to the effective date of such resignation will be subject to withholding pending a final resolution of the matter. Any such amounts withheld by Blue Shield will not be subject to the assessment of interest until thirty (30) calendar days following a Review Committee decision. Should a Review Committee decision result in the reduction or the elimination of an overpayment amount, any excess monies withheld will be promptly returned to the provider. A participating provider may seek judicial review of an unfavorable Review Committee decision to the extent permitted by Pennsylvania law.
21. Every member shall be supplied with an appropriate identification card and participating providers shall be entitled to require members to present their identification card when services are requested.
22. A participating provider shall permit Blue Shield representatives to make reasonable examination of the provider's financial records insofar as it relates to determining appropriate reimbursement levels, usual charges or the costs associated with high cost technology equipment.
23. In regard to certain fee schedule programs which include income limits and certain UCR programs which include income limits, a participating provider shall perform covered services without making an additional charge above the fee paid by Blue Shield (except for certain deductibles, co-insurance and/or maximums) for those members who are defined as low income members in accordance with the program under which they are enrolled. If the program prescribes certain deductibles and/or co-insurance, a participating provider shall make no additional charge for covered services other than the applicable deductible and/or co-insurance, provided the low income member pays the deductible and/or co-insurance within the time limit set forth in the Subscription Agreement or Master Contract under which the member is enrolled.
24. In regard to UCR programs which do not include income limits, a participating provider shall perform covered services without making an additional charge above the fee paid by Blue Shield (except for certain deductibles, co-insurance and/or maximums) for all members who are enrolled under such programs. If the program prescribes certain deductibles and/or co-insurance, a participating provider shall make no additional charge for covered services other than the applicable deductibles and/or co-insurance, provided the member pays the deductible and/or co-insurance within the time limit set forth in the Subscription Agreement or Master Contract under which the member is enrolled.
25. Participating providers shall make the initial determination as to whether a member is of "low income" or "over-income." It shall be the member's responsibility to furnish proof of income to the participating provider within 90 days of a request. In the event of any dispute concerning the income status of a member, the final determination shall be made by Blue Shield. Annual income shall mean total income from all sources of the applicant-member and eligible dependents. In determining eligibility for payment in full, the participating provider will not take into account the total assets of the applicant-member, hospital accommodations or other non-income factors.

26. A participating provider may not routinely charge Blue Shield members more than the provider charges patients not covered by third-party payment plans. When requested, a participating provider must substantiate his or her usual charges to Blue Shield. If a review of a provider's records indicates any usual charge of record is not valid, Blue Shield may use this additional information in its determination of a usual charge. A participating provider who provides services under a bona fide contractual arrangement, such as health maintenance organizations authorized to operate under the Health Maintenance Organization Act, Act. No. 234 of 1980, may enter into agreements with such plans to charge their members differently than the provider routinely charges Blue Shield members. Additionally, a participating provider may charge a discounted fee to benefit a financially disadvantaged patient, provided the reason for such charge is appropriately noted in the provider's records.
27. Predetermination, the pretreatment review by Blue Shield of a treatment plan to determine the eligibility of the member, the member's coverage for services under his or her agreement and the Blue Shield allowance for such services, is a contractual obligation under the terms of certain Blue Shield programs. Predetermination must be requested prior to the initiation of any treatment plan in accordance with the member's contract with Blue Shield. It shall be the member's responsibility to inform the participating provider of his or her contractual requirements for predetermination. Appropriate diagnostic aids, such as, but not limited to, radiographs, must be submitted with a request for predetermination as required by Blue Shield in accordance with accepted standards of practice. Charges for services rejected because the participating provider failed to initiate predetermination shall not be collected from the member.
28. Precertification, the pretreatment review by Blue Shield of a treatment plan and/or treatment site, is a contractual obligation under the terms of certain Blue Cross and Blue Shield medical/surgical and hospitalization programs. Precertification must be requested prior to the initiation of any treatment plan in accordance with the member's contract with Blue Cross and Blue Shield. It shall be the member's responsibility to inform the participating provider of his or her contractual requirements for precertification. Blue Shield may require certain clinical records and diagnostic aids, which shall be in accordance with accepted standards of practice, to be included with requests for precertification. Charges for services rejected because the participating provider failed to initiate precertification shall not be collected from the member.

### **C. REIMBURSEMENT**

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Payment will be made by Blue Shield in accordance with the methodology referred to in the Subscription Agreement or Master Contract under which the member is enrolled.



## APPENDIX A

### BYLAWS OF HIGHMARK INC.

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EXCERPT REVISED NOVEMBER 11, 1998

#### ARTICLE IX REVIEW COMMITTEES

- 9.1 Dispute Resolution.** All matters, disputes or controversies arising out of the relationship between the Corporation and professional health care providers who render health services to the Corporation's members, including any questions involving professional ethics, shall be considered and determined by the appropriate one of the Review Committees established under this Article, whose decision shall be final on all such matters and controversies.
- 9.2 Medical Review Committee.** There shall be a Medical Review Committee consisting of at least eight (8) members. A majority of the members of the Medical Review Committee shall be providers who are participating providers or preferred providers with the Corporation ("provider members"), and the balance shall be consumers covered under health care contracts issued by the Corporation ("consumer members"). At least three fourths of the provider members of the Committee shall be medical doctors or doctors of osteopathy.
- 9.3 Dental Review Committee.** There shall be a Dental Review Committee consisting of at least eight (8) members. A majority of the members of the Dental Review Committee shall be dentists who are participating providers or preferred providers with the Corporation ("provider members"), and the balance shall be consumers covered under health care contracts issued by the Corporation ("consumer members").
- 9.4 Selection of Review Committee Members.** Members of the Review Committees shall be appointed by the Review Committee Selection Committee appointed pursuant to Section 6.3 of these Bylaws. Any person may submit the names of prospective provider members or consumer members to the Selection Committee for consideration. The Selection Committee shall make appointments to the Review Committees using the following criteria:
- 9.4.1** All provider members shall be participating providers or preferred providers of the Corporation.
- 9.4.2** No member shall be a director of the Corporation.
- 9.4.3** At least two thirds of the members of any Review Committee shall have no relationship with the Corporation (other than as providers who submit claims in the ordinary course of business or members covered under one of the Corporation's health care programs).
- 9.4.4** No member of any Review Committee shall have any conflict of interest that would prevent him or her from rendering a fair and impartial decision in any dispute between the Corporation and its health care providers.
- 9.4.5** The provider members shall have no history of utilization problems with the Corporation.
- 9.4.6** The provider members of the Medical Review Committee shall be broadly representative of the various health care professions and specialties whose services are covered by the Corporation, and the provider members of the Dental Review Committee shall be broadly representative of dental specialties.

**9.4.7** Members of any Review Committee must be willing to commit to regular attendance at Committee meetings and to devoting adequate time to Committee business to permit them to fully understand the Committee's work and give full and fair consideration to all matters coming before the Committee. Failure to regularly attend meetings and devote adequate attention to Committee work shall be cause for dismissal.

Members of the Review Committees shall be appointed for terms of two (2) years and shall be subject to dismissal during their terms only for cause as determined by the Selection Committee.

**9.5 Officers of Review Committees.** Each Review Committee shall have three officers: a chairperson, a vice-chairperson and a secretary, selected as follows:

**9.5.1** The Selection Committee shall appoint a chairperson for each Review Committee. The chairperson shall preside at all meetings of the Committee, but shall not vote in any matter being considered by the Committee except when necessary to break a tie.

**9.5.2** The Selection Committee shall appoint a vice-chairperson for each Review Committee. The vice-chairperson shall preside at meetings of the Committee in the chairperson's absence and, when serving in such capacity, shall only vote when necessary to break a tie. The vice-chairperson shall also perform such other duties as the chairperson shall assign.

**9.5.3** The Corporation shall provide one of its employees to serve as secretary for each Review Committee. The secretary's role shall be solely that of administrator, and not that of a member of the Committee. The secretary shall keep the minutes of the Committee, and shall perform the duties enumerated in Section 9.8 of this Article, and such other duties as the Committee shall assign.

**9.6 Submission of Matters to the Review Committee.** Matters may be submitted to a Review Committee by corporate management or by any participating provider or preferred provider. All matters to be submitted to a Review Committee shall be set forth in writing and delivered to the secretary of the Review Committee involved.

**9.7 Review Committee Proceedings.**

**9.7.1** The Review Committees shall maintain written procedural guidelines to assure that all providers receive full and fair consideration of any issues presented to the Committees.

**9.7.2** Only the provider members of a Review Committee shall vote on any matter brought before it.

**9.7.3** In considering any matter brought before it, a Review Committee shall have authority to take any one or more of the following actions:

- (a) Refer the matter to the other Review Committee for appropriate action.
- (b) Refer the case for recommendation or action by any appropriate committee, board or division of the state professional society or local professional society of the Provider involved.
- (c) Refer the matter to an appropriate law enforcement officer or agency of the federal, state or any local government if the Committee has probable cause to believe that the provider involved secured payment from the Corporation for services performed by the provider for a member on the basis of material false information submitted to the Corporation with the intention of defrauding it.
- (d) Refer the matter to the state professional licensure board of the provider involved.
- (e) Render a finding that the Corporation is entitled to a refund of fees paid to the provider.

- (f) Render a finding that authorizes the Corporation to collect any refund by withholding future payments due from the Corporation to the provider involved.
- (g) Render such decision or take any other such action as may be necessary or appropriate to fully resolve any dispute presented to the Committee.

**9.7.4** If a particular matter involves conduct which would justify denying a provider enrollment as a participating provider of the Corporation under the Blue Shield Act, or termination of the individual's enrollment, the Committee may direct that a hearing be held in accordance with Section 9.8 of this Article to consider the provider's participating status. Such conduct may include:

- (a) Violation of the provider's agreement with the Corporation;
- (b) Violation of the regulatory legislation applicable to the Corporation;
- (c) Violation of the Regulations for Participating Providers of the Corporation;
- (d) Refusal to adhere to the billing, payment, or service benefit provisions of any health plan in which the participating provider participates; or
- (e) Violation of federal or state criminal statutes.

**9.8 Proceedings Involving Status of an Individual as a Participating Provider.** The procedures set forth in this section apply in all cases where the Committee has directed that a hearing be held to determine the status of an individual as a participating provider of the Corporation. In all such cases, the Corporation shall prepare an appropriate complaint setting forth the allegations against the individual. The Chairperson of the Review Committee shall promptly fix a time, date and place for a hearing. The provider involved shall be given at least fifteen (15) days written notice by the secretary of the Committee of the date, time and place of such hearing, and shall be furnished with a copy of the complaint. The provider shall be allowed to file a written answer to the complaint, provided such answer is filed with the secretary of the Committee at least five (5) days prior to the hearing. At the hearing, such witnesses may be heard and such evidence may be received as is deemed to be relevant and of reasonable probative value; provided, however, that formal rules of evidence need not be followed. The provider affected by the complaint shall be afforded a reasonable opportunity to be heard before the committee, either in person or by counsel, and to produce evidence and witnesses at such hearing. All testimony shall be recorded and a complete record shall be kept of the hearing.

After the hearing, the Review Committee, by majority vote of those members who are providers, shall take whatever action it deems appropriate, based on the evidence and testimony produced at the hearing and, if such action involves either the denial of registration as a participating provider, or suspension or termination of that provider's enrollment, the matter shall be promptly referred to the Secretary of Health of the Commonwealth of Pennsylvania for approval or for such other action as the Secretary of Health may deem appropriate.

**9.9 Preferred Provider Appeals.** The Review Committees shall also serve as the final appeal for providers who are rejected or terminated as preferred providers by any preferred provider panel operated by the Corporation under Pennsylvania's preferred provider legislation (40 P.S. § 764a) or any successor legislation. Any provider who is rejected as a panel member or whose status as a panel member has been terminated by the credentialing committee of any such panel may appeal in writing to the secretary of the appropriate Review Committee. The provider in such appeals shall be entitled to appear before the Review Committee and present evidence or argument, but the hearing need not be recorded and the Committee's decision need not be referred to the Secretary of Health for approval. The decision of the Review Committee on all such appeals shall be final.

## APPENDIX B

### HIGHMARK BLUE SHIELD

### REVIEW COMMITTEE GUIDELINES

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Highmark Blue Shield operates under the provisions of Act 271 of 1972 (40 PA. C.S. Section 6301 et seq.). Section 6324 (c) of the Act requires that all matters, disputes or controversies relating to professional health service doctors or any questions involving professional ethics shall be considered and determined only by health service doctors selected in a manner prescribed in the Bylaws of the professional health service corporation involved.

The Highmark Inc. Bylaws (Article IX) stipulate that Review Committees be formed to consider and determine matters, disputes or controversies arising out of the relationship between Blue Shield and professional providers who render health services.

The Medical Review Committee considers all matters, disputes or controversies involving all professional providers who render health services. The Dental Review Committee considers matters, disputes or controversies involving dentists.

The matters referred to the Review Committees generally concern disputes with respect to overutilization and/or misutilization of services, quality of care, service benefits and usual charge problems.

The following procedures are applicable to Review Committees:

1. For matters involving potential overutilization and/or misutilization of services or inappropriate quality of care, a complete review is conducted of the provider's practice pattern prior to referral to a Review Committee. During this review, a sample of patient records, statistics, diagnostic aids, and/or other informational sources is reviewed. The results of such review, as well as the complete methodology used, will be made available to the provider when any adverse findings result. Should the provider disagree with the results of the review due to the sample size, the provider may request an expanded review.
2. If it is determined that an overpayment has been made, the amount of the overpayment will be calculated for a period of time not to exceed that permitted by the Statute of Limitations. The results of such overpayment calculations will be made available to the provider. The provider will be furnished with the methodology used to calculate the overpayment, including any variables used to adjust multi-year overpayment determinations.
3. If it is discovered in the review process that an underpayment has occurred, the provider may seek reimbursement, through the appropriate appeal mechanisms, for all claims involved during the same time period as the review by Blue Shield. Such claims must be supported by clinical records.
4. If the matter will not be referred for prosecution, and does not pertain to a hearing to consider whether a provider should be suspended or terminated as a participating provider, a Blue Shield representative will contact the provider to discuss all findings. If the provider elects not to meet with a representative or if a meeting cannot be arranged within a reasonable period of time, the information will be transmitted to the provider by mail. At that time, the provider is advised of all findings of an adverse or problematic nature and of the appeal mechanisms available to the provider. The provider is provided with a detailed, written statement outlining the basis of any refund request. The provider is also advised of the repayment options available to him or her, and is provided with a copy of the Review Committee Guidelines. The provider will be encouraged to submit any additional information which could have a bearing on the matter and/or create the basis for a settlement or adjustment to the refund amount requested, if any.

5. Should further communications fail to result in an agreement as to the provider's refunding an overpayment, if any, or other matters pertaining to the review, the provider will receive written notification at least thirty (30) calendar days in advance of the date of the Review Committee meeting at which the provider's case will be considered, of his or her right to appear before the Committee and of his or her right to be represented by legal counsel. The provider is again encouraged to provide any information which may be pertinent to the resolution of the matter. Accompanying the letter is another copy of the basis of any refund request, the applicable section(s) of the Highmark Inc. Bylaws pertaining to Review Committees, the Review Committee Guidelines and, if applicable, the Participating Provider's Agreement and the Regulations for Participating Providers.
6. At least fifteen (15) calendar days prior to the date of the Review Committee meeting at which the provider's case will be considered, the provider will be given a copy of the documentation to be presented to the Review Committee.
7. A provider may forward information to the Review Committee or, upon written request to the secretary of the Committee, may appear before the Committee. A provider who requests to appear before the Committee will be notified of the date and time of his or her appearance at least fifteen (15) calendar days prior to the meeting. Such notification will inform the provider of the exact nature of the proceeding, of the provider's right to represent his or her disagreement and to provide any other information which will aid the Committee in its deliberation of the matter.
8. Matters scheduled to be brought before the Review Committee will not be deliberated on a formal or an informal basis between Blue Shield staff and Committee members prior to the scheduled date of the Committee meeting except at the request of the provider. Should the provider make such a request, the results will be fully disclosed to the provider in writing.
9. A Review Committee's consideration of any matter, dispute or controversy concerning a provider who has requested to appear will be continued until after the scheduled appearance of the provider except as follows:
  - (a) If the provider is notified of the Committee meeting 45 or more calendar days in advance of such meeting and advises the secretary of the Committee that he or she wishes to attend but is unable to be present on the specific date scheduled, the Committee will proceed with its consideration of the matter. However, the provider will be given the opportunity to appear before the Committee at its next scheduled meeting.
  - (b) If notification is sent less than 45 calendar days prior to the Committee meeting and the provider advises the secretary of the Committee that he or she wishes to attend the meeting, but is unable to do so on the specific date scheduled, the provider will be granted one continuance. The Committee will proceed with its consideration of the matter at the next scheduled meeting if the provider, following notification as provided for in Item 5 above, fails to appear.
10. Following the Review Committee meeting, the provider will be advised in writing within thirty (30) calendar days of all determinations made by the Committee. Such notification will include, but not be limited to, the amount of any refund at issue, the facts and reasoning supporting Blue Shield's conclusions, and, for participating providers, the specific basis in regulation of Blue Shield's claim. For those matters involving the participating status of a provider, the provider will be notified within thirty (30) calendar days following a determination by the Secretary of Health.

11. Any overpayment amounts which have not been returned to Blue Shield within thirty (30) calendar days of notification of the Review Committee's determination will be subject to withholding of payments due the participating provider and the assessment of interest. Interest will also be assessed on installment payment arrangements which exceed 90 days. The rate of interest is based upon the 90 day Treasury Bill rate in effect at the beginning of the calendar quarter during which a Review Committee decision or an installment repayment agreement is reached.
12. If the Review Committee determines that a hearing should be held to consider whether a provider should be suspended or terminated as a participating provider, the proceedings will be conducted as set forth in Article IX, Section 9.8, of the Highmark Inc. Bylaws, and in the manner described in these guidelines.

## APPENDIX C

### HIGHMARK BLUE SHIELD

### ASSIGNMENT ACCOUNT GUIDELINES

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#### I. INTRODUCTION

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An assignment account is an account established by Blue Shield to permit one or more individual providers, practicing together, to direct Blue Shield payments to an entity other than the individual providers. An assignment account will be permitted only if the provider(s), as well as the entity to which payment is being directed, meet, and continue to comply with, the guidelines set forth below.

The guidelines set forth below apply exclusively to payments under Highmark Blue Shield's private business programs. These guidelines were developed to accommodate the needs of groups of providers practicing together while, at the same time, addressing Blue Shield's concerns regarding appropriate, efficient utilization of services and appropriate application of payment limitations for ineligible providers.

#### II. ELIGIBLE ENTITIES

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For the purpose of these guidelines, a provider will be considered to be a duly licensed health service doctor eligible for payment by Blue Shield.

Upon acceptable completion of the assignment account application forms, Blue Shield will permit an assignment account to be established for the following types of entities:

- A. **Group Practice** — Two or more providers practicing together as a group in the same location may establish an assignment account to permit the group to be recognized as a single entity for purposes of billing and payment. Acceptable types of group practice arrangements are:
1. Two or more providers practice as a partnership;
  2. One or more provider(s) form a professional corporation in accordance with the Professional Corporation Law (15 P.S. SS2901, et seq.) and the corporation becomes the employer of the provider(s). This would include solo practitioners who incorporate their practices; or
  3. A provider employs one or more other provider(s) as associates in his or her practice.

In each type of group practice, the providers will be required to provide documentation that they are a group practice eligible to establish an assignment account. For example, in the case of an employer-employee relationship, Blue Shield will require proof that a bona fide employment relationship exists, including copies of W-2 forms and other relevant documents. In the case of a professional corporation, the approved articles of incorporation must be provided. Existence of a professional partnership may be demonstrated by a signed copy of the partnership agreement. The agreement should demonstrate that only eligible providers are partners.

- B. **Limited Partnership** — In cases in which the general partner of a limited partnership is an eligible entity in accordance with these guidelines, an account may be established in the name of the general partner. Limited partners may not be included. For example, if the general partner of a limited partnership is a professional corporation, then the general partner may establish an assignment account in the name of the professional corporation. The limited partners would not be members of the assignment account.

- C. **Non-profit Corporation** – A non-profit corporation, established for the purpose of providing health services, through duly licensed health service doctors, which is not being reimbursed by any Blue Cross Plan for the same services, may establish an assignment account at the discretion of Blue Shield. The non-profit corporation, and all members of the proposed assignment account who are licensed health service doctors, will be required to execute an agreement, agreeing to be jointly and severally liable for overpayments and misreporting by the account.
- D. **Business Corporation** – A business corporation, sometimes also referred to as a for-profit corporation, established for the purpose of providing health services, through duly licensed health service doctors, which is not being reimbursed by any Blue Cross Plan for the same services, may establish an assignment account at the discretion of Blue Shield. The business corporation, and all members of the proposed assignment account who are licensed health service doctors, will be required to execute an agreement, agreeing to be jointly and severally liable for overpayments and misreporting by the account.
- E. **Health Care Facility** – Providers who are employed by a health care facility or an affiliate of such a facility, for which Blue Shield has payment responsibility, may establish an assignment account at the discretion of Blue Shield for the purpose of having fees for services paid by Blue Shield directed to the health care facility or its affiliate. It should be noted that the majority of such fees are not eligible for payment under Blue Shield contracts, and that such assignment accounts are solely for the purpose of directing professional fees which are otherwise payable under the subscription agreements and master contracts to the appropriate entity. For purposes of this Section, an affiliate of a health care facility is a corporation which either controls, or is controlled by, the health care facility.

### III. INELIGIBLE ENTITIES

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The following entities are not eligible to establish an assignment account with Blue Shield:

- A. **Business Corporation as defined in the Business Corporation Law (15 P.S. SS1001, et seq.)** — Blue Shield has concluded that it will not permit an assignment account to be established in order to direct payment(s) to a business corporation, except as stipulated in Section II.D.
- B. **Mixed Participating/Non-participating Provider Assignment Accounts** — Non-participating providers may not be included in a Blue Shield assignment account which also contains participating providers.
- C. **Groups Seeking Solely to Purchase Services** — An assignment account will not be permitted in a situation which would effectively evade Blue Shield's purchased services requirement. Blue Shield will not permit an assignment account to be formed in which the account intends solely to purchase professional services from independent contractors.
- D. **Groups Established Solely as Investment Vehicles** — Assignment accounts are established for the purpose of permitting providers who practice together to bill under a single provider identification number. They will not be established in situations in which the apparent purpose of including members in the assignment account is to provide an investment vehicle for those members. In a situation in which there is a question as to whether the account is being established for investment purposes, the proposed providers will be required to certify their intent to provide professional services on behalf of the assignment account.
- E. **Groups Providing Non-covered Services** — Assignment accounts will not be permitted in situations where it is apparent that the majority of services to be provided will not be covered under Blue Shield contracts. For example, an assignment account will not be established for providers who are compensated for their services by a hospital or skilled nursing facility, or by a direct subsidiary of a hospital or skilled nursing facility.



- F. **Group Practices with Outstanding Utilization Review Problems** — Blue Shield will not permit an assignment account to be established in any situation in which any proposed member(s) of the assignment account has a pending utilization review problem with Blue Shield. Furthermore, Blue Shield will not permit the addition or deletion of members in any situation in which either the members or the existing assignment account have a pending utilization review problem with Blue Shield.
- G. **Groups Seeking Multiple Assignment Accounts** — Blue Shield reserves the right to refuse duplicate assignment accounts. Multiple accounts composed of the same providers, with the same tax identification number, in the same locale will be refused.
- H. **Mixed License Assignment Accounts** – Limited license providers may not be included in a Blue Shield assignment account which also contains doctors of medicine and/or doctors of osteopathy. Blue Shield has concluded that it will not permit such an assignment account, since it would eliminate the ability to determine that a limited license provider reporting services is operating within the scope of his or her license.

#### **IV. APPLICATION PROCESS**

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A group of providers desiring to establish an assignment account must complete and submit an application form provided by Blue Shield. The application form and accompanying paperwork can be obtained from the providers' local Provider Relations representative. The following requirements apply to the application process (Additional instructions are included with the form itself.):

- A. Each member of the group must provide his or her name and Blue Shield individual provider number.
- B. The assignment account must provide its proposed tax identification number. If a tax identification number of an entity other than the group making the application is to be used, the group must identify the entity whose number is being used.
- C. The group must provide a statement signed by each member which certifies that each member is billing fee-for-service and agrees to assign his or her fees to the group account.
- D. The group must agree to inform Blue Shield of any changes in the group's contractual arrangements that would necessitate Blue Shield payments being made to some entity other than that designated in the assignment account application.
- E. The group must agree that every claim submitted to Blue Shield will bear the name of the individual provider who actually performed the service(s).
- F. The group must agree to notify Blue Shield in writing of any subsequent changes in the membership of the assignment account **prior to the effective date of each change**.
- G. The group must agree to timely completion and return of Blue Shield's annual information update form. This form will be mailed to the assignment account each year, and will request verification of current account membership, location of practice, specialties of member providers and other pertinent information.
- H. Each member of the group must sign a statement agreeing that the entity sponsoring the assignment account and each individual member will be jointly and severally liable for any overpayment that the account receives.

**V. TERMINATION**

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Blue Shield reserves the right to dissolve any assignment account which is determined by Blue Shield not to meet the requirements set forth in these guidelines. The assignment account and its member providers shall be given written notice of a decision by Blue Shield to dissolve the account. Dissolution of an assignment account will not affect the right of the individual providers to submit claims under their individual provider numbers.

**VI. APPEALS**

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Because it is impossible to address all possible billing and business arrangements in these guidelines, providers shall have the right to appeal Blue Shield's decision to deny an assignment account in any situation in which there is a question whether the group qualifies for the assignment account.

Such appeals must be in writing. Proposed assignment accounts that do not strictly meet the eligibility criteria stated in these guidelines may be approved if it is established to the satisfaction of Blue Shield that creation of the assignment account will significantly increase the delivery of high quality, cost effective health care to Blue Shield members. Such exceptions will only be granted in extraordinary circumstances; they are not a matter of course. Blue Shield reserves the right to deny any proposed assignment account that does not comply with all of the criteria set forth in these guidelines.

Blue Shield will maintain records of decisions on all written appeals of denials of assignment accounts which are filed in accordance with these guidelines, to assure consistency and fairness in the granting of such accounts.

## ***PremierBlue Shield Preferred Provider Agreement With Highmark Blue Shield***

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Under the applicable laws of the Commonwealth of Pennsylvania, I am duly authorized to engage in the practice of \_\_\_\_\_ . In consideration of being registered by Highmark Inc. d/b/a Highmark Blue Shield, an independent licensee of the Blue Cross and Blue Shield Association (hereinafter termed "Blue Shield"), as a preferred provider in the PremierBlue Shield network, I do hereby agree as follows:

For Blue Shield members (hereinafter termed "members"), enrolled in a PremierBlue Shield preferred provider program, I will abide by all terms of this Agreement and will accept Blue Shield's allowance under the member's contract as payment in full for covered services.

I will also accept an allowance not less than the comparable Blue Shield allowance applicable under this Agreement as payment in full for participants enrolled in programs other than PremierBlue Shield preferred provider programs when Blue Shield has entered into an agreement providing for access to the PremierBlue Shield network. I agree to allow my name, office address and similar information to be listed in provider directories distributed to participants.

I will perform services for members and make reports to Blue Shield concerning such services.

I understand that my registration as a preferred provider under this Agreement, as well as compensation for services provided as such, will be in accordance with the Blue Shield Regulatory Act, as heretofore or hereafter reenacted or amended, and the Bylaws, the applicable Regulations, the applicable member contracts, all as heretofore or hereafter adopted or entered into by Blue Shield under authority of said Regulatory Act, with any required governmental approval.

Copies of the Blue Shield Regulatory Act, and the Bylaws, Regulations and member contracts referred to in this Agreement shall be available for examination by me during regular business hours at the principal office of Blue Shield. A copy of the Regulations shall be provided to me upon execution of this Agreement and thereafter upon my request.

For preferred provider programs that include the use of primary care physician gatekeepers, I understand that Blue Shield will provide me with a reference manual, and periodic updates thereto, that will provide pertinent information concerning my obligations under such programs.

I understand that this Agreement constitutes a contract between Blue Shield and me, that Blue Shield is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting Blue Shield to use the service mark in the Commonwealth of Pennsylvania, and that Blue Shield is not contracting as the agent of the Association. I further understand and agree that I have not entered into this Agreement based upon representations by any person other than Blue Shield and that no person, entity or organization other than Blue Shield shall be held accountable or liable to me for any of Blue Shield's obligations created under this Agreement.

This Agreement shall be effective only when accepted by Blue Shield, and this Agreement shall continue in effect thereafter, until terminated by either party according to the following provisions:

1. This Agreement may be terminated by either party upon sixty (60) days prior written notice.
2. This Agreement may be terminated by Blue Shield, immediately, if Blue Shield becomes aware that services are being rendered in a manner that could cause harm to patients.

**Main practice address** (primary physical practice location)

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Street

\_\_\_\_\_  
Name - *Please print*

\_\_\_\_\_  
City State ZIP code

( )

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone number

\_\_\_\_\_  
Specialty

**Mailing address** (if different from above)  
(address where administrative work is done)

\_\_\_\_\_  
Social security number

\_\_\_\_\_  
Street

\_\_\_\_\_  
Pennsylvania license number

\_\_\_\_\_  
City State ZIP code

\_\_\_\_\_  
Accepted by

If you need to **change** any addresses related to your practice, please complete form 9111 (PDS Change of Address).

\_\_\_\_\_  
Date

\_\_\_\_\_  
Highmark Blue Shield provider number

**Mail To:**

PROVIDER DATA SERVICES  
POST OFFICE BOX 898842  
CAMP HILL, PA 17089-8842

## ***PremierBlue Shield™ Preferred Provider Agreement with Highmark Blue Shield for Primary Care Physicians in Managed Care Programs***

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Under the applicable laws of the Commonwealth of Pennsylvania, I am duly authorized to engage in the practice of \_\_\_\_\_. In consideration of being registered by Highmark Blue Shield, an independent licensee of the Blue Cross and Blue Shield Association (hereinafter termed "Blue Shield") as a Primary Care Physician Preferred Provider in the PremierBlue Shield Network, I do hereby agree as follows:

For Blue Shield Subscribers enrolled in PremierBlue Shield Managed Care Preferred Provider Programs (hereinafter termed subscribers), I will abide by all terms of this Agreement and will accept Blue Shield's allowance under the subscriber's contract as payment in full for covered services.

I will also accept an allowance not less than the comparable Blue Shield allowance applicable under this Agreement as payment in full for participants enrolled in programs other than PremierBlue Shield Managed Care Preferred Provider Programs when Blue Shield has entered into an agreement providing for access to the PremierBlue Shield network. I agree to allow my name, office address, and similar information to be listed in provider directories distributed to participants.

I understand that there can be two distinct types of Managed Care Preferred Provider Programs. In certain instances, a subscriber may not be required to pre-select a designated Primary Care Physician, but may self-select any Primary Care Physician from the panel registered as such by Blue Shield. In this type of program, referrals to specialty care Preferred Providers may or may not be required. In other instances, a subscriber may be required to pre-select a Primary Care Physician. This requires a level of commitment by the Primary Care Physician and a level of oversight on the part of Blue Shield, as described in this Agreement, substantially different from those associated with other Blue Shield programs.

I will perform services for subscribers and make reports to Blue Shield concerning such services.

I understand that my registration as a Primary Care Physician Preferred Provider under this Agreement, as well as compensation for services provided as such, will be in accordance with the Blue Shield Regulatory Act, as heretofore or hereafter reenacted or amended, and the By-laws, the applicable Regulations, the applicable subscriber contracts, all as heretofore or hereafter adopted or entered into by Blue Shield under authority of said Regulatory Act, with any required governmental approval.

Copies of the Blue Shield Regulatory Act, and the By-laws, Regulations and subscriber contracts referred to in this Agreement shall be available for examination by me during regular business hours at the principle office of Blue Shield. A copy of the Regulations shall be provided to me upon execution of this Agreement and thereafter upon my request.

I understand that Blue Shield will provide me with a Reference Manual, and periodic updates thereto, which will provide pertinent information concerning my obligations as a Primary Care Physician.

In addition to the terms and provisions of this Agreement, I understand that I must abide by the applicable Regulations. In the case of any conflict(s) between the Agreement and the applicable Regulations, this Agreement shall take precedence.

**A. REGISTRATION OF PRIMARY CARE PHYSICIANS**

Any physician who is a Family Practitioner/General Practitioner, General Internist, Pediatrician, or Obstetrician/Gynecologist (limited to maternity care and annual gynecological exams with required follow-up care) is entitled to apply to participate as a Primary Care Physician.

**B. GENERAL REGULATIONS**

1. A Primary Care Physician is responsible for providing initial and primary medical care for subscribers enrolled in Managed Care Preferred Provider Programs.
2. A Primary Care Physician will maintain the continuity of medical care for subscribers, and will be responsible for initiating all required referrals to specialty care Preferred Providers in accordance with policies and procedures established by Blue Shield. This requirement is in addition to the stipulations of General Regulations B-14, of the Regulations for Preferred Providers.
3. When a Primary Care Physician initiates a referral of a subscriber to a specialty care Preferred Provider, the Primary Care Physician, in accordance with accepted standards of practice, will also forward all relevant diagnostic test results for use by the specialty care Preferred Provider.
4. A Primary Care Physician will perform all services for subscribers in accordance with Blue Shield's Quality Assessment Program. Blue Shield will make all relevant Quality Assessment Program criteria available to Primary Care Physicians.
5. A Primary Care Physician shall accept as patients those subscribers who have selected or have been assigned to the Primary Care Physician, without regard to the health status or health care needs of the subscribers. A Primary Care Physician shall notify Blue Shield, as least sixty (60) days in advance, of any intent to close his/her practice to additional subscribers.
6. A Primary Care Physician shall make necessary and appropriate arrangements to assure the availability of physician services for subscribers on a 24 hour per day, 7 day per week basis. This includes arrangements to assure coverage of subscribers after-hours or when the Primary Care Physician is otherwise absent.
7. As required by Blue Shield, a Primary Care Physician shall maintain active hospital admitting privileges in a participating program hospital. Any change to such privileges shall immediately be reported in writing to Blue Shield. A Primary Care Physician shall admit subscribers to such a hospital, in non-emergency situations, in accordance with Blue Shield policies and procedures.
8. In addition to the stipulations of General Regulations B-3 and B-4, of the Regulations for Preferred Providers, a Primary Care Physician agrees that in no event, including, but not limited to non-payment by Blue Shield, or insolvency or breach of this agreement by Blue Shield, shall the Primary Care Physician bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a subscriber or person(s) other than Blue Shield acting on the subscriber's behalf for covered services. This provision shall not prohibit collection of coinsurances or copayments in accordance with the terms of the applicable Subscriber Agreement.

A Primary Care Physician further agrees that (1) the hold harmless provision herein shall survive the termination of this Agreement, regardless of the cause giving rise to such termination, and that (2) this hold harmless provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the Primary Care Physician and the subscriber or person(s) acting on his/her behalf.

9. A Primary Care Physician shall maintain medical records in accordance with standards set forth by Blue Shield, and shall provide such medical information to Blue Shield and/or the Department of Health, or an external review organization, approved by the Department of Health, as may be necessary for compliance by Blue Shield with all applicable laws and regulations, as well as for purposes of Managed Care Program management. Blue Shield shall have access, upon request, to a Primary Care Physicians billing and medical records relating to health care services provided to subscribers. This access shall include information regarding the charges for such services, and regarding deductibles, co-payments and co-insurances received by the Primary Care Physician from subscribers for covered services.
10. Blue Shield shall have the right to inspect the offices of Primary Care Physicians pursuant to Blue Shield's credentialing and Quality Assessment Programs.
11. Primary Care Physicians agree to cooperate with, participate in, and comply with the decisions of such Managed Care Preferred Provider Program review programs as may be established by Blue Shield. These will include, but may not be limited to, utilization review, the Quality Assessment Program and the Subscriber Grievance Procedure.

### C. REIMBURSEMENT

I understand that this Agreement constitutes a contract between Blue Shield and me, that Blue Shield is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting Blue Shield to use the service mark in the Commonwealth of Pennsylvania, and that Blue Shield is not contracting as the agent of the Association. I further understand and agree that I have not entered into this Agreement based upon representations by any person other than Blue Shield and that no person, entity, or organization other than Blue Shield shall be held accountable or liable to me for any of Blue Shield's obligations created under this Agreement.

This Agreement shall be effective only when accepted by Highmark Blue Shield, and this Agreement shall continue in effect thereafter, until terminated by either party according to the following provisions:

1. This Agreement may be terminated by either party upon sixty (60) days prior written notice.
2. This Agreement may be terminated by Highmark Blue Shield, immediately, if Highmark Blue Shield becomes aware that services are being rendered in a manner that could cause harm to patients.

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Name - *Please print*

\_\_\_\_\_  
Date

\_\_\_\_\_  
Specialty

\_\_\_\_\_  
Social security number

\_\_\_\_\_  
Pennsylvania license number

\_\_\_\_\_  
Accepted by

\_\_\_\_\_  
Date

\_\_\_\_\_  
Highmark Blue Shield provider number

**Mail To:**

PROVIDER DATA SERVICES  
POST OFFICE BOX 898842  
CAMP HILL, PA 17089-8842

**Main practice address** (primary physical practice location)

\_\_\_\_\_  
Office street address

\_\_\_\_\_  
City State ZIP code  
( )

\_\_\_\_\_  
Telephone number

**Mailing address** (if different from above)  
(address where administrative work is done)

\_\_\_\_\_  
Street

\_\_\_\_\_  
City State ZIP code

If you need to **change** any addresses related to your practice,  
please complete form 9111 (PDS Change of Address).



## HIGHMARK BLUE SHIELD PREMIERBLUE SHIELD REGULATIONS FOR PREFERRED PROVIDERS

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### A. REGISTRATION OF PREFERRED PROVIDERS

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1. Any health service doctor or ancillary provider duly authorized to practice as such under the applicable laws of the Commonwealth of Pennsylvania is entitled to apply to participate as a preferred provider with Highmark Inc. d/b/a Highmark Blue Shield, (hereafter referred to as "Blue Shield"), and, upon acceptance by Blue Shield, to continue participation, upon maintaining a current license and upon complying with these Regulations as amended from time to time with approval of the Pennsylvania Department of Health. Any such amendments will be reproduced in their entirety in Blue Shield's professional publications within the calendar quarter immediately following their approval or in any other manner approved by the Department of Health, and will become effective 30 days after their publication.
2. Applications for registration as a preferred provider shall be submitted to Blue Shield on forms provided by it for such purpose, such form to be signed by the provider making application and to contain such information as the form may indicate.
3. The registration of any provider as a preferred provider shall be conditioned upon his or her execution and delivery to Blue Shield of the Preferred Provider Agreement in effect at the time.
4. Blue Shield may, on consideration of applicable selection criteria pertaining to cost effectiveness, quality of care, or economic factors, which have been approved by the Department of Health, refuse to place the name of any provider upon its register of preferred providers. To assure consistency, Blue Shield will maintain records of all such decisions.
5. The registration of any provider as a preferred provider shall be effective immediately upon acceptance by Blue Shield of the provider's application, and Blue Shield shall promptly supply to the provider an appropriate sign or certificate to display in his or her professional office evidencing the provider's registration as a preferred provider.
6. A provider's registration with Blue Shield as a preferred provider shall continue until such time as terminated by either party in accordance with the terms of the Preferred Provider Agreement.
7. Blue Shield may reject the application of a prospective preferred provider, or may terminate the registration of a preferred provider in accordance with the terms of the Preferred Provider Agreement. A prospective preferred provider shall have the right to appeal a rejection based upon cause, and a preferred provider shall have the right to appeal a termination initiated by Blue Shield. Such appeals shall be in writing and shall be addressed to the credentialing committee. Reinstatement of a terminated preferred provider may be approved if it is established to the satisfaction of the credentialing committee, that such reinstatement will facilitate the delivery of quality, cost effective health care to Blue Shield members enrolled in a preferred provider program (hereafter referred to as "members"). To assure consistency, Blue Shield will maintain records of all such appeals which are denied.

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Highmark Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association.

8. Every preferred provider whether heretofore or hereafter registered as such, shall when requested by Blue Shield, execute and deliver to Blue Shield a revised Preferred Provider Agreement reflecting changes in the law applicable to Blue Shield or duly approved changes in its mode of operation, if such revised Preferred Provider Agreement has been approved by the Department of Health.
9. Only individual providers may be registered as preferred providers of Blue Shield. A preferred provider may assign his or her rights to payment for covered services performed for members only in accordance with such procedure as Blue Shield may prescribe in the Assignment Account Guidelines, which are reproduced as Appendix C.
10. Each preferred provider shall promptly advise Blue Shield of any change in the address of his or her professional office or place of practice.

#### **B. GENERAL REGULATIONS**

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1. Preferred providers must participate in all preferred provider programs under which they provide covered services except those programs which have been determined by the Department of Health to require their own unique participation agreements.
2. The member contracts may be changed or supplemented from time to time when deemed advisable by Blue Shield in order to reflect changing conditions, provided that such changes or supplements are approved by the Pennsylvania Insurance Department.
3. Preferred providers shall submit all claims for payment for services performed for members upon the claim form provided by Blue Shield. The utilization of a format other than this claim form must receive prior approval from Blue Shield. The information required by the form shall be set forth and the form shall be signed or verified by the provider in such manner as Blue Shield may prescribe.
4. Preferred providers shall not collect charges from members for covered services, with the exception of applicable deductibles and co-insurance, prior to the receipt of claim disposition from Blue Shield.
5. To the greatest extent possible, preferred providers shall report services in terms of the procedure codes listed in the Blue Shield **Procedure Terminology Manual**. In unusual cases, a description of service, a copy of the hospital records, or other appropriate documentation should be submitted.
6. All claim forms for covered services performed for members shall be submitted as soon as possible, but in no event later than one year after the date of performance of the services involved, unless an extension of this period is granted by Blue Shield at the request of the preferred provider. Charges for services rejected as being over the time limit shall not be collected from the member.
7. A preferred provider performing covered services for a member shall be fully and completely responsible for all statements made on any claim form submitted to Blue Shield with respect to such services, regardless of the mode of execution or verification of such report which may be accepted by Blue Shield. A preferred provider who misreports services to Blue Shield shall be responsible for reimbursing Blue Shield for all payments which were caused by such misreporting.
8. A preferred provider shall not bill or collect from a member, or from Blue Shield, charges itemized and distinguished from the professional services provided. Such charges include, but are not limited to, malpractice surcharges, overhead fees or facility fees, or fees for completing claim forms or submitting additional information to Blue Shield.

9. A preferred provider performing covered services for members is not an employee of Blue Shield, and Blue Shield shall do nothing to interfere with the customary provider-patient relationship in such cases. Blue Shield shall not be liable or responsible to anyone or any person whatsoever as a result of any negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any preferred provider performing services for members.
10. The determination as to whether any covered service meets accepted standards of practice shall be made by Blue Shield in consultation with providers engaged in active clinical practice. Fees for covered services deemed not to meet accepted standards of practice shall not be collected from the member.
11. A preferred provider shall bill Blue Shield for covered services performed for members only if such services are medically necessary or otherwise specifically listed as covered services in the member contract. The determination as to whether any covered service is medically necessary shall be made by Blue Shield in consultation with providers engaged in active clinical practice. Whenever criteria related to medical necessity are developed, they will be made available to preferred providers in Blue Shield's professional publications. Fees for covered services deemed not medically necessary shall not be collected from the member unless the member requests the services and the preferred provider informs the member of his or her financial liability, and the member chooses to receive the service(s). The preferred provider should document such notification to the member in the provider's records.
12. A preferred provider shall render covered services in the most cost effective manner and in the least costly setting required for the appropriate treatment of the member. Blue Shield shall monitor the provision of covered services by preferred providers, and shall include consideration of cost effectiveness in its determination as to whether or not a provider will be retained as a preferred provider.
13. A preferred provider shall cooperate fully with and abide by the decisions of Blue Shield's Quality Assessment Program and Member Grievance Procedure. These systems, which are approved by the Department of Health, are integral parts of managed care preferred provider programs in which members are required to preselect designated primary care physician gatekeepers. They are designed to assure that members receive quality care that is both efficient and effective. All matters related to the quality of care, in such programs, shall be determined and acted upon by the appropriate Quality Assessment Committee. The program includes, but is not limited to, the periodic review of the structural characteristics of a preferred provider and his or her practice (for example, professional qualifications, documentation standards and active hospital staff privileges), ongoing analysis of inappropriate outcomes, and ongoing survey and analysis of patient satisfaction. Blue Shield shall include consideration of quality assessment in the determination as to whether or not a provider will be retained as a preferred provider. Whenever Blue Shield's criteria related to the structural characteristics of a preferred provider and his or her practice are modified, they will be promulgated by Blue Shield. Each preferred provider shall promptly advise Blue Shield of any relevant change (for example, a change in active program hospital staff privileges or licensure status). Blue Shield may impose financial penalties or other sanctions on preferred providers who fail to meet quality standards or follow administrative procedures included in such managed care preferred provider programs. In the event that Blue Shield imposes such financial penalties, the preferred provider shall make no additional charge to the member. Preferred providers shall have the right to appeal such penalties to the appropriate Quality Assessment Committee.

14. Except in emergency situations or upon prior approval of Blue Shield, a preferred provider must make any necessary referral to another preferred provider and/or to a participating program hospital. A preferred provider shall notify Blue Shield of any referral to a non-preferred provider or to a non-participating program hospital, and shall document the reason for such in the member's records.
15. A preferred provider may, at all times, bill a member for non-covered services.
16. The determination as to whether any services performed by a preferred provider for a member are covered by a member contract and the amount of payment for such services shall be made by Blue Shield.
17. All covered services provided for members by a preferred provider shall be performed by such providers either personally or under their direct personal supervision. Direct personal supervision requires that a provider be in the immediate vicinity to perform or to manage the procedure personally, if necessary.
18. Each preferred provider shall permit Blue Shield representatives to make reasonable examination of the provider's clinical records, including X-rays, relating to any covered service performed for members, when such examination is necessary to resolve any question concerning such services. Additionally, for managed care preferred provider programs in which members are required to preselect designated primary care physician gatekeepers, a preferred provider shall maintain medical records in accordance with standards set forth by Blue Shield, and shall provide such medical information to Blue Shield and/or the Department of Health, or an external review organization approved by the Department of Health, as may be necessary for compliance by Blue Shield with all applicable laws and regulations for such programs.
19. Upon prior request by Blue Shield, a preferred provider agrees to take pre- and/or post-operative X-rays and submit tissue for examination by a pathologist. Such procedures shall be performed in accordance with accepted standards of practice.
20. Each preferred provider shall cooperate with Quality Assessment Committees, utilization committees, or other similar committees, established by the provider's state society, and sub-division thereof, or by Blue Shield.
21. A preferred provider is prohibited from paying or receiving a fee, rebate or any other consideration in return for referring a Blue Shield member to another provider, or in return for furnishing services to a member referred to him or her by another provider.
22. In the event any preferred provider has received either from Blue Shield or from the member, an amount in excess of the amount determined by Blue Shield to be payable to the provider with respect to services performed for the member, such excess amount shall be returned promptly to Blue Shield, or to the member, as the case may be.
23. All matters, disputes or controversies relating to the services performed by preferred providers or any questions involving professional ethics, except as specified in Regulation A-7 and Regulations B-12, and B-13, supra, shall be considered, acted upon, disposed of and determined only by providers in the manner provided by Article IX of the Bylaws of Highmark Inc., which is reproduced as Appendix A, and the Review Committee Guidelines, which are reproduced as Appendix B. If such disputes involve overpayments which have not been returned to Blue Shield within thirty (30) calendar days of notification of a Review Committee determination, claim payments otherwise due the preferred provider will be subject to withholding and the assessment of interest on the unpaid balance. The rate of interest shall be determined in the manner provided in the Review Committee Guidelines, which are reproduced as Appendix B. If a preferred provider resigns while an overpayment is being disputed, claim payments

otherwise due the preferred provider for services rendered prior to the effective date of such resignation will be subject to withholding pending a final resolution of the matter. Any such amounts withheld by Blue Shield will not be subject to the assessment of interest until thirty (30) calendar days following a Review Committee decision. Should a Review Committee decision result in the reduction or the elimination of an overpayment amount, any excess monies withheld will be promptly returned to the provider. A preferred provider may seek judicial review of an unfavorable Review Committee decision to the extent permitted by Pennsylvania law.

24. Every member shall be supplied with an appropriate identification card and a preferred provider shall be entitled to require members to present their identification card when services are requested.
25. A preferred provider shall permit Blue Shield representatives to make reasonable examination of the provider's financial records insofar as it relates to determining appropriate reimbursement levels or the costs associated with high cost technology equipment.
26. A preferred provider shall make no additional charge for covered services other than the applicable deductibles and/or co-insurance, provided the member pays the deductible and/or co-insurance within the time limit set forth in the member contract under which the member is enrolled. For managed care programs in which members are required to preselect designated primary care physician gatekeepers, a preferred provider agrees that in no event, including, but not limited to non-payment by Blue Shield, or insolvency or breach of this agreement by Blue Shield, shall the preferred provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a member or person(s) other than Blue Shield acting on the member's behalf for covered services. This provision shall not prohibit collection of co-insurances or co-payments in accordance with the terms of the applicable Member Agreement.

A preferred provider further agrees that (1) the hold harmless provision herein shall survive the termination of this Agreement, regardless of the cause giving rise to such termination, and that (2) this hold harmless provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the preferred provider and the member or person(s) acting on the member's behalf.

27. Predetermination, the pretreatment review by Blue Shield of a treatment plan to determine the eligibility of the member, the member's coverage for services under his or her agreement and the Blue Shield allowance for such services, is a contractual obligation under the terms of certain Blue Shield programs. Predetermination must be requested prior to the initiation of any treatment plan in accordance with the member's contract with Blue Shield. Appropriate diagnostic aids, such as, but not limited to, radiographs, must be submitted with a request for predetermination as required by Blue Shield in accordance with accepted standards of practice. Charges for services rejected because the preferred provider failed to initiate predetermination shall not be collected from the member.
28. Precertification, the pretreatment review by Blue Shield of a treatment plan and/or treatment site, is a contractual obligation under the terms of Blue Cross and Blue Shield preferred provider programs. Precertification must be requested prior to the initiation of any treatment plan in accordance with the member's contract with Blue Cross and Blue Shield. Blue Shield may require certain clinical records and diagnostic aids, which shall be in accordance with accepted standards of practice, to be included with requests for precertification. Charges for services rejected because the preferred provider failed to initiate precertification shall not be collected from the member.

**C. MANAGED CARE PROVISIONS**

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The following provisions will apply in all instances where the preferred provider is providing services to a member enrolled in a Managed Care Plan as defined by the Quality Health Care Accountability and Protection Act of 1998, June 17, P.L. 464, No. 68, 40 Pa.C.S. § 991.2101 et seq. ("Act 68").

1. The preferred provider acknowledges and reaffirms the hold harmless provision in Regulation B.26, and agrees that such provision shall survive the termination of the Preferred Provider Agreement and is to be construed for the benefit of the members.
2. All member records shall be kept confidential by Blue Shield and the preferred provider in accordance with section 2131 of Act 68 and other applicable state and federal laws and regulations, including, without limitation, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Gramm-Leach-Bliley Act of 1999 (GLBA).
3. The preferred provider will maintain medical records in accordance with standards set by Blue Shield, and shall permit Blue Shield, the Department of Health, the Insurance Department, and, when necessary, the Department of Public Welfare, access to records for the purpose of quality assurance, investigation of complaints or grievances, enforcement or other activities related to compliance with Act 68, the regulations of the Department of Health adopted thereunder, and other Pennsylvania Laws, provided, however, that records shall only be accessible to Department employees or agents with direct responsibilities for the functions enumerated above.
4. The preferred provider will participate in and abide by the decisions of all quality assurance, utilization review and member complaint and grievance systems applicable to Blue Shield Managed Care Plans.
5. The preferred provider will adhere to all state and federal laws and regulations applicable to the provision of professional health care services under this Agreement.
6. Blue Shield will pay all "clean claims" (as defined in Section 2102 of Act 68) in accordance with the prompt payment standards of Section 2166 of Act 68, the Insurance Department's regulations at 31 Pa. Code § 154.18, and any other applicable law.
7. Blue Shield will notify the preferred provider in writing at least thirty (30) days before it implements any changes to its contracts, policies or procedures that affect: (a) the preferred provider, (b) the manner in which health care services are provided to members, or (c) the manner in which Blue Shield pays for health care services. No such notice shall be required if the change is required by law or regulation.
8. Nothing in these regulations shall be construed to limit or prohibit any preferred provider's right to discuss, and the preferred provider may freely discuss, with any member, or, where applicable, on behalf of such member with such member's representative: (a) the process that Blue Shield uses or proposes to use to deny payment for a health care service; (b) medically necessary and appropriate care available to such member that is within the preferred provider's scope of practice, including information regarding the nature of treatment, risks of treatment, alternative treatments, or the availability of alternate therapies, consultation or tests, regardless of benefit coverage limitations under the terms of the member's Blue Shield Managed Care Plan; and (c) the decision of Blue Shield to deny payment for a health care service.

9. As required by Act 68, Blue Shield will not sanction, fail to renew or terminate the preferred provider's participation in Blue Shield Managed Care Plans for any of the following reasons:
  - a. The preferred provider's advocating for medically necessary and appropriate health care for a member, where such care is consistent with the degree of learning and skill ordinarily possessed by a reputable health care provider practicing according to the applicable legal standard of care;
  - b. The preferred provider's filing of a grievance in accordance with the terms of Act 68, or assisting members in filing their own grievances;
  - c. The preferred provider's protesting a decision, policy or practice that the preferred provider, consistent with the degree of learning and skill ordinarily possessed by a reputable health care provider practicing according to the applicable legal standard of care, reasonably believes interferes with the preferred provider's ability to provide (based on the preferred provider's clinical judgment) medically necessary and appropriate health care;
  - d. The preferred provider's having a practice that includes a substantial number of patients with expensive medical conditions;
  - e. The preferred provider's objecting to the provision of, or refusing to provide, perform, participate in or refer a member for health care services when the refusal of the preferred provider is based on moral or religious grounds and the preferred provider makes adequate information available to members or, if applicable, prospective members;
  - f. The preferred provider's communicating with a member or a member's representative in accordance with the terms of Regulation C.8; or
  - g. The preferred provider's taking any other action specifically permitted under Sections 2113, 2121 and 2171 of Act 68 (40 P.S. §§ 991.2113, 991.2121 and 991.2171).
10. In the event of the voluntary or involuntary termination of the Preferred Provider Agreement, the preferred provider agrees upon request to cooperate with Blue Shield in its obtaining information regarding those members enrolled in a Managed Care Plan that may be affected by such termination because they are undergoing an ongoing course of treatment or are otherwise active patients of the preferred provider. Such information includes the name, address and identification number of affected Managed Care Plan members.

#### **D. REIMBURSEMENT**

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Payment will be made by Blue Shield directly to the preferred provider in accordance with the payment schedule(s) currently in effect. Blue Shield will make the payment schedules available by posting them on its internet site or by other readily accessible means, and will provide printed schedules of payment allowances, by specialty, upon request. Payments will be subject to the coinsurance, copayment and deductible provisions of the member's benefit contract and to Blue Shield's policies and reimbursement guidelines.

## APPENDIX A

### BYLAWS OF HIGHMARK INC.

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EXCERPT REVISED NOVEMBER 11, 1998

#### ARTICLE IX - REVIEW COMMITTEES

- 9.1 Dispute Resolution.** All matters, disputes or controversies arising out of the relationship between the Corporation and professional health care providers who render health services to the Corporation's members, including any questions involving professional ethics, shall be considered and determined by the appropriate one of the Review Committees established under this Article, whose decision shall be final on all such matters and controversies.
- 9.2 Medical Review Committee.** There shall be a Medical Review Committee consisting of at least eight (8) members. A majority of the members of the Medical Review Committee shall be providers who are participating providers or preferred providers with the Corporation ("provider members"), and the balance shall be consumers covered under health care contracts issued by the Corporation ("consumer members"). At least three fourths of the provider members of the Committee shall be medical doctors or doctors of osteopathy.
- 9.3 Dental Review Committee.** There shall be a Dental Review Committee consisting of at least eight (8) members. A majority of the members of the Dental Review Committee shall be dentists who are participating providers or preferred providers with the Corporation ("provider members"), and the balance shall be consumers covered under health care contracts issued by the Corporation ("consumer members").
- 9.4 Selection of Review Committee Members.** Members of the Review Committees shall be appointed by the Review Committee Selection Committee appointed pursuant to Section 6.3 of these Bylaws. Any person may submit the names of prospective provider members or consumer members to the Selection Committee for consideration. The Selection Committee shall make appointments to the Review Committees using the following criteria:
- 9.4.1** All provider members shall be participating providers or preferred providers of the Corporation.
- 9.4.2** No member shall be a director of the Corporation.
- 9.4.3** At least two thirds of the members of any Review Committee shall have no relationship with the Corporation (other than as providers who submit claims in the ordinary course of business or members covered under one of the Corporation's health care programs).
- 9.4.4** No member of any Review Committee shall have any conflict of interest that would prevent him or her from rendering a fair and impartial decision in any dispute between the Corporation and its health care providers.
- 9.4.5** The provider members shall have no history of utilization problems with the Corporation.
- 9.4.6** The provider members of the Medical Review Committee shall be broadly representative of the various health care professions and specialties whose services are covered by the Corporation, and the provider members of the Dental Review Committee shall be broadly representative of dental specialties.



**9.4.7** Members of any Review Committee must be willing to commit to regular attendance at Committee meetings and to devoting adequate time to Committee business to permit them to fully understand the Committee's work and give full and fair consideration to all matters coming before the Committee. Failure to regularly attend meetings and devote adequate attention to Committee work shall be cause for dismissal.

Members of the Review Committees shall be appointed for terms of two (2) years and shall be subject to dismissal during their terms only for cause as determined by the Selection Committee.

**9.5 Officers of Review Committees.** Each Review Committee shall have three officers: a chairperson, a vice-chairperson and a secretary, selected as follows:

**9.5.1** The Selection Committee shall appoint a chairperson for each Review Committee. The chairperson shall preside at all meetings of the Committee, but shall not vote in any matter being considered by the Committee except when necessary to break a tie.

**9.5.2** The Selection Committee shall appoint a vice-chairperson for each Review Committee. The vice-chairperson shall preside at meetings of the Committee in the chairperson's absence and, when serving in such capacity, shall only vote when necessary to break a tie. The vice-chairperson shall also perform such other duties as the Chairperson shall assign.

**9.5.3** The Corporation shall provide one of its employees to serve as secretary for each Review Committee. The secretary's role shall be solely that of administrator, and not that of a member of the Committee. The secretary shall keep the minutes of the Committee, and shall perform the duties enumerated in Section 9.8 of this Article, and such other duties as the Committee shall assign.

**9.6 Submission of Matters to the Review Committee.** Matters may be submitted to a Review Committee by corporate management or by any participating provider or preferred provider. All matters to be submitted to a Review Committee shall be set forth in writing and delivered to the secretary of the Review Committee involved.

**9.7 Review Committee Proceedings.**

**9.7.1** The Review Committees shall maintain written procedural guidelines to assure that all providers receive full and fair consideration of any issues presented to the Committees.

**9.7.2** Only the provider members of a Review Committee shall vote on any matter brought before it.

**9.7.3** In considering any matter brought before it, a Review Committee shall have authority to take any one or more of the following actions:

- (a) Refer the matter to the other Review Committee for appropriate action.
- (b) Refer the case for recommendation or action by any appropriate committee, board or division of the state professional society or local professional society of the provider involved.
- (c) Refer the matter to an appropriate law enforcement officer or agency of the federal, state or any local government if the Committee has probable cause to believe that the provider involved secured payment from the Corporation for services performed by the provider for a member on the basis of material false information submitted to the Corporation with the intention of defrauding it.
- (d) Refer the matter to the state professional licensure board of the provider involved.
- (e) Render a finding that the Corporation is entitled to a refund of fees paid to the provider.
- (f) Render a finding that authorizes the Corporation to collect any refund by withholding future payments due from the Corporation to the provider involved.
- (g) Render such decision or take any other such action as may be necessary or appropriate to fully resolve any dispute presented to the Committee.

9.7.4 If a particular matter involves conduct which would justify denying a provider enrollment as a participating provider of the Corporation under the Blue Shield Act, or termination of the individual's enrollment, the Committee may direct that a hearing be held in accordance with Section 9.8 of this Article to consider the provider's participating status. Such conduct may include:

- (a) Violation of the provider's agreement with the Corporation;
- (b) Violation of the regulatory legislation applicable to the Corporation;
- (c) Violation of the Regulations for Participating Providers of the Corporation;
- (d) Refusal to adhere to the billing, payment, or service benefit provisions of any health plan in which the participating provider participates; or
- (e) Violation of federal or state criminal statutes.

9.8 **Proceedings Involving Status of an Individual as a Participating Provider.** The procedures set forth in this section apply in all cases where the Committee has directed that a hearing be held to determine the status of an individual as a participating provider of the Corporation. In all such cases, the Corporation shall prepare an appropriate complaint setting forth the allegations against the individual. The chairperson of the Review Committee shall promptly fix a time, date and place for a hearing. The provider involved shall be given at least fifteen (15) days written notice by the secretary of the Committee of the date, time and place of such hearing, and shall be furnished with a copy of the complaint. The provider shall be allowed to file a written answer to the complaint, provided such answer is filed with the secretary of the Committee at least five (5) days prior to the hearing. At the hearing, such witnesses may be heard and such evidence may be received as is deemed to be relevant and of reasonable probative value; provided, however, that formal rules of evidence need not be followed. The provider affected by the complaint shall be afforded a reasonable opportunity to be heard before the Committee, either in person or by counsel, and to produce evidence and witnesses at such hearing. All testimony shall be recorded and a complete record shall be kept of the hearing.

After the hearing, the Review Committee, by majority vote of those members who are providers, shall take whatever action it deems appropriate, based on the evidence and testimony produced at the hearing and, if such action involves either the denial of registration as a participating provider, or suspension or termination of that provider's enrollment, the matter shall be promptly referred to the Secretary of Health of the Commonwealth of Pennsylvania for approval or for such other action as the Secretary of Health may deem appropriate.

9.9 **Preferred Provider Appeals.** The Review Committees shall also serve as the final appeal for providers who are rejected or terminated as preferred providers by any preferred provider panel operated by the Corporation under Pennsylvania's preferred provider legislation (40 P.S. § 764a) or any successor legislation. Any provider who is rejected as a panel member or whose status as a panel member has been terminated by the credentialing committee of any such panel may appeal in writing to the secretary of the appropriate Review Committee. The provider in such appeals shall be entitled to appear before the Review Committee and present evidence or argument, but the hearing need not be recorded and the Committee's decision need not be referred to the Secretary of Health for approval. The decision of the Review Committee on all such appeals shall be final.

## APPENDIX B

### HIGHMARK BLUE SHIELD REVIEW COMMITTEE GUIDELINES

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Highmark Blue Shield operates under the provisions of Act 271 of 1972 (40 PA. C.S. Section 6301 et seq.). Section 6324 (c) of the Act requires that all matters, disputes or controversies relating to professional health service doctors or any questions involving professional ethics shall be considered and determined only by health service doctors selected in a manner prescribed in the Bylaws of the professional health service corporation involved.

The Highmark Inc. Bylaws (Article IX) stipulate that Review Committees be formed to consider and determine matters, disputes or controversies arising out of the relationship between Blue Shield and professional providers who render health services.

The Medical Review Committee considers all matters, disputes or controversies involving all professional health service doctors except dentists. The Dental Review Committee considers matters, disputes or controversies involving dentists.

The matters referred to the Review Committees generally concern disputes with respect to overutilization and/or misutilization of services, quality of care, service benefits and usual charge problems.

**The following procedures are applicable to Review Committees:**

1. For matters involving potential overutilization and/or misutilization of services or inappropriate quality of care, a complete review is conducted of the provider's practice pattern prior to referral to a Review Committee. During this review, a sample of patient records, statistics, diagnostic aids, and/or other informational sources is reviewed. The results of such review, as well as the complete methodology used, will be made available to the provider when any adverse findings result. Should the provider disagree with the results of the review due to the sample size, the provider may request an expanded review.
2. If it is determined that an overpayment has been made, the amount of the overpayment will be calculated for a period of time not to exceed that permitted by the Statute of Limitations. The results of such overpayment calculations will be made available to the provider. The provider will be furnished with the methodology used to calculate the overpayment, including any variables used to adjust multi-year overpayment determinations.
3. If it is discovered in the review process that an underpayment has occurred, the provider may seek reimbursement, through the appropriate appeal mechanisms, for all claims involved during the same time period as the review by Blue Shield. Such claims must be supported by clinical records.
4. If the matter will not be referred for prosecution, and does not pertain to a hearing to consider whether a provider should be suspended or terminated as a preferred provider, a Blue Shield representative will contact the provider to discuss all findings. If the provider elects not to meet with a representative or if a meeting cannot be arranged within a reasonable period of time, the information will be transmitted to the provider by mail. At that time, the provider is advised of all findings of an adverse or problematic nature and of the appeal mechanisms available to the provider. The provider is provided with a detailed, written

statement outlining the basis of any refund request. The provider is also advised of the repayment options available to him or her, and is provided with a copy of the Review Committee Guidelines. The provider will be encouraged to submit any additional information which could have a bearing on the matter and/or create the basis for a settlement or adjustment to the refund amount requested, if any.

5. Should further communications fail to result in an agreement as to the provider's refunding an overpayment, if any, or other matters pertaining to the review, the provider will receive written notification at least thirty (30) calendar days in advance of the date of the Review Committee meeting at which the provider's case will be considered, of his or her right to appear before the Committee and of his or her right to be represented by legal counsel. The provider is again encouraged to provide any information which may be pertinent to the resolution of the matter. Accompanying the letter is another copy of the basis of any refund request, the applicable section(s) of the Highmark Inc. Bylaws pertaining to Review Committees, the Review Committee Guidelines and, if applicable, the Preferred Provider Agreement and the Regulations for Preferred Providers.
6. At least fifteen (15) calendar days prior to the date of the Review Committee meeting at which the provider's case will be considered, the provider will be given a copy of the documentation to be presented to the Review Committee.
7. A provider may forward information to the Review Committee or, upon written request to the secretary of the Committee, may appear before the Committee. A provider who requests to appear before the Committee will be notified of the date and time of his or her appearance at least fifteen (15) calendar days prior to the meeting. Such notification will inform the provider of the exact nature of the proceeding, of the provider's right to represent his or her disagreement and to provide any other information which will aid the Committee in its deliberation of the matter.
8. Matters scheduled to be brought before the Review Committee will not be deliberated on a formal or an informal basis between Blue Shield staff and Committee members prior to the scheduled date of the Committee meeting except at the request of the provider. Should the provider make such a request, the results will be fully disclosed to the provider in writing.
9. A Review Committee's consideration of any matter, dispute or controversy concerning a provider who has requested to appear will be continued until after the scheduled appearance of the provider except as follows:
  - (a) If the provider is notified of the Committee meeting 45 or more calendar days in advance of such meeting and advises the secretary of the Committee that he or she wishes to attend but is unable to be present on the specific date scheduled, the Committee will proceed with its consideration of the matter. However, the provider will be given the opportunity to appear before the Committee at its next scheduled meeting.
  - (b) If notification is sent less than 45 calendar days prior to the Committee meeting and the provider advises the secretary of the Committee that he or she wishes to attend the meeting, but is unable to do so on the specific date scheduled, the provider will be granted one continuance. The Committee will proceed with its consideration of the matter at the next scheduled meeting if the provider, following notification as provided for in Item 5 above, fails to appear.

10. Following the Review Committee meeting, the provider will be advised in writing within thirty (30) calendar days of all determinations made by the Committee. Such notification will include, but not be limited to, the amount of any refund at issue, the facts and reasoning supporting Blue Shield's conclusions, and, for preferred providers, the specific basis in regulation of Blue Shield's claim.
11. Any overpayment amounts which have not been returned to Blue Shield within thirty (30) calendar days of notification of the Review Committee's determination will be subject to withholding of payments due the preferred provider and the assessment of interest. Interest will also be assessed on installment payment arrangements which exceed 90 days. The rate of interest is based upon the 90 day Treasury Bill rate in effect at the beginning of the calendar quarter during which a Review Committee decision or an installment repayment agreement is reached.
12. If the Review Committee determines that a hearing should be held to consider whether a provider should be suspended or terminated as a preferred provider, the proceedings will be conducted as set forth in Article IX, Section 9.8, of the Highmark Inc. Bylaws, and in the manner described in these guidelines.

## APPENDIX C

### HIGHMARK BLUE SHIELD ASSIGNMENT ACCOUNT GUIDELINES

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#### I. INTRODUCTION

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An assignment account is an account established by Highmark Blue Shield to permit one or more individual providers, practicing together, to direct Highmark Blue Shield payments to an entity other than the individual providers. An assignment account will be permitted only if the provider(s), as well as the entity to which payment is being directed, meet, and continue to comply with, the guidelines set forth below.

The guidelines set forth below apply exclusively to payments under Highmark Blue Shield's private business programs. These guidelines were developed to accommodate the needs of groups of providers practicing together while, at the same time, addressing Highmark Blue Shield's concerns regarding appropriate, efficient utilization of services and appropriate application of payment limitations for ineligible providers.

#### II. ELIGIBLE ENTITIES

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For the purpose of these guidelines, a provider will be considered to be a duly licensed health service doctor eligible for payment by Highmark Blue Shield.

Upon acceptable completion of the assignment account application forms, Highmark Blue Shield will permit an assignment account to be established for the following types of entities:

- A. Group Practice** — Two or more providers practicing together as a group in the same location may establish an assignment account to permit the group to be recognized as a single entity for purposes of billing and payment. Acceptable types of group practice arrangements are:
1. Two or more providers practice as a partnership;  
One or more provider(s) form a professional corporation in accordance with the Professional Corporation Law (15 P.S. SS2901, et seq.) and the corporation becomes the employer of the provider(s). This would include solo practitioners who incorporate their practices; or
  2. One or more provider(s) form a professional corporation in accordance with the Professional Corporation Law (15 P.S. SS2901, et seq.) and the corporation becomes the employer of the provider(s). This would include solo practitioners who incorporate their practices; or
  3. A provider employs one or more other provider(s) as associates in his or her practice. In each type of group practice, the providers will be required to provide documentation that they are a group practice eligible to establish an assignment account. For example, in the case of an employer-employee relationship, Highmark Blue Shield will require proof that a bona fide employment relationship exists, including copies of W-2 forms and other relevant documents. Existence of a professional partnership may be demonstrated by a signed copy of the partnership agreement. The agreement should demonstrate that only eligible providers are partners.
- B. Limited Partnership** — In cases in which the general partner of a limited partnership is an eligible entity in accordance with these guidelines, an account may be established in the name of the general partner. Limited partners may not be included. For example, if the general partner of a limited partnership is a professional corporation, then the general partner may establish an assignment account in the name of the professional corporation. The limited partners would not be members of the assignment account.

- C. Non-profit Corporation** - A non-profit corporation, established for the purpose of providing health services, through duly licensed health service doctors, which is not being reimbursed by any Blue Cross Plan for the same service, may establish an assignment account at the discretion of Highmark Blue Shield. The non-profit corporation, and all members of the proposed assignment account who are licensed health service doctors, will be required to execute an agreement, agreeing to be jointly and severally liable for overpayments and misreporting by the account.
- D. Business Corporation** - A business corporation, sometimes also referred to as a for-profit corporation, established for the purpose of providing health services, through duly licensed health service doctors, which is not being reimbursed by any Blue Cross Plan for the same services, may establish an assignment account at the discretion of Highmark Blue Shield. The business corporation, and all members of the proposed assignment account who are licensed health service doctors, will be required to execute an agreement, agreeing to be jointly and severally liable for overpayments and misreporting by the account.
- E. Health Care Facility** - Providers who are employed by a health care facility or an affiliate of such a facility, for which Highmark Blue Shield has payment responsibility, may establish an assignment account at the discretion of Highmark Blue Shield for the purpose of having fees for services paid by Highmark Blue Shield directed to the health care facility or its affiliate. It should be noted that such assignment accounts are solely for the purpose of directing professional fees which are otherwise payable under the subscription agreements and master contracts to the appropriate entity. For purposes of this Section, an affiliate of a health care facility is a corporation which either controls, or is controlled by, the health care facility.

### III. INELIGIBLE ENTITIES

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The following entities are not eligible to establish an assignment account with Highmark Blue Shield:

- A. Business Corporation as defined in the Business Corporation Law (15 P.S. SS1001, et seq.)** Highmark Blue Shield has concluded that it will not permit an assignment account to be established in order to direct payment(s) to a business corporation, except as stipulated in Section II.D.
- B. Mixed Participating/Non-participating Provider Assignment Accounts** — Non-participating providers may not be included in a Highmark Blue Shield assignment account which also contains participating providers.
- C. Groups Seeking Solely to Purchase Services** — An assignment account will not be permitted in a situation which would effectively evade Highmark Blue Shield's purchased services requirement. Highmark Blue Shield will not permit an assignment account to be formed in which the account intends solely to purchase professional services from independent contractors.
- D. Groups Established Solely as Investment Vehicles** — Assignment accounts are established for the purpose of permitting providers who practice together to bill under a single provider identification number. They will not be established in situations in which the apparent purpose of including members in the assignment account is to provide an investment vehicle for those members. In a situation in which there is a question as to whether the account is being established for investment purposes, the proposed providers will be required to certify their intent to provide professional services on behalf of the assignment account.

- E. Groups Providing Non-covered Services** — Assignment accounts will not be permitted in situations where it is apparent that the majority of services to be provided will not be covered under Highmark Blue Shield contracts.
- F. Group Practices with Outstanding Utilization Review Problems** —Highmark Blue Shield will not permit an assignment account to be established in any situation in which any proposed member(s) of the assignment account has a pending utilization review problem with Highmark Blue Shield. Furthermore, Highmark Blue Shield will not permit the addition or deletion of members in any situation in which either the members or the existing assignment account have a pending utilization review problem with Highmark Blue Shield.
- G. Groups Seeking Multiple Assignment Accounts** — Highmark Blue Shield reserves the right to refuse duplicate assignment accounts. Multiple accounts composed of the same providers, with the same tax identification number, in the same locale will be refused.
- H. Mixed License Assignment Accounts** - Limited license providers may not be included in a Highmark Blue Shield assignment account which also contains doctors of medicine and/or doctors of osteopathy. Highmark Blue Shield has concluded that it will not permit such an assignment account, since it would eliminate the ability to determine that a limited license provider reporting services is operating within the scope of his or her license.

#### **IV. APPLICATION PROCESS**

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A group of providers desiring to establish an assignment account must complete and submit an application form provided by Highmark Blue Shield. The application form and accompanying paperwork can be obtained from the providers' local Provider Relations representative. The following requirements apply to the application process (Additional instructions are included with the form itself.):

- A.** Each member of the group must provide his or her name and Highmark Blue Shield individual provider number.
- B.** The assignment account must provide its proposed tax identification number. If a tax identification number of an entity other than the group making the application is to be used, the group must identify the entity whose number is being used.
- C.** The group must provide a statement signed by each member which certifies that each member is billing fee-for-service and agrees to assign his or her fees to the group account.
- D.** The group must agree to inform Highmark Blue Shield of any changes in the group's contractual arrangements that would necessitate Highmark Blue Shield payments being made to some entity other than that designated in the assignment account application.
- E.** The group must agree that every claim submitted to Highmark Blue Shield will bear the name of the individual provider who actually performed the service(s).
- F.** The group must agree to notify Highmark Blue Shield in writing of any subsequent changes in the membership of the assignment account **prior to the effective date of each change.**



- G. Each member of the group must sign a statement agreeing that the entity sponsoring the assignment account and each individual member will be jointly and severally liable for any overpayment that the account receives.

#### **V. TERMINATION**

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Highmark Blue Shield reserves the right to dissolve any assignment account which is determined by Highmark Blue Shield not to meet the requirements set forth in these guidelines. The assignment account and its member providers shall be given written notice of a decision by Highmark Blue Shield to dissolve the account. Dissolution of an assignment account will not affect the right of the individual providers to submit claims under their individual provider numbers.

#### **VI. APPEALS**

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Because it is impossible to address all possible billing and business arrangements in these guidelines, providers shall have the right to appeal Highmark Blue Shield's decision to deny an assignment account in any situation in which there is a question whether the group qualifies for the assignment account.

Such appeals must be in writing. Proposed assignment accounts that do not strictly meet the eligibility criteria stated in these guidelines may be approved if it is established to the satisfaction of Highmark Blue Shield that creation of the assignment account will significantly increase the delivery of high quality, cost effective health care to Highmark Blue Shield members. Such exceptions will only be granted in extraordinary circumstances; they are not a matter of course. Highmark Blue Shield reserves the right to deny any proposed assignment account that does not comply with all of the criteria set forth in these guidelines.

Highmark Blue Shield will maintain records of decisions on all written appeals of denials of assignment accounts which are filed in accordance with these guidelines, to assure consistency and fairness in the granting of such accounts.

