

## Provider Network Management

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## Introduction

This section explains our procedures for managing the PremierBlue Shield network. Where this network is utilized to support managed care products, Highmark Blue Shield must credential and utilize procedures to comply with NCQA and Pennsylvania Department of Health regulations.

## Network Management

### **Practitioner credentialing/recredentialing**

Highmark Blue Shield staff follows an established process to credential providers for the PremierBlue Shield network. In addition, we have delegated credentialing arrangements with a limited number of institutions that we have audited to assess their compliance with our credentialing standards.

Providers are initially credentialed prior to network admission and recredentialled every three years. Highmark Blue Shield conducts verification of the practitioners as defined by its policies, state and federal regulations and in accordance with accrediting standards. The initial credentialing process includes:

- Completion of an application
- Signed attestation verifying all information on the application and stating any reasons for inability to perform essential duties, lack of illegal drug use, loss of license/privileges, felony and disciplinary action
- Primary source verification
- Inquiry to National Practitioner Data Bank for sanction history
- Other verification as needed
- Results of onsite reviews for primary care physicians and ob-gyns and high-volume behavioral health providers

The recredentialing process includes the same components as initial credentialing with the exception of an onsite review, that is conducted during the initial process and/or as needed. At the time of recredentialing a review of quality information which includes, when available, member satisfaction, member complaints related to both administrative and quality of care issues, malpractice history, medical record reviews, office site review information, and information regarding clinical quality actions or sanction activity will be considered for continued network participation.

### **Availability of network practitioners**

Network evaluations are performed annually on the number and geographic distribution of the provider network in relationship to the location of its members.

In addition, Highmark Blue Shield takes into consideration the special and cultural needs of members in maintaining its network of providers.

### **Accessibility**

Highmark Blue Shield monitors the ability for member access to primary care physicians and specialists for routine, urgent, emergency and after-hour care. The standards of care are as follows:

- Immediate appointment for emergency or life threatening illness or injury.
- Appointment within 24 hours for urgent conditions.
- Appointment within two to four days for routine symptomatic conditions.
- Appointment within 30 days for evaluation of a routine preventive condition.

- Telephone accessibility by the provider or covering provider, 24 hours a day, seven days a week.
- After hours care, return call within 30 minutes.

Additionally, primary care physicians shall provide office hour accessibility to its members a minimum of 20 hours per week.

Highmark Blue Shield also monitors access to behavioral health care providers as follows:

- Immediate intervention for emergency or life threatening harm to patient or others.
- Non-life threatening emergency within six hours.
- Urgent care within 48 hours.
- Appointment within 10 days for routine office visit.
- Highmark Blue Shield will monitor telephone accessibility to behavioral health members through its Customer Service area.

## **Primary Care/Specialist Essentials**

### **Primary care physician basics**

Primary care physicians in the PremierBlue Shield network play an important role in managing all aspects of health care for members who select their practice. The information below serves as an introduction to the roles and responsibilities of the primary care physician. Generally, primary care physicians in the PremierBlue Shield network are paid fee-for-service.

### **Specialist basics**

Specialists in the PremierBlue Shield network play the important role of providing specialty services to members. Network specialists are paid fee-for-service.

### **Voluntary or Involuntary Specialist Termination From the Network**

In the event of the voluntary or involuntary termination of the PremierBlue Shield Preferred Provider Agreement, the specialist/specialty group must cooperate with Highmark Blue Shield in its obtaining information regarding those members enrolled in DirectBlue or SelectBlue products that may be affected by such termination because they are undergoing an ongoing course of treatment or are otherwise active patients of the specialist/specialty group. Such information includes the name, address, and identification number of affected DirectBlue or SelectBlue members. This information must be provided timely so that affected members may be notified prior to the effective date of the termination. Highmark Blue Shield has a process in place to notify these members, as obligated by state regulation and federal law.

### **How members select a primary care physician**

Members may be asked to choose a primary care physician at the time of enrollment. SelectBlue members and DirectBlue members who have the option to select a primary care physician, may select any network primary care physician listed in the provider directory they receive at enrollment, as long as the following conditions are met:

- The primary care physician practice is open to new members.
- The member fits into the primary care physician's patient age range as specified by specialty, e.g., pediatrics.

SelectBlue and DirectBlue members may switch primary care physicians at any point after enrollment, upon notification to Highmark Blue Shield.

There are no administrative requirements for primary care physicians associated with PPOBlue. Therefore, PPOBlue members may select or switch PremierBlue Shield primary care physicians as they choose without notifying Highmark Blue Shield.

**Responsibilities specific to primary care physicians include:**

- Office visits
- Inpatient hospital, emergency room, skilled nursing and home visits
- Routine pediatric and adult immunizations
- Maintenance allergy injections
- Routine diagnostic procedures
- Minor surgeries performed in office
- Lab services performed in office
- Preventive and early detection interventions
- Most acute and chronic services
- Other services as necessary
- Coordinating specialty care services
- Keeping accurate medical records
- Maintaining active staff privileges at a minimum of one Highmark Blue Shield-contracted hospital
- Providing 24-hour telephone availability year-round
- Providing physician coverage at all times
- Referrals to network providers when specialty care is required
- Cooperating with Highmark Blue Shield's quality improvement programs to the extent permitted by federal and state law including, but not limited to the following:
  - Clinical initiatives
  - Disease management programs
  - Credentialing
  - Clinical studies
- Providing access to members' medical records

**Communication procedure**

PremierBlue Shield network primary care physicians and specialists, including medical, surgical and behavioral health must communicate with one another in order to assure continuity and coordination of care for members. Following is the communication procedure:

- Before the member's visit to the specialist, the primary care physician must provide relevant clinical information to the specialist in addition to the referral (for a SelectBlue member) or authorization. Acceptable forms of communication are formal letter, referral form and/or copies of relevant portions of the patient's medical chart. Referrals are not required for behavioral health services.
- Within 10 business days of the first visit, the specialist must provide the primary care physician with information about his or her visit with the member. Acceptable methods of communication are the standardized form, formal letter and/or copies of relevant portions of the patient's medical chart.
- In the case of behavioral health, member's consent is needed for the behavioral health specialist to release information to the primary care physician. If a patient refuses to give consent, the behavioral health specialist must document this refusal in the patient's behavioral health treatment record.

- The primary care physician must document his or her review of the reports, labs, X-rays and other diagnostic tests received from the specialist or health care facility in the patient's chart. The primary care physician must also indicate any subsequent action necessary. To indicate that he or she has reviewed the information, the primary care physician should initial each page.

Neither primary care physicians nor specialists should ask members to communicate findings, reports, lab results, etc. to another provider.

### **Compliance monitoring**

Where the network supports managed care products, Highmark Blue Shield will monitor compliance of the communication procedure as part of the medical record review program. During medical record review, representatives will check for the provider's initials on the patient's chart and ensure that any necessary follow-up actions are addressed. The goal is to ensure the exchange of information in an effective, timely and confidential manner to promote appropriate diagnosis, treatment, and referral for members.

### **Organizational provider communication**

Highmark Blue Shield network organizational providers, such as hospitals, emergency facilities, ambulatory surgery centers, home health agencies, and skilled nursing facilities must promote continuity and coordination of care for network members by communicating with primary care physicians when care is delivered to their patients. Primary care physicians should expect a written description of the care given to their patients any time services have been rendered by these providers.

## **Preventive Care Responsibilities for Network Physicians**

Highmark Blue Shield network physicians have a unique opportunity to recommend or administer certain services and lifestyle improvements that can prevent future illness or injury. Highmark Blue Shield charges its primary care physicians and specialists with promoting and helping to maintain the health of members, through the preventive services noted below.

### **Primary care physician responsibilities**

- Administer childhood and adolescent immunizations
- Administer influenza and pneumococcal vaccines to at-risk and age-appropriate members
- Administer Hepatitis B vaccine to members at risk
- Provide timely and comprehensive well-care exams

### **Primary care physician and ob-gyn responsibilities**

- Provide or recommend screening mammograms, cervical cancer screenings, and chlamydia screenings. A member can self-refer for her annual mammogram; but she should be encouraged to consult her primary care physician or ob-gyn for help with coordination of care.
- Provide or recommend prenatal care, especially in the first trimester
- Provide or recommend post-partum exams by the 42nd day after delivery
- Provide appropriate counseling to women for menopause and domestic violence

### **Primary care physician and specialist responsibilities**

- Provide or recommend beta-blocker treatment after heart attack.
- Advise smokers to quit
- Recommend the Dr. Dean Ornish Program for Reversing Heart Disease to members who could benefit from participating in the program
- Provide or recommend adequate care for diabetics, including foot and eye exams
- When appropriate, refer members to disease management programs including congestive heart failure, diabetes, chronic obstructive pulmonary disease and asthma
- Provide appropriate and comprehensive care for members with hypertension
- Recommend appropriate medication to members with asthma

Network providers should submit accurate claims and document their preventive care services and recommendations in the member's chart. If performed by a specialist, the interventions, dates they were performed, and their results should be communicated in writing to the primary care physician. Likewise, information about such interventions performed by the primary care physician should be communicated to a specialist when the information is pertinent to the condition the specialist is treating.

### **Member Removal Policy**

Primary care physicians may request that a member be removed from their practice for valid reasons. The relationship between a primary care physician and his or her patients is crucial in the managed care environment. But sometimes problems can occur which cause a serious rift in the doctor/patient relationship. In such cases, we first ask the primary care physician to attempt to resolve the matter directly with the member. If this does not correct the problem, primary care physicians are supported in their effort to remove the member from their practice.

### **Valid reasons for member removal**

The reasons below are valid reasons for you to remove a member.

- **Patient fraud:** Cases of fraud should also be reported to Highmark Blue Shield's Special Investigations Department at 1-800-438-2478.
- **Abusive behavior:** Must be documented in the member's chart. Examples include profanity or threats of physical violence. For mentally competent members over the age of 21, the noted behavior must be exhibited by the member and not by family members. For mentally incompetent adults or minors, the noted behavior must be exhibited by the immediate family members and/or guardians.
- **Medical non-compliance:** This includes a member failing to follow a recommended course of treatment. The provider must be able to demonstrate that non-compliance has jeopardized, or could likely jeopardize, the health/safety of the member.
- **Network procedure non-compliance:** Includes, but is not limited to, members who miss more than two appointments within the past twelve months without proper notification. The provider must have a written policy that informs the member of the consequences of missed appointments.
- **Members who fail to meet financial obligations of the plan:** Includes, but is not limited to, non-payment of co-payments after a reasonable effort has been made to collect monies. This does not apply to outstanding charges the member may have owed before his or her enrollment.
- **Legal action:** Includes, but is not limited to, past legal action by member or legal action that has been threatened against the provider or the provider's staff. It does not include legal action involving providers other than the provider requesting the discharge.
- **Out-of-area members:** Primary care physician and member are unable to establish or maintain a relationship because the member permanently resides outside the Highmark Blue Shield service area.
- **Exceptional circumstances:** Includes, but is not limited to, circumstances where there is a breakdown in the doctor/patient relationship. Such circumstances must be documented in the member's chart.

Below are some reasons that are **not valid** for removing a member from your practice:

- Race
- Sexual orientation
- Age (unless the member's age is outside of the scope of the practice. For example, an adult patient in a pediatric practice.)
- National origin
- Diagnosis
- Physical disability
- Religion
- Gender
- Health status factors (e.g., medical condition, claims experience, receipt of healthcare medical history, genetic information or evidence of insurability)
- Health care insurance coverage

Removing a member from your practice should be used as a last resort. You must make a sincere attempt to resolve the situation with the member prior to requesting his or her removal. Your efforts must be documented in the member's chart.

#### **Member removal procedure: your role**

The information below is intended to instruct you how to remove a member from your practice. Follow the procedure below if you need to remove a member from your practice.

Step	Action
1	Identify problem behavior, communicate problem to member clearly and objectively.
2	Document the problem and the discussion you had about the problem with the member in the member's medical record. Does the problem improve? If yes, process complete. If no, proceed to step 3.
3	Mail or fax a written request on practice letterhead to your Provider Relations representative. Include the following member information: <ul style="list-style-type: none"><li>■ Name (first and last)</li><li>■ ID number</li><li>■ Insurance program</li><li>■ Address</li><li>■ Telephone number</li><li>■ Also include specific, objective documentation of the situation as documented in medical records.</li><li>■ Documentation of your attempts to resolve the situation.</li></ul>
4	Continue to provide member with urgent care if necessary and with access to services until you receive notice that member has been reassigned.
5	Forward medical records to new primary care physician if requested to do so. Do not charge member for this service. The transfer of records must be completed in a timely fashion to ensure continuity of care.



## How to Close and Re-open Your Practice to Members

### **Definition: closed and open practices**

When a practice is “closed to new members,” it means that the primary care physician practice is temporarily not available for selection by new members (“new” meaning members not previously treated by a primary care physician within the practice).

### **Rationale**

By closing to new members, your practice can limit the number of new members. This can be especially helpful to practices that are new to managed care, or to practices that have a shortage of physicians or office staff.

### **Guidelines**

- Your practice must provide written notice 60 days prior to the anticipated closing date.
- Closure takes place on the first day of the month following the 60-day period.
- You must continue to accept new members up to the end of the 60-day period when closure is in place. You must accept existing members who choose you as their primary care physician.
- You must close to all Highmark Blue Shield products.

To close or re-open your practice to new members, simply mail or fax written notification on practice letterhead, including practice name, address, vendor number, and effective date of the requested change, to:

Highmark Blue Shield  
Provider Data Services  
P.O. Box 890146  
Camp Hill, PA 17001-9987

Fax: 1-866-731-2896

## Gynecological and Obstetrical Services

### **Participation as a PremierBlue Shield network ob-gyn**

Obstetricians and gynecologists in the PremierBlue Shield network play a very important role by providing health care to our female members. Network ob-gyns are paid fee-for-service. Women have direct access to any network ob-gyn for their healthcare needs.

### **Communication procedure**

Direct access enables members to have contact with their ob-gyns without going through their primary care physicians. While this enhances member satisfaction, communication between ob-gyns and primary care physicians is still vital, especially when routine annual gynecological exams and mammograms are provided. Please refer to pages 3 and 4 of this section for an explanation of our communication and compliance monitoring procedures.

The communication to the primary care physician from the ob-gyn is regularly monitored as part of Highmark Blue Shield’s Quality Improvement Program.

The following should be faxed or mailed within 30 days to the member’s primary care physician for each office visit:

- Clinical findings
- Test results

- Treatment plans
- A summary report at the conclusion of the treatment period
- Acceptable formats include typed letters, physician forms and progress notes

### **Direct access**

Direct access to women's health care means that no members in need of gynecological or obstetrical services need to obtain referrals from their primary care physicians.

Direct access offers the following advantages for members seeing a credentialed network ob-gyn:

- No referral for annual routine gynecological exam
- No referral for sick visits
- No referral for follow-up care
- No referral for maternity services

Direct access does not extend to services provided by ob-gyn residents or to gynecological services provided in a hospital clinic setting. These services may be paid at the lowest level for SelectBlue members. All referrals must come from the patient's primary care physician.

### **Ob-gyn referrals**

If an ob-gyn sees a member and determines that the member may need the services of another specialty practitioner, the ob-gyn should refer the member back to her primary care physician. Ob-gyns are not authorized to refer members to other specialty practitioners.

If a member requests a visit for symptoms that do not appear to be gynecological in nature, the ob-gyn should refer the member back to her primary care physician.

### **Mammography screening vs. diagnostic mammography**

A screening mammogram is an ordinary check-up intended to detect any problems. A diagnostic mammogram is a test intended to follow-up on a confirmed or suspected irregularity or diagnosis. A referral is not necessary for mammograms; a prescription is all that is required.

## **Credentialing and Recredentialing**

### **Introduction**

Highmark Blue Shield performs the credentialing process with PremierBlue Shield network providers. In addition, at least once every three years, Highmark Blue Shield completes the recredentialing process for the PremierBlue Shield network where the network supports managed care products. Our internal policies require credentialing and recredentialing for the protection of our members. The credentialing and recredentialing programs adhere to NCQA guidelines and Pennsylvania Department of Health requirements.

### **Purpose**

The credentialing and recredentialing processes are performed by Highmark Blue Shield employees who work cooperatively with network providers to ensure that they meet credentialing and recredentialing standards.

### **PremierBlue Shield network credentialing policy**

During the credentialing process, credentialing representatives may ask detailed questions regarding malpractice cases. If the requested information is not submitted, we score the application at the highest risk level.

In order to receive an accurate score, please submit the requested information regarding malpractice cases. All information obtained in the credentialing process, except as otherwise provided by law, is kept confidential.

### **When must providers be credentialed?**

<b>If the provider is...</b>	<b>and he/she is...</b>	<b>then the provider...</b>
completely new, has never been credentialed	beginning to practice solo in the network area	must be credentialed.
completely new, has never been credentialed	beginning to practice with an established network practice	must be credentialed.
established, has already been credentialed	leaving a group practice to begin a solo practice	does not need to be recredentialed before the established three-year recredentialing period.

### **Providers' credentialing rights**

Providers who are applying to the PremierBlue Shield network have the right to review information submitted in support of their credentialing application.

This includes the right to review any information that we receive from outside primary sources during the credentialing process. The following primary sources may be contacted as part of the credentialing process:

- National Practitioner Data Bank
- Education program the provider completed
- Drug Enforcement Agency
- State Licensing Bureau
- American Board of Medical Specialties or American Osteopathic Association, if applicable
- OIG sanction data

### **How practices can review information**

In cases where Highmark Blue Shield Credentialing Department representatives receive information from a primary source that differs from that submitted by the provider that would jeopardize admission to the network, a representative will contact the physician in writing.

Alternatively, the provider may specifically request that the information submitted by primary sources be sent to him or her. To do so, the provider must submit a written request to Highmark Blue Shield within 30 days of submitting an application.

### **Right to revise inaccurate information**

During the credentialing process, providers also have the right to correct any inaccurate or erroneous information we receive from a primary source if it varies substantially from the information submitted by the provider.

Highmark Blue Shield will send directions on how to revise information along with the notification of the conflicting information.

**Credentialing process**

<b>Step</b>	<b>Description</b>
1	A provider calls Highmark Blue Shield 1-866-763-3224, and requests an application.
2	A Credentialing Department representative mails an application packet to the provider.
3	The provider completes the application and returns it to the address indicated in the application packet.
4	The Credentialing Department representative reviews the application. Is all of the information complete? <b>If yes</b> , proceed to step 6. <b>If no</b> , proceed to step 5.
5	The Credentialing Department representative contacts the provider to request the missing information. Does the provider send the requested information within the required period? <b>If yes</b> , proceed to step 6. <b>If no</b> , process is halted.
6	The Credentialing Department representative may verify the information with the following sources: <ul style="list-style-type: none"> <li>■ National Practitioner Data Bank</li> <li>■ Educational program the provider completed</li> <li>■ Drug Enforcement Agency</li> <li>■ State Licensing Bureau</li> <li>■ American Board of Medical Specialties or American Osteopathic Association, if applicable</li> <li>■ OIG sanction data</li> </ul> Have all sources provided notification to meet standards? <b>If yes</b> , proceed to step 9. <b>If no</b> , the process may be delayed.
7	The credentialing department will also review the application for the following requirements: <ul style="list-style-type: none"> <li>■ Ability to enroll new members (PCP)</li> <li>■ Ability to provide urgent/routine care</li> <li>■ Twenty four hours a day, seven days a week coverage (if applicable)</li> <li>■ Practice availability twenty hours/week (PCP)</li> </ul>
8	For primary care physicians, ob-gyns and high volume behavioral health: A nurse from Network Quality Improvement performs onsite and record reviews at the provider's practice site.
9	A Credentialing Department Specialist verifies that all information required for NCQA and/or state and federal regulatory agencies is complete.
10	The Credentialing Committee reviews the provider based on the application information. Does the committee approve the provider for entrance into the network? <b>If yes</b> , proceed to step 11. <b>If no</b> , the Quality Improvement medical director sends written notification to the provider. The letter provides the procedure to appeal the decision. The process is complete. <b>Note:</b> In some instances, the committee may require additional information from the provider before rendering a decision.
11	Provider information is entered into the Highmark Blue Shield provider database that feeds the Provider Directory and the claims payment system.
12	A welcome letter is mailed to the new PremierBlue Shield provider. Process complete.

**Caution!**

**Participation in the PremierBlue Shield network is effective only upon completion of the credentialing process.**

**Recredentialing process**

Highmark Blue Shield employees perform the recredentialing process. These employees work cooperatively with network providers to ensure they are still meeting the same high standards that they met when they entered the PremierBlue Shield network.

Step	Description
1	A Credentialing Department representative sends out a copy of credentialing information on file.
2	The provider verifies the credentialing information and makes any necessary corrections.
3	A Credentialing Department representative conducts a primary source verification.
4	The provider application is reviewed by the Credentialing Committee.
5	If not approved, the provider is notified with 60 calendar days.

On-site reviews are conducted upon initial credentialing, relocation or adding a new site as dictated by NCQA and the Pennsylvania Department of Health. Nurse reviewers go to each practice location of primary care physicians, ob-gyns and certain specialty practitioners to conduct on-site reviews of each practice.

On-site reviews are not necessarily performed at the same time as recredentialing.

**Malpractice insurance**

A provider must carry the minimum required amount of malpractice insurance to maintain credentialing.

<b>If you are not CAT-fund eligible</b>	In accordance with Pennsylvania law, and/or PremierBlue Shield policy, all network providers who are not CAT-fund eligible are required to carry a minimum of \$1,000,000 single and \$3,000,000* aggregate medical malpractice insurance. These providers include, but are not limited to the following: <ul style="list-style-type: none"> <li>■ Audiologists</li> <li>■ Doctors of chiropractic</li> <li>■ Certified registered nurse anesthetists* exception 500,000/1,500,000</li> <li>■ Nurse practitioners</li> <li>■ Optometrists</li> <li>■ Oral surgeons</li> <li>■ Physical therapists</li> <li>■ Speech therapists</li> </ul>
<b>If you are CAT-fund eligible</b>	In accordance with Pennsylvania law, all network providers who are CAT-fund eligible are required to carry a minimum of \$500,000 per occurrence and \$1,500,000 aggregate medical malpractice insurance. These providers includes, but are not limited to the following: <ul style="list-style-type: none"> <li>■ Medical doctors</li> <li>■ Doctors of osteopathy</li> <li>■ Podiatrists</li> <li>■ Nurse midwives</li> </ul>

## Reporting Changes in Your Practice

### **Policy for changing practice information**

Network providers must notify Highmark Blue Shield of any change to their practices. Notification should occur 60 days before the change. This is a requirement of your network agreement.

The provider database maintained by Highmark Blue Shield contains vital information regarding each network provider. You may contact Provider Data Services to request a copy of the information that is currently on the Highmark Blue Shield provider file.

By keeping your practice information updated, you help us to do the following:

- Process claims correctly
- Notify members of the names and addresses of network providers
- Notify primary care physicians of available specialists to whom they may refer

Most changes will require Highmark Blue Shield to revise existing provider files. In most cases, membership or claims payment will be affected by changes in your practice. Therefore, if you do not give advance notification, we cannot guarantee accurate membership information, claims and/or payments.

### **Type of changes to report**

The following is a list of changes in your practice that must be communicated to Highmark Blue Shield.

- Practice location change
- Billing/mailing address change
- Telephone number change
- Fax number change
- Hospital affiliation change
- Office hour change
- New tax identification number
- Practice name change
- Providers joining the practice
- Providers leaving the practice (including through retirement or death)
- Practice mergers
- Practice acquisitions
- Addition or closure of a practice site

### **Important!**

**All providers joining or leaving an established practice or leaving a Highmark Blue Shield network must notify Highmark Blue Shield 60 days before the event. Refer to the following page regarding how to report changes in your practice.**

New providers who are not participating with Highmark Blue Shield but wish to join the network may call 1-866-763-3224 to request the appropriate paperwork.

The provider agreement between Highmark Blue Shield and network providers is not assignable. In cases of practice mergers, acquisitions, etc., it is necessary to send written notification, on practice letterhead, to:

Highmark Blue Shield  
Provider Data Services  
P.O. Box 890146  
Camp Hill, PA 17001-9987  
Fax: 1-866-731-2896

**How to report changes in your practice**

Send the *Request to Change Existing Assignment Account Information* form, signed by the managing partner, to the address shown below. This form is illustrated in the appendix. You may obtain a copy of the form from us, or may photocopy the form in the appendix to submit your changes.

Highmark Blue Shield  
Provider Data Services  
P.O. Box 898842  
Camp Hill, PA 17001-9987

Fax: 1-866-731-2896

**NOTE:** If you are adding a new physician to an existing practice, the new physician must sign the letter or form.

**Mergers and acquisitions**

You must send written notification on your practice letterhead of anticipated mergers, acquisitions, etc., to the address listed above at least 60 days before the change(s) occur. The managing partner of the practice must sign the written notification. Include the following information:

- Effective date of the change
- Highmark Blue Shield provider number, new tax identification number\* (if applicable)
- Changes to physician staffing
- Changes to physician location

\*When reporting a new tax identification number, include the IRS Tax Notification as evidence.

**Reminder: consequences to not giving 60 days' notice**

Most changes will require Highmark Blue Shield to revise existing provider files. In most cases, membership or claims payment will be affected by major changes in your practice. Therefore, if you do not give advance notification, we cannot guarantee accurate membership information and/or claims payments.

**Sample practice change notification letter**

Please include information in your letter as shown below.

**XYZ Medical Associates  
1000 Main Street  
Somewhere, PA 15000  
1-717-555-4000**

**7/1/02**

Re: Highmark Blue Shield Provider Number 999999

To: Provider Data Services

The following changes are occurring in our practice:

Old information was as follows:

Phone number 1-717-555-3900

New information is as follows:

Phone number 1-717-555-4000

New information effective as of:

September 15, 2002

Signature of Managing Partner,

John Smith, MD



## **Network Compliance**

### **Policy**

Network providers must comply with the terms and conditions of their provider agreement and meet acceptable standards for quality of clinical care, resource utilization and administrative compliance in order to ensure that the network operates in an effective and efficient manner. This also ensures that members receive high quality, medically appropriate and cost-effective care.

Providers who are not compliant are subject to the network corrective action policy providing for corrective action, sanctioning, suspension and termination of providers arising from non-compliance with contractual obligations or failure to meet acceptable standards of clinical care, resource utilization and/or administrative compliance.

### **Categories of non-compliance**

Non-compliance can be divided into three categories:

- Quality of care concerns
- Unacceptable resource utilization
- Administrative non-compliance

### **Quality of care concerns**

A quality of care concern arises when an episode of care deviates from accepted medical standards. The occurrence of an adverse outcome does not, in and of itself, indicate a breach of accepted medical standards and/or warrant action.

### **Examples of quality of care concerns**

Examples include, but are not limited to:

- Actions or omissions that result or may result in an adverse effect on a patient's well being
- Delayed services/referrals
- Missed diagnoses
- Medication errors
- Delayed diagnosis/treatment
- Unexpected operative complications
- Invasive procedure complications
- Inappropriate procedures
- Unanticipated, unexplainable death
- Actions requiring a report to the National Practitioner Data Bank or other adverse actions

### **Unacceptable resource utilization**

Unacceptable resource utilization is defined as a pattern of utilization that is at variance with recognized standards of clinical practice or with specialty-specific aggregated data.

Examples of patterns of unacceptable resource utilization include, but are not limited to:

- Inappropriate or unnecessary admissions
- Inappropriate utilization of emergency services
- Inappropriate or unnecessary inpatient hospital stay days
- Patterns of inappropriate utilization of outpatient surgery

- Patterns of inappropriate PCP-scheduled encounters per member per year – often times, the member is the one making excessive appointments
- Patterns of inappropriate utilization of referrals
- Under utilization (i.e., withholding) of necessary and appropriate medical services

### **Administrative non-compliance**

Administrative non-compliance is defined as behavior that is detrimental to the successful functioning of Highmark Blue Shield. Examples include, but are not limited to:

- Direct or unauthorized billing for services
- Balance billing a member for services
- Failure to cooperate/comply with Highmark Blue Shield's administrative, quality improvement, utilization review, member service, reimbursement and other procedures
- Conduct that is unprofessional toward the member, family members and/or staff of Highmark Blue Shield
- Failure to comply with any contractual obligation
- Failure to comply with policies and procedures of Highmark Blue Shield
- Failure to comply with or violation of state or federal laws or regulations

### **Medical record review**

Highmark Blue Shield periodically engages in the review of members' medical records as well as inspection of network providers' offices.

Highmark Blue Shield reviews medical records for a number of reasons pertaining to the administration of high-quality managed care benefit programs. The reasons include, but are not limited to:

- Performing utilization review
- Measuring the standard of quality achieved by the network providers
- Credentialing and recredentialing network providers
- Conducting condition management for the benefit of members
- Collecting data for HEDIS<sup>1</sup> sampling
- Investigating complaints about the quality of clinical care provided to Highmark Blue Shield members
- Verifying immunization of pediatric and adult patients

### **Consent to review medical records**

To review medical records, Highmark Blue Shield has received a general consent from our members. Each member completes and signs an enrollment form that provides for the release of any information relating to past, present or future health care examinations or treatments for anyone covered under the enrollment form. Such consent is necessarily broad to enable Highmark Blue Shield to administer high-quality managed care benefit programs. Information collected is handled with a high level of security and respect for privacy.

### **Provider cooperation**

The terms of the network agreement require the full cooperation of network providers with all office reviews. Failure to supply requested copies of medical records or failure to cooperate with office inspections of medical records may result in termination from Highmark Blue Shield network participation.

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<sup>1</sup> HEDIS is a registered trademark of The National Committee for Quality Assurance.

**Network corrective action process**

Providers identified with one of the following issues will be reported to a network medical director and to the manager of Quality Management:

- Quality of care
- Administrative non-compliance
- Unacceptable resource utilization
- Service-related issue

The determination to take corrective action shall be made by a medical director.

Corrective action may vary according to the situation and may include, but is not limited to, one or more of the following actions as they relate to the circumstance, action or omission that requires corrective action:

- Sending a written warning to the provider
- Engaging in a discussion or a series of discussions with the provider
- Monitoring the provider's performance
- Requiring that the provider complete a continuing medical education course regarding the treatment, procedure, or service in question
- Limiting the provider's authority to perform certain procedures
- Requiring that the provider enter a preceptor relationship with another provider to monitor and observe the provider subject to corrective action
- Termination or suspension

The determination to take corrective action shall be based on an assessment of the severity level of the action based on the judgment of a network medical director. The following are general guidelines used by the medical directors when assigning severity levels.

<b>Severity Level</b>	<b>Guideline</b>
Minor – Low	Deviation from the standard of care without harm to the member.
Moderate – Medium	Deviation from the standard of care with temporary harm to the member.
Severe – High	Deviation from the standard of care with harm to the member resulting in permanent sequelae or death.

**Termination from the Network****Valid reasons for termination**

PremierBlue Shield network providers shall be terminated in accordance with the relevant terms of their provider agreement if they do not meet, as determined by Highmark Blue Shield, the following criteria:

- Maintain an active DEA certificate, when applicable
- Maintain coverage for malpractice insurance in the minimum amounts required by Highmark Blue Shield and participate in the CAT fund
- Maintain acceptable professional liability claims history as evidenced by the National Practitioner Data Bank and other resources
- Participate in recredentialing, as required by Highmark Blue Shield, which includes providing all requested recredentialing information, and be recredentialed for network participation

- Provide acceptable clinical quality of care to members
- Obtain and maintain required standards for network recredentialing

PremierBlue Shield network providers shall also be terminated if, at Highmark Blue Shield's sole discretion, any of the following occur, or are in imminent danger of occurring:

- Acts or omissions that jeopardize the health or welfare of a member.
- Acts or omissions that negatively affect the operation of the Highmark Blue Shield network.
- Acts or omissions that cause Highmark Blue Shield to violate any law or regulation or that negatively impact Highmark Blue Shield under any regulatory or certification requirements.
- Failure to provide an acceptable level of care.

#### **Invalid reasons for termination**

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

- Advocating for medically necessary and appropriate health care 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.
- Filing a grievance against Highmark Blue Shield in response to a disapproval of payment for a requested service, an approval of the requested service at a lower scope or duration, or a disapproval of the requested service but an approval of payment of an alternative service.
- Protesting a decision, policy or practice that the 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 provider's ability to provide medically necessary and appropriate health care.
- The provider has a practice that includes a substantial number of patients with expensive medical conditions.
- Objection to the provision of or refusal to provide a health care service on moral or religious grounds.
- Any refusal to refer a patient for health care services when the refusal of the provider is based on moral or religious grounds and the provider has made adequate information available to the members in the provider's practice.
- Discussing plan information with the member, such as:
  - The process that Highmark Blue Shield uses or proposes to use to deny payment for a health care service
  - Medically necessary and appropriate care with or on behalf of a member, including information regarding the nature of treatment, risks of treatment, alternative treatments, or the availability of alternate therapies, consultations or tests, regardless of benefit coverage limitations
- The decision of Highmark Blue Shield to deny payment for a health care service

#### **Policy for reconsideration and appeals**

The provider is entitled to a hearing if the corrective action or termination involves or results in a termination or suspension of the provider's network status, such that it is reportable to the National Practitioner Data Bank and/or limits the provider's ability to perform certain procedures such that it may be reportable to the National Practitioner Data Bank.

If a provider seeks to challenge corrective action not included in the categories described in the preceding paragraph, he or she may do so only by submitting in writing to the senior medical director the basis for disagreeing with the corrective action and any supporting documentation. After receipt of this material, the senior medical director shall decide whether the corrective action proposed and/or alternative corrective action is warranted.

## **Hearings**

If a hearing is available as described above, the procedure is as follows:

1. If the provider requests a hearing within 30 days of notice, the provider will be notified in writing regarding the date and time of the hearing.
2. The provider will be given written notice of the proposed action.

<b>If the corrective action or termination giving rise to the hearing has been invoked by...</b>	<b>Then...</b>
A medical director	<p>The hearing shall be held before the Highmark Blue Shield Credentialing Committee, comprised of network practitioners.</p> <ol style="list-style-type: none"> <li>1. The provider will have the right to submit written materials to be presented at the hearing.</li> <li>2. The committee will review the information presented.</li> <li>3. The committee will render a recommendation for action to the medical director who proposed the corrective action.</li> <li>4. The medical director will make a decision after considering the recommendation of the committee.</li> </ol>
The Highmark Blue Shield Credentialing Committee	<p>A separate peer review hearing body will be convened by Highmark Blue Shield, consisting of at least three physicians who have not had prior involvement in the case.</p> <ol style="list-style-type: none"> <li>5. Highmark Blue Shield will seek the consent of the provider for the date and time of the hearing and the composition of the hearing body.</li> <li>6. The provider may present information addressing the concerns leading to the termination or suspension.</li> <li>7. The peer review hearing body will make a recommendation to the Highmark Blue Shield Credentialing Committee.</li> </ol>

**Appealing hearing decisions**

If the Credentialing Committee's decision will result in an adverse action that is reportable to the National Practitioner Data Bank or that limits the provider's ability to perform certain functions, the provider may appeal to the Highmark Blue Shield Credentialing Committee. The appeal must be filed within 30 days of receiving the decision.

Step	Action
1	The practitioner may submit any documentation believed to be relevant for consideration during the appeal process to Highmark Blue Shield within 30 days of receiving the decision.
2	The committee will determine whether: <ul style="list-style-type: none"><li>■ The provider's termination or suspension decision was handled correctly according to Highmark Blue Shield's policies and procedures.</li><li>■ The provider was afforded a reasonable opportunity to address the issues, concerns or deficiencies that led to the decision.</li><li>■ The corrective action or termination process was performed without bias, conflict of interest, or inadequate attention to the documentation presented.</li></ul>
3	Based on that determination, the committee will decide to uphold or reverse the decision. The committee's decision is final.

