

Behind the

SUMMER/FALL 2007

# Shield



## SPECIAL EDITION



# 2007 Credentialing Review

for network providers

Highmark Blue Shield endeavors to keep network practitioners and providers informed about network credentialing policies and procedures. Many of these changes have already been communicated to you through letters, *Special Bulletins* and *Behind the Shield*. This special edition summarizes the 2007 credentialing information.

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# Highmark Implementing Standardized National Credentialing System

**Highmark continually seeks ways to make its network credentialing process easier for physicians and allied health care providers. As part of these efforts, in 2008, Highmark will be implementing a standardized national online credentialing system that will further streamline credentialing.**

Universal Credentialing DataSource – developed by the Council for Affordable Quality Healthcare (CAQH) – is a single, national process that eliminates the need for multiple credentialing applications. Through this online service, providers complete one standardized application to meet the needs of Highmark and other participating health plans and health care organizations.

Highmark plans to implement Universal Credentialing DataSource in two phases, starting with initial credentialing and followed by recredentialing in 2008.

We will notify you via NaviNet® and in a future issue of *Behind the Shield* when this change takes effect.

The American College of Physicians (ACP) has formally supported the CAQH credentialing process since 2003, and the service is endorsed by the American Academy of Family Physicians (AAFP).

*Note: The April/May 2007 issue of Behind the Shield and the June 2007 issue of PRN stated the original planned 2007 implementation date of the CAQH credentialing process. However, the implementation has been delayed until 2008.*

## Proof of Medicare Eligibility for Newly Credentialed Practitioners

**Historically, the Unique Physician Identification Number (UPIN) has been the identifying element to determine Medicare eligibility for physicians and allied practitioners who bill on CMS 1500 forms. However, the Centers for Medicare and Medicaid Services discontinued its UPIN Registry on June 29, 2007.**

While all Medicare-eligible practitioners must have a National Provider Identifier (NPI) number, the NPI cannot be used as proof of Medicare eligibility as not every practitioner with an NPI will choose to participate in Medicare.

### **New Form of Proof of Eligibility Accepted**

Therefore, at the time of credentialing, all newly credentialed practitioners joining the PremierBlue<sup>SM</sup> Shield and Medicare Advantage networks on or after June 29, 2007, will be asked to supply a Medicare welcome (participation) letter as proof of Medicare eligibility:

## QM Resource Tool Kit on NaviNet®

The Network Quality Management Resource Tool Kit is available on NaviNet. The tool kit includes a variety of resource materials, such as age-specific progress records, preventive health records and sample office policies to assist the practitioner in meeting Highmark standards. Member-specific educational materials are also available for physicians to assist their patients with preventive health care.

# Recredentialing Tips

New users can view a complete step-by-step guide of how to complete your recredentialing application online.

- ▶ From the NaviNet® Tool Bar, choose *Customer Service*, then *NaviNet Customer Care*.
- ▶ Under *User Guides*, choose *Highmark*, then scroll down to *Action Items*.
- ▶ Click "How do I use *NaviNet for Recredentialing?*"

## NaviNet-Enabled Providers Are Required to Use Online Recredentialing Process\*

*\* In 2008, Highmark will begin to use the Council for Affordable Quality Healthcare's (CAQH's) process for initial credentialing and recredentialing (see article on Page 2).*

Prior to implementing the CAQH credentialing process in 2008, all NaviNet-enabled providers are required to use NaviNet to submit their recredentialing application. This means that all practitioners who are associated with any NaviNet-enabled office will receive their recredentialing application via Action Items in NaviNet. **Paper applications are no longer mailed to practitioners associated with NaviNet-enabled offices.**

*Note: The electronic recredentialing application is sent to the practice that is listed in Highmark's records as the practitioner's primary affiliation.*

To receive a pre-filled recredentialing application via NaviNet, all practitioners need to have a NaviNet username and password.

### Getting a Username Is Easy

If you don't already have a NaviNet username, there's no need to call Highmark or NaviMedix®. Highmark will contact NaviMedix to request usernames for all practitioners whose recredentialing cycle is about to begin. NaviMedix will then create the practitioner's username. Each practice's NaviNet Security Officer will be notified via an Admin message on the NaviNet system. Just click on the envelope icon to view the message when the username has been created.

Recredentialing applications are sent directly to the practitioner's username via NaviNet the first week of each month. Practitioners will receive the application several months prior to the end of their credentialing cycle. A simple click of the bright orange flag in the upper, right corner of Plan Central takes the user

directly to *Incomplete Action Items*. A click on the *Recredentialing Summary* link takes the user to the Main Recredentialing page.

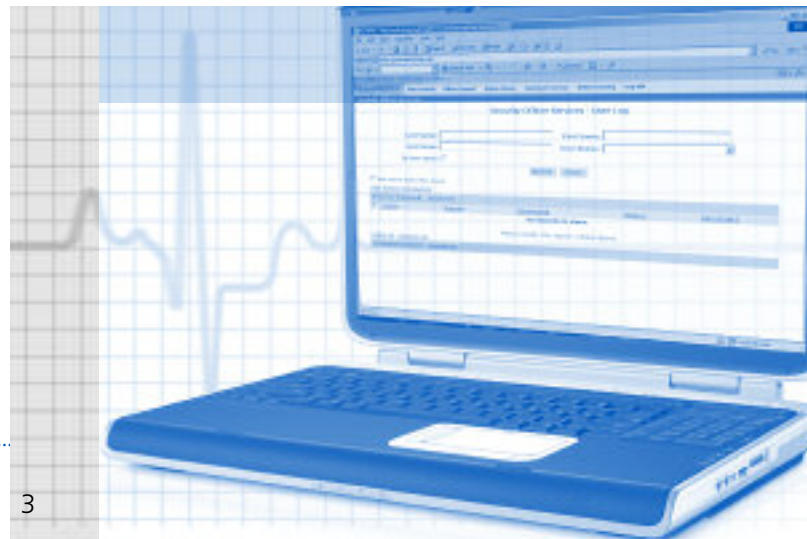
### Security Officer Responsibilities

Security Officers will generate initial passwords for all practitioner users. To do so simply:

- ▶ Go to *Customer Service*; click *Security Officer Services* from the dropdown menu
- ▶ Click on *Is new user* and click on *search*
- ▶ All new users in the office will appear
- ▶ To generate the initial password, select the user by clicking on the box to the left and then click *generate password*. (Please note: you may select *check all* if multiple practitioners have been added.)
- ▶ You may then print off the individual username and temporary password information for each practitioner user in your office.

*Note: Each office must have a Security Officer who logs onto NaviNet on a regular basis. The NaviNet Security Officer must share the username and password with each practitioner or the administrative staff member responsible for the recredentialing function.*

Providers are reminded that, in addition to generating new passwords, NaviNet Security Officers may also reset old or expired passwords.



# Highmark's Simplified Credentialing Process Saves Time

**Highmark Blue Shield strives to work more effectively and efficiently with practitioners. One way we do this is by saving you time and easing the administrative burden for network practitioners during recredentialing. Practitioners can process their recredentialing application through NaviNet and in the future will be able to utilize the new online standardized application as developed by the Council for Quality Healthcare (CAQH). (For more information about the CAQH credentialing process, see story on page 2.) If you have any questions regarding your application, you can contact a Highmark representative at 1-866-763-3224, Option 4.**

Highmark encourages and welcomes your participation in the PremierBlue<sup>SM</sup> Shield and Medicare Advantage networks. Because there is no "business need" criteria, more practitioners can apply to join the PremierBlue Shield and Medicare Advantage networks. This gives Highmark members a wider choice of physicians and health care professionals. All applicants, however, still must have the necessary professional qualifications based on all applicable accrediting and regulatory requirements and Highmark policies to complete the credentialing process and participate in the network.

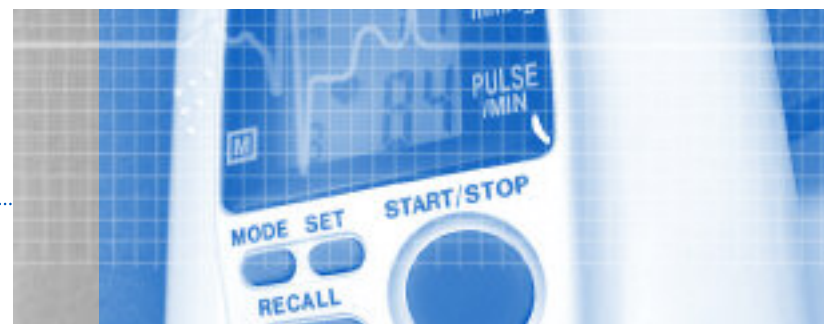
- ▶ Our three-year credentialing cycle is consistent with the National Committee for Quality Assurance, Pennsylvania Department of Health and Centers for Medicare and Medicaid Services recredentialing standards.
- ▶ Practitioners attest to their hospital clinical privileges and medical liability insurance coverage via their signature on the attestation page. A copy of the malpractice face sheet from the carrier is also acceptable.
- ▶ Primary care physicians (family practitioners, pediatricians, internists and general practitioners) are required to have admitting privileges in good standing at an in-network participating hospital. Applicable physician specialists are required to have clinical privileges in good standing at an in-network hospital.
- ▶ The hospital clinical privilege requirement is waived for the following specialties:
  - anesthesiology
  - dental anesthesiology
  - emergency medicine
  - nuclear medicine
  - oral maxillofacial surgery
  - oral maxillofacial radiology (for the outpatient setting only)
  - oral maxillofacial pathology (for the outpatient setting only)
  - pathology (for the outpatient setting only)

- podiatry
- psychiatry/physical medicine
- psychiatry
- radiology
- clinical privileges, including admitting, will be waived for all physicians who document arrangements for adequate coverage on the application that is acceptable to Highmark through another credentialed in-network practitioner with privileges at an in-network hospital or credentialed in-network group of the same specialty. The name(s) of the covering physician(s) must be provided on the application (a co-signed document from the covering physician(s) is not required).

Highmark will maintain its high standards to ensure its network practitioners meet professional qualifications, such as licensure and board certification requirements, and that members have access to only those practitioners who have been properly credentialed. In addition, Highmark practitioners are required to use participating practitioners for all coverage arrangements.

Highmark will continue to:

- ▶ Review member complaints and require that practitioners with significant member complaints take corrective action to address deficiencies.
- ▶ Conduct office site and medical record documentation reviews of applicable network providers/provider groups.
- ▶ Monitor network practitioners for any changes to their licensure status, Medicare opt-out status, Medicare/Medicaid sanctions or any adverse actions or legal proceedings against them.
- ▶ Monitor the performance of physicians through the quality component of QualityBLUE<sup>SM</sup>.





# How the Credentialing and Recredentialing Processes Work

To be considered a PremierBlue<sup>SM</sup> Shield or FreedomBlue<sup>SM</sup>-participating practitioner and support the PremierBlue Shield, Medicare Advantage (FreedomBlue in central Pennsylvania) and Highmark Blue Shield managed care products, all new practitioners must be approved by the Mid-Atlantic Credentials Committee\* and sign an agreement with Highmark Blue Shield.

Highmark Blue Shield uses the PremierBlue Shield network for PPOBlue<sup>SM</sup>, DirectBlue<sup>®</sup> and the Medicare Advantage Network for FreedomBlue. Prospective practitioners will receive an application and an agreement. Your participation begins only after you have signed and returned the agreement, been approved by the Mid-Atlantic Credentials Committee and the agreement has been executed by Highmark Blue Shield. A welcome letter that specifies the effective date of your participation will be sent to you, along with a copy of the executed agreement. NaviNet-enabled practitioners who are seeking recredentialing must obtain a username and password from NaviMedix and complete their application online.

*\*The Credentials Committee is comprised of practicing network practitioners.*

► *Note: Behavioral health practitioners who participate in the PremierBlue Shield Network follow the same three-year credentialing cycle as practitioners from other specialties.*

The process for credentialing new providers and recredentialing existing network providers is essentially the same. Network practitioners must be recredentialed at least every three years. In general, here's how the process works:

- 1 For initial credentialing, practitioners complete all of the information requested on the application and return it to Provider Data Services for initial processing. For recredentialing, providers must use the NaviNet recredentialing process (see article on page 3). This processing includes, but is not limited to, verification or confirmation of the following:
  - Unrestricted licensing in the state in which you practice\*
  - DEA certificate (if applicable)\*
  - Medical education and training (if applicable)\*
  - Board certification (if applicable)\*
  - History of liability claims
  - Malpractice coverage amounts
  - Work history (initial credentialing)
  - Medicare participating status (for Medicare Advantage only)
  - National Practitioner Data Bank (NPDB)
  - Office of the Inspector General Medicare and Medicaid sanctions list

\* These elements are verified through primary sources

*Note: Primary source verification of hospital clinical privileges and medical liability insurance coverage is no longer required. A signed attestation statement is all that is needed. (See page 4 for more details.)*

- 2 Practitioners who fail to complete and return their recredentialing application or fail to supply all required information will be subjected to an administrative termination from the network(s) or discontinuation of the credentialing process for initial applicants. For recredentialing practitioners, your members may receive notification that you have been terminated from the network.
- 3 For initial, new and relocated office sites for PCP, ob/gyn, high-volume behavioral health or independently practicing CRNP or nurse midwife practices, and dual-credentialed practitioners\*, Highmark contacts the practitioner to arrange for an office site review of the practice. During the review, the following will be evaluated:
  - Environment and safety
  - Medications/emergency procedures and supplies
  - Office procedures/accessibility
  - Medical record documentation
  - Preventive health services documentation
- 4 During recredentialing, practitioners are evaluated on their professional performance, judgment and clinical competence. Criteria used may include, but may not be limited to, quality of care concerns, malpractice history, sanctioning history, member complaints, participation with quality improvement activities and condition management programs, data completeness, overutilization and underutilization.

\* See page 10 for more information on dual credentialing

- 5 After all required credentialing elements are obtained and any required office site and medical/treatment record evaluations are completed, your application will

*(Continued on page 6)*

undergo decision-making via medical director approval or the Highmark Mid-Atlantic Credentials Committee, depending upon whether or not all credentials file elements meet Highmark's credentialing policy requirements. Credentialing and recredentialing decisions will not be based on an applicant's race, religion, ethnic/national identity, gender, age, sexual orientation or the types of procedures or patients in which the practitioner specializes.

- 6 Initial practitioners will receive written notification upon approval of the Mid-Atlantic Credentials Committee. You also will receive notification within 60 calendar days if, for some reason, you are denied credentialing or recredentialing status. (During initial credentialing, practitioners also participate in the contracting process.) If you are denied initial credentialing or terminated at the time of recredentialing, you will be offered the opportunity to appeal the Credentials Committee's decisions. (See page 11 for more details.)

Participation in networks supporting Medicare Advantage products, such as FreedomBlue, will require evidence of medical eligibility or participation in Medicare prior to contracting. In addition, quarterly reports of practitioners who have opted out of Medicare are obtained. Practitioners who have opted out of Medicare are not eligible to see FreedomBlue members.

- 7 Highmark Blue Shield is required to verify all application information within 180 days from the date the practitioner signs the attestation statement. If verification cannot be completed within the 180-day time frame, the applicant will be asked to re-sign and re-date the attestation statement. Electronic signatures are acceptable on the application.
- 8 Physicians who are applying to the PremierBlue Shield and Medicare Advantage networks have the right to review information submitted in support of their credentialing application, be notified of information that varies substantially from primary sources and correct erroneous information.
- 9 Please be aware of the Highmark credentialing requirement that all network practitioners must provide coverage for members 24 hours-a-day, seven days a week. This can be accomplished either directly or through an on-call arrangement with another participating network practitioner of the same or similar specialty, who is a Highmark credentialed practitioner.

Practitioners who provide care for children under the age of 13 years must provide appropriate coverage, if applicable. This allows a Highmark

member or another practitioner the ability to access a practitioner (or his/her designee) directly in urgent or emergent situations. The 24/7 coverage can be accomplished through an answering service, pager or via direct telephone access whereby the practitioner (or his/her designee) can be directly accessed, if needed.

A referral to a crisis line or the nearest ER is NOT acceptable coverage unless there is an arrangement made between the practitioner and the crisis line or ER whereby the practitioner (or his/her designee) can be contacted directly, if needed. It is NOT acceptable for any non-PCP practitioner to refer patients to their PCP after normal business hours.

The following specialties are exempt from this requirement:

- audiologists
- dermatopathologists
- dietitians/nutritionists (Federal Employees Health Benefits Program [FEP], and FreedomBlue<sup>SM</sup> only)
- occupational therapists (FreedomBlue only)
- pathologists (only if working outside of the acute care setting)
- oral and maxillofacial pathologists (only if working outside of the acute care setting)
- physical therapists
- preventive medicine specialists
- speech/language pathologists

All network practitioners must be able to accept new patients and provide urgent and routine care. PCP practices must be available to see and treat Highmark members at least 20 hours per week per site.

Certain changes, such as address, group, membership and tax ID, may necessitate the issuance of a new contract. Be sure to notify us before you make any of these changes. Write to Provider Data Services, P.O. Box 898842, Camp Hill, PA 17001-9987, or send a fax to 1-800-236-8641.

If a practitioner submits a signed, explicit document stating that he/she no longer wishes to be a PremierBlue Shield or Medicare Advantage participating practitioner, and there is a break in service/contract of greater than 30 days, the practitioner will be required to undergo initial credentialing if he/she subsequently wishes to return to the network. If a practitioner is joining an existing PremierBlue Shield or Medicare Advantage participating group of the same specialty, the *Request to Change Existing Assignment Account Information* form must be completed. This is only applicable when the practitioner has previously been approved by the Mid-Atlantic Credentials Committee to practice the group's specialty.

*Note: If the group consists of multiple specialties, the practitioner will be recognized by Highmark Blue Shield for the specialty for which he/she has been credentialed.*

# Practitioner Quality and Board Certification

**Note: All practitioners without board certification who qualify for a board certification exception must provide documentation that over the previous three-year period the practitioner has an average of at least 50 Continuing Medical Education (CME) hours per year in their current practice activity.\***

To be credentialed in the PremierBlue<sup>SM</sup> Shield and Medicare Advantage networks, PCPs and specialists — including podiatrists — are required to be board certified in the specialty in which they practice. Doctors of chiropractic and general practitioners do not need board certification. For general practitioners to be eligible to treat members under age 13, they must complete 20 percent of the CME requirement (10 hours per year) in pediatrics. For more information, see the October 2006 issue of *PRN*. Highmark recognizes the following boards for certification: American Board of Medical Specialties, The American Osteopathic Boards, The American Board of Podiatric Orthopedics and Primary Podiatric Medicine, American Board of Podiatric Surgery, American Board of Oral and Maxillofacial Pathology, American Board of Oral and Maxillofacial Surgery and American Academy of Oral and Maxillofacial Radiology. The following are exceptions to this policy:

- Practitioners who have completed an approved, applicable residency or fellowship in the specialty of practice and have graduated from an accredited medical, osteopathic, dental or podiatric school, and finished training prior to Dec. 31, 1987.
- Practitioners who have not practiced for a sufficient length of time to complete board certification. Practitioners must complete the board certification within two years of meeting the eligibility requirement.
- At the time of the practitioner's credentialing or recredentialing review, 50 percent or more of the existing practice's credentialed associates are already board certified in the specialty being requested, and the practitioner has completed an approved, applicable residency or fellowship in the specialty of practice.
- Rural practitioners must have greater than five years of experience in the specialty in which they practice and have completed an approved applicable residency or fellowship in the specialty of practice.
- Podiatrists who are non-board-certified and meet one of the above listed exceptions with a surgical focus are required to have an average of 50 CMEs per year in podiatry (150 CMEs in three years). Whereas podiatrists who are non-board-certified with a non-surgical focus are required to have an average of 15 CMEs per year (45 CMEs in three years) in podiatry and attest to a non-surgical practice or submit a malpractice face sheet indicating their status as non-surgical.

## Additional Requirements for Certain Specialties

In addition to the standard requirements for specialists, certain specialties must satisfy other criteria.

- ▶ Emergency medicine physicians may satisfy the board certification requirement with board certification in emergency medicine, family medicine, internal medicine, pediatrics or general surgery and completion of two or more years of post-medical school residency training. Emergency medicine physicians (and any physician who works in the Emergency Department) must also have current certification in advanced cardiac life support (ACLS), advanced trauma life support (ATLS) and pediatric advanced life support (PALS) unless they are board certified in emergency medicine.
- ▶ Highmark does not require facility-based pathologists, oral maxillofacial pathologists, anesthesiologists, radiologists, oral maxillofacial radiologists or emergency medicine specialists who practice exclusively in an acute care hospital setting to complete the standard Highmark credentialing or recredentialing process for the PremierBlue Shield and Medicare Advantage networks. However, these providers must complete the appropriate provider agreements to participate with Highmark Blue Shield's Participating Provider and PremierBlue Shield and Medicare Advantage networks. Please contact your Highmark Provider Relations representative if you have questions regarding this process.
- ▶ Highmark does not require credentialing or recredentialing for the PremierBlue Shield network when these requirements are met:

The practitioner must:

- provide 100 percent of his or her services to members exclusively in the acute care or general hospital setting
- possess a current Pennsylvania medical license in good standing
- have current active malpractice insurance that meets or exceeds Pennsylvania state requirements
- actively participate with Medicare or Medicaid and have never been debarred from or excluded from participation in, any Medicare or Medicaid government programs
- sign an Affirmation of Medical Practice Statement (form No. 282)

*\*Be sure to take advantage of the free CME credit opportunities offered in our quarterly publication, Clinical Views. It's mailed to all PremierBlue Shield physicians and is available online at [www.highmarkblueshield.com](http://www.highmarkblueshield.com).*

**(Continued on page 8)**

- ▶ If a provider begins to provide medical services to members outside of a Highmark Blue Shield network-participating acute care hospital, the practitioner will be required to complete a Provider Application and go through the credentialing process.
- ▶ Psychologists must be licensed as a psychologist in the state in which they practice. Psychologists that hold a doctoral degree in psychology must meet one of the following criteria:
  - Certification from the Council for the National Register of Health Service Providers in Psychology
  - Certification from the American Board of Professional Psychology, Diplomate in Clinical Counseling, Family Psychology, Neuropsychology or Health Psychology
  - A dissertation for the doctoral degree that is primarily psychological in nature with a specialty in clinical counseling or professional-scientific psychology
  - Graduation from an APA-approved internship or successful completion of an APA-equivalency form
- ▶ Licensed clinical social workers (LCSWs\*) must hold a master’s degree or doctoral degree in social work from a school accredited by the Council on Social Work education and must be licensed at the highest level for independent practice in the state in which they practice.
- ▶ Clinical nurse specialists must be licensed as a registered nurse in the state in which they practice and hold a certificate of Clinical Nurse Specialty in psychiatric mental health nursing as issued by the ANA/ANC.
- ▶ Psychiatric-certified, registered nurse practitioners (CRNPs) must be licensed as a registered nurse and a CRNP in the state in which they practice. A CRNP with a secondary license type in mental health must have a collaborative agreement with a credentialed PremierBlue Shield network psychiatrist.
- ▶ Master’s-prepared therapists+ (other than clinical social workers or nurses) must hold licensure or certification in an accepted human services specialty, such as master’s level psychologist, licensed professional counselor LPC, marriage and family therapists, etc., at an independent practice level in the state in which they practice.

\* For Federal Employees Health Benefits Program (FEP) and FreedomBlue only  
 † For FreedomBlue

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

## Office Site and Medical Record Documentation Reviews

**Office site and medical record documentation reviews are conducted for all initial, new and relocated PCPs, ob/gyns, independently practicing certified registered nurse practitioners and nurse midwives, and for initial potential high-volume behavioral health sites. Initial potential high-volume practitioners are identified as those located in counties not meeting a practitioner-to-member ratio of one practitioner for every 5,000 members for MDs and one practitioner for every 1,200 members for non-MDs. In lieu of performing a review, we will accept practitioners that have been recognized by the National Committee for Quality Assurance’s (NCQA’s) Physician Practice Connections Program. The office must provide a copy of NCQA’s recognition letter as evidence. Reviews will continue to be conducted triennially for all dual-credentialed practitioners. The reviews assess the following general elements:**

- ▶ **CPR Certification**
- ▶ **Office Site Evaluation**
  - Handicapped parking
  - Physical appearance of the office
  - Adequate exam rooms
  - Fire extinguishers
  - Emergency/evacuation plan
  - Handicapped accessibility
  - Adequate waiting rooms
  - Secure medical/treatment records
  - Marked exits
  - Proper handling of biohazardous waste
  - Proper sterilization of equipment
  - Properly secured medication and prescription pads
  - Emergency drugs and airway equipment availability
  - Proper storage of medications and lab specimens
  - Confidentiality



► **Office Accessibility**

- Availability of emergent, urgent, routine and preventive appointments
- Guidelines for telephone triage, advance directives, disclosure of confidential information
- Coverage availability 24 hours a day, seven days per week

► **Medical Records Documentation**

- Personal biographical data
- Problem lists
- Preventive services flow sheet
- All entries dated
- Past medical history
- Vital signs at each visit
- Coordination of care and notation of follow-up plans
- History and Physical identifies pertinent subjective and objective data
- Immunizations as recommended for age
- Preventive health services as recommended for age and sex
- Medication flow sheet
- Medication allergies and adverse reactions
- All entries contain author identification
- Use of cigarettes, alcohol and substance abuse
- Discussion of advance directives
- Growth and development appropriate for age
- The Plan's Primary Medical Record Standards shall reflect:
  - all services provided directly by the practitioner
  - all ancillary services and diagnostic tests ordered by a practitioner
  - all diagnostic and therapeutic services for which a member was referred by practitioners, such as:
    - home health nursing reports
    - specialty physician reports
    - hospital discharge reports
    - physical therapy reports

► **Treatment Record Documentation**

(for behavioral health practitioners)

- Personal biographical data
- Psychiatric history
- Developmental history
- Mental status exam
- Risk factors
- Identification of DSM-IV diagnoses
- Treatment plan and goals

Other indicators are also reviewed. A detailed list is available by calling 717-302-3353. All office site reviews will be scored in the aggregate for each component of the comprehensive site visit tool used by Highmark: *Office Site Evaluation, Medical/Treatment Record Documentation and Preventive Services Review*. A score of at least 80 percent on the Environmental Assessment, Medical Record Documentation and Preventive Services evaluation must be met.

Assessments may also be conducted in response to information obtained from quality improvement activities, including member complaints. To monitor the network for ongoing compliance, a statistically valid random sample of practice sites will undergo an evaluation using selected components of the elements listed on this page. These evaluations require an aggregate visit score of 80 percent.

Practices not meeting PremierBlue Shield or Medicare Advantage compliance standards on office site, medical/ treatment record or preventive services evaluations are expected to correct the deficiencies and will be re-evaluated within six months. The re-evaluation will be a reassessment of the non-compliant elements from the previous site review. (Practices failing to correct deficiencies may be sanctioned and become ineligible for QualityBLUE<sup>SM</sup> incentive payments. Practices with office deficiencies on repeated re-evaluations may be terminated from network participation.)



# Dual Credentialing & Recredentialing as Both Primary Care Physician and Specialist

Highmark Blue Shield contracts with network physicians (MDs and DOs) as either PCPs (family practitioners, general practitioners, internists or pediatricians) or as specialists (all other MDs and DOs).

Dual agreements for both categories of practitioners may be allowed when an individual practitioner meets network credentialing standards for each category requested. In addition, all practitioners who want to be credentialed as both a PCP and specialist must:

- ▶ Demonstrate that their practice adequately provides primary care services to members
- ▶ Meet the standards for PCPs
- ▶ Provide documentation of an average of 50 CME hours per year for the preceding three years. This requirement is waived if board certified in both specialties.
- ▶ Participate in an office site and medical record evaluation with a compliance rate of 80 percent.

Dual-credentialed practitioners must also have their medical records reviewed for compliance with Preventive Service Medical Record Documentation and attain an aggregate score of 80 percent or higher.

Dual-credentialed practitioners will undergo full recredentialing for PCP and specialist participation every three years, which includes an office site review, medical record documentation review and preventive services review. All dual-credentialed practitioners will appear in the provider directories as both PCPs and specialists and can receive referrals from other PCPs.

## Malpractice Insurance

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

By law, these providers must maintain primary medical malpractice insurance with liability limits of \$500,000 per medical incident and \$1.5 million in the annual aggregate in addition to the limits provided by the MCARE Fund of \$500,000 per medical incident and \$1.5 million in the annual aggregate.

All other practitioners are required to have \$500,000 per claim and \$1.5 million per year.

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

These practitioners include, but are not limited to, audiologists, doctors of chiropractic, CRNAs, nurse practitioners, optometrists, oral maxillofacial surgeons and physical therapists.

# Reconsideration of a Mid-Atlantic Credentials Committee Decision

**An appeal hearing is available to a professional network provider in the event that a denial or termination action or a limited or modified decision is made by the Mid-Atlantic Credentials**

**Committee due to:**

- ▶ The lack of required qualifications at the time of recredentialing. (This includes, but is not limited to, loss of an unrestricted state license, loss of DEA license, failure to obtain or keep appropriate board certification, lack of adequate clinical hospital privileges, and/or insufficient malpractice insurance coverage.)
- ▶ Any reason reportable to the National Practitioner Data Bank (NPDB). Reports to the NPDB are made through the state licensing agency and/or the Healthcare Integrity Protection Data Bank (HIPDB) pursuant to the requirements of the Health Insurance Portability and Protection Act of 1996.

# Appeal of a Mid-Atlantic Credentials Committee Decision

**An appeal of a Mid-Atlantic Credentials Committee decision is available to a professional network provider if the Mid-Atlantic Credentials Committee upholds a denial or termination action following a reconsideration hearing. In the event of an appeal, the Highmark Medical Review Committee shall be available, upon written request, to any professional network provider who has been notified of the termination or denial decision. Highmark's Medical Review Committee decision is final and not subject to further appeal.**

When a final determination has been made concerning a proposed corrective action that adversely affects the clinical privileges or provider status of a provider for a period longer than 30 days, or a final decision

notification of termination has been rendered, the Director of Quality Management or his/her designee shall report such corrective action to the appropriate parties, including the state licensing agency and/or the HIPDB.



## Keys to a Faster Application Process

▶ **Use NaviNet®! But if you don't have access yet ...**

- Complete the application accurately.
- Be sure to sign and date the attestation statement.

Do not delay in mailing the completed application and attestation statement back to Highmark Blue Shield. (Return within 30 days of receipt.)

## Credentialing Information

▶ **Use NaviNet®! But if you don't have access yet ...**

▶ **1-866-763-3224, option 4 - Stage 1:**  
Credentialing application status

▶ **717-302-3353 - Stage 2:** Office site and Medical Record Documentation Review, preparation for the Mid-Atlantic Credentials Committee, request additional information about credentialing processes.

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### Telephone Numbers to Fax Provider Information

To make changes to your assignment account or current information on our file, such as your practice, mailing or check address, fax the information to Provider Data Services, toll-free, at 1-800-236-8641.

To submit information to credential a provider for one of Highmark's networks, fax the documents, toll-free, to 1-800-236-5907.

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HEDIS is a registered trademark of the National Committee for Quality Assurance.

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