MOUNTAIN STATE BLUE CROSS BLUE SHIELD
NETWORK CREDENTIALING POLICY & PROCEDURE

TITLE: Professional Network Provider Denial and Termination Policy

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Networks and Lines of Business:

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POLICY: The Plan requires that all professional network providers comply with the terms and conditions of their Provider Contracts and meet acceptable standards for quality of clinical care and administrative compliance in order to assure that the Plan's networks operate in an effective and efficient manner and that members receive high quality, medically appropriate, and cost-effective care.

PURPOSE: This policy is intended to outline the procedures for provider denials and terminations arising from non-compliance with contractual obligations or failure to meet acceptable standards of clinical care, and/or administrative compliance.
It is also intended to provide a method of ensuring that all physicians/providers who are responsible for delivering medical services to members using the Plan's networks provide a consistent level of high quality, medically appropriate, cost-effective and ethical medical services. To promote this purpose, this standard policy and procedure for denial and termination of professional network providers was established. It is recognized that the provider agreements may provide for termination "without cause" by either the plan or the provider. It is also recognized that provider contracts may be immediately terminated under certain circumstances. It is not the intent or purpose of this Policy to in any manner abrogate or modify any right to terminate network participation "without cause," or immediately, as set forth in any provider contract.

PROCEDURES:

I. TERMINATIONS

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

1. Maintain an active unrestricted license to practice unless practitioner holds an institutional license and has been reviewed and approved by the Medical Director.
2. Maintain an active DEA certificate, where applicable.
3. Maintain coverage for malpractice insurance in the minimum amounts required.
4. Maintain acceptable professional liability claims history.

5. Participate in credentialing/recredentialing which includes providing all requested information for network participation.
6. Meet appropriate credentialing/ recredentialing requirements.

B. Professional network providers shall also be denied or terminated if, in the plan's sole discretion, any of the following occur, or are in imminent danger of occurring:

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

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

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

D. Decisions to deny or terminate a provider may be made by the Plan's Medical Director(s) or by the Credentials Committees. A provider shall be provided with a written decision of the denial or termination with the specific reason for the decision and any appeal/reconsideration rights in accordance with Article II or III of this policy.

E. Practitioners that are non-compliant in returning their recredentialing applications or providing missing information the plan will follow the voluntary withdrawal process as outlined in policy "Decision-Making Process for the Credentialing/ Recredentialing of Network Practitioners and Credentialing Related Committees".

II. RECONSIDERATION PROCESS FOR DENIAL OR TERMINATION ACTION

A. A request for a reconsideration of a denial or termination decision by the Credentials Committees is available to a professional network provider in the following instances:

1. The termination action or denial by a Medical Director or by the applicable Credentials Committee was due to the lack of required qualifications at the time of credentialing/recredentialing. This includes, but is not limited to, loss of an unrestricted state license, loss of DEA license, lack of adequate hospital privileges, and/or insufficient malpractice insurance coverage.
2. The termination action or denial by a Medical Director or by the Credentials Committees was due to any other reason not reportable to the National Practitioner Data Bank (as described in Section III).

B. The provider must request the reconsideration in writing within 30 days of notice of the denial or termination. The provider shall be given the opportunity to present information to the Credentials Committee by one or any of the following options.
1. In writing, to the Credentials Committee for consideration which shall take place during a Credentials Committee meeting.
2. Appearing in person at a Credentials Committee meeting.
3. Participating via a telephone conference call at a Credentials Committee meeting.

C. After the meeting, the provider shall receive written notice of the final decision of the Credentials Committee, which will include the basis for the decision, the appeal process and the practitioner's right to a final appeal within 30 days if the decision is upheld.

D. A contracted provider will remain in the network until the Credentials Committee's final decision to terminate and an effective date of termination is established (as described in Section IV of this policy).

III. APPEALS OF CREDENTIALS COMMITTEE FINAL DECISION

A. In the event of an appeal, the Plan's other regional Credentials Committee (comprised of professional peers) shall be available, upon written request, to any professional network provider who has been notified of the final termination decision, denial, or suspension from the Plan's network, pursuant to the procedures in Section II of this policy.

B. The provider must request the appeal, in writing, within thirty-days (30) of receipt of written notification of an adverse decision pursuant to Section II C of this policy. The provider remains in the Plan's network until the appeal process is completed, unless the provider has been subject to an immediate termination. No appeal is available if the provider has waived or forfeited the right to an appeal.

C. If an appeal is requested, the provider may submit to the Office of Network Credentialing any documentation believed to be relevant for consideration during the appeal process.

D. The provider will then receive a notice of the hearing place, date and time and an explanation of the Committee hearing process. This includes the practitioner's right to representation by legal counsel and/or other individuals to support his/her position and a record of the proceedings.

E. All relevant documentation, including but not limited to, the provider's credentialing file and minutes of the applicable credentials committee meeting(s); and all applicable recommendations and decisions will be presented at a meeting of the appropriate regional Credentials Committee. The Committee's members shall be peers and not be in direct economic competition with the provider. The Committee will determine if:

1. The denial or termination process was handled correctly according to the plan's Policies and Procedures.
2. The provider was afforded a reasonable opportunity to address the issues, concerns or deficiencies that led to the decision.
3. The denial or termination process was performed with merit and without bias, conflict of interest or inadequate attention to the documentation presented.

F. The plan's appropriate regional Credentials Committee will decide whether to uphold or reverse the decision. The Committee's decision is final and not subject to further appeal.

G. The Medical Director will notify the provider, in writing, of the Committee's decision, including a statement of the basis of the decision. The notification will address any future action that may be forthcoming as a result of that appeal decision.

IV. REPORTING

A. When the provider fails to respond within 30 days of notification as described in above sections, or all reconsiderations, hearings, and appeals have been exhausted, the applicable Credentials Committee will establish the effective date of any termination. A final decision notification of denial or termination will be mailed to the provider. An effective date of any termination will be in the notification.

B. 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 Network Credentialing or his/her designee shall report such corrective action to the appropriate parties, including the state licensing agency and/or the National Practitioner Data Bank, (NPDB) pursuant to the requirements of the Healthcare Quality Improvement Act and/or the Healthcare Integrity Protection Data Bank (HIPDB) pursuant to the requirements of the Health Insurance Portability and Protection Act of 1996. (Refer to the policy entitled "Incorporation of Quality of Care Information and Performance Data into the Recredentialing Process").

C. Any final determination, which is reportable to the NPDB or the HIPDB, shall be made in a timely manner.

D. Nothing set forth in Section III B of this policy shall preclude the Plan from immediately suspending or restricting clinical privileges where the failure to take any such action may result in imminent danger to the health of any member, provided subsequent notice and right to a hearing are given.

E. A contracted provider shall remain in the network until the Credentials Committee's final decision to terminate and an effective date of termination is established.

V. MISCELLANEOUS

A. This policy and procedure is not contractual in nature and may, at the plan's sole discretion, be changed.

B. Neither this policy nor the failure to follow such policy, nor any breach related to this policy, is intended to entitle any provider to any additional rights, remedies, damages or injunctive relief.

C. No decisions made hereunder are subject to challenge in any legal or equitable proceeding and may not be presented to arbitration.

D. Nothing in this policy is intended to waive any right that the plan has under any provider contract to immediately terminate the provider contract, or to terminate it after notice, whichever is applicable.