

Chapter 3. Credentialing and Re-credentialing

3.1 Introduction	3
3.2 Types of Providers Credentialed	3
3.3 Credentialing Criteria	5
3.3.1 Physicians	5
3.3.2 Facilities and Organizational Providers	7
3.3.3 Allied Health Practitioners	8
3.3.4 Locum Tenens	8
3.3.5 Additional Criteria Applicable to all Provider Types	9
3.4 The Credentialing Process	9
3.4.1 Network Quality and Credentials Committee	9
3.4.2 Network Credentialing Area	10
3.4.3 Applications	11
3.4.4 Review Process	12
3.4.5 Opportunity to Review and Correct Information	12
3.4.6 On-site Reviews	12
3.4.7 Time Frames	13
3.5 Initial Credentialing	14
3.6 Re-credentialing	14
3.6.1 Physicians and Allied Health Providers	14
3.6.2 Facilities and Organizational Providers	15
3.6.3 Ongoing Monitoring	15
3.7 Corrective Action, Termination and Appeals	16
3.7.1 Availability of Policies; Non-Contractual Nature	16
3.7.2 Network Compliance Policy	16
3.7.3 Corrective Action	17
3.7.4 Termination	18
3.7.5 Reconsideration	19
3.7.6 Hearings and Appeals	20
3.8 Reporting of Actions	21

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3.1 Introduction

Mountain State credentials and regularly re-credentials providers participating in the Mountain State commercial PPO and POS networks and Highmark's FreedomBlue® network. Therefore, providers must satisfy initial credentialing requirements in order to become network providers and must maintain compliance with Mountain State's and Highmark's re-credentialing standards (as they may be amended from time to time) in order to continue participating.

The Mountain State's credentialing and re-credentialing standards, policies, and procedures are reviewed by the Highmark West Virginia Network Quality and Credentials Committee, which is comprised of practicing Mountain State network physicians of various specialties who make recommendations to Mountain State regarding the adoption of provider credentialing standards. The credentialing process is designed to meet national accreditation standards and also to comply with federal requirements governing Medicare Advantage plans.

In selecting and credentialing providers for the associated networks, Mountain State does not discriminate in terms of participation or reimbursement, against any healthcare professional who is acting within the scope of his or her license or certification under state law solely on the basis of the license or certification. In addition, Mountain State does not discriminate against professionals who serve high-risk populations or who specialize in the treatment of costly conditions.

If Mountain State declines to include a given provider in its networks, Mountain State will furnish written notice to the affected provider of the reason for its decision.

3.2 Types of Providers Credentialed

Mountain State currently credentials the following types of providers:

Physicians	Facilities/Organizational Providers	Allied Health Practitioners
Medical Doctors (MD)	Acute Care Hospitals	Audiologists
Doctors of Osteopathic Medicine (DO)	Ambulance Services	Clinical Social Workers
Podiatrists (DPM)	Ambulatory Surgical Centers	Counselors and Therapists
Dental Specialists (DDS/DMD) including oral & maxillofacial surgeons, oral & maxillofacial radiologists; oral & maxillofacial pathologists; and orthodontists	Behavioral Health Centers	Occupational Therapists
General Dentists who provide covered medical/surgical services	Cancer Treatment Centers	Optometrists
Chiropractors (DC)	Critical Access Hospitals	Physical Therapists
	Durable Medical Equipment (DME) Providers	Psychologists
	Federally Qualified Health Centers	Registered Dieticians
	Hearing Aid Vendors	Registered Nurse Anesthetists
	Home Health Agencies	Registered Nurse Midwives
	Home Infusion Therapy Providers	Registered Nurse Practitioners
	Hospices	Speech Pathologists and Therapists
	Portable X-ray Suppliers	Acupuncturists
	Psychiatric Hospitals	Massage Therapists
	Physical Therapy Centers	Certified Diabetic Educators
	Rehabilitation Hospitals	
	Renal Dialysis Centers	
	Retail Clinics	
	Urgent Care Centers	
	Freestanding Laboratories; providing moderate/high complexity testing	
	Sleep Medicine Centers	
	Rural Health Clinics	
	Skilled Nursing Facilities	
	Specialty Hospitals	
	Outpatient CT Providers	

Mountain State will no longer require credentialing information for Physician Assistants in West Virginia and bordering counties. West Virginia state law does not allow a Physician Assistant to practice independently but rather under the direction of a supervising physician.

3.3 Credentialing Criteria

This Section 3 presents a general description of Mountain State's credentialing criteria. It is not intended to be a complete description of all credentialing requirements and procedures.

If you have questions about policies or any other credentialing issue, please call the Network Quality and Credentialing Area at 1-888-475-2391.

3.3.1 Physicians

A. General Criteria

MDs, DOs, DDSs/DMDs, DPMs and DCs must furnish satisfactory proof of the following:

- Active state license in each state in which the practitioner provides services;
- Active Drug Enforcement Agency ("DEA") certificate in each state in which the practitioner is providing services to members;
- Acceptable 5-year work history for initial credentialing;
- Professional liability insurance (\$1 million/occurrence, \$3 million aggregate or compliance with WV Code §55-7B-12);
- Acceptable malpractice history;
- Privileges at a network or participating Blue Cross Blue Shield hospital;
- Written proof of Medicare eligibility for the FreedomBlue® network;
- No Medicare or Medicaid sanctions;
- Availability to see Mountain State members at least 20 hours a week for primary care physicians;
- For the FreedomBlue® network, cannot have opted out of the Medicare Part B program;
- The ability directly or through on-call arrangements with other qualified Mountain State participating practitioners of the same or similar specialty to provide coverage 24 hours a day including a credentialed and contracted practitioner of the same network who meets Mountain State's standards for care of children under 13 years of age if applicable, seven

days a week for urgent and emergent care and PCPs to provide triage and appropriate treatment or referrals for treatment;

- Physicians practicing in the Emergency Department or Credentialed Urgent Care Facility and are not boarded in Emergency Medicine must have obtained current Advanced Cardiac Life Support (“ACLS”), Advanced Trauma Life Support (“ATLS”), and Pediatric Advanced Life Support (“PALS”) certification.

****Certain elements only apply to specific provider types.**

B. *Education and Training*

All physicians must furnish proof of graduation from an American Council for Graduate Medical Education (“ACGME”) or American Osteopathic Association (“AOA”) accredited training program. Alternatively, MDs and DOs may possess current Educational Commission for Foreign Medical Graduation (“ECFMG”) certification and have passed the Federation Licensing Examination (“FLEX”) or United States Medical Licensing Exam (“USMLE”).

MDs and DOs must have completed at least one year of postgraduate training. Oral & Maxillofacial surgeons, General Dentists, and Orthodontists must have completed training accredited by the Commission on Dental Accreditation (“CODA”) and podiatrists must have completed an accredited residency program recognized by either the American Board of Podiatric Surgery (“ABPS”) or the American Board of Podiatric Orthopedics and Primary Podiatric Medicine (“ABPOPPM”).

C. *Specialty Training and Provider Directory Listing*

MDs and DOs may be credentialed and listed in the provider directories in a specialty recognized by the American Board of Medical Specialties (“ABMS”) or American Osteopathic Association (“AOA”) if they have completed an ABMS or AOA accredited residency program in that specialty. A physician who has not completed an accredited residency program may be listed in the provider directory as a general practitioner, if certain requirements are met.

Oral and maxillofacial surgeons may be credentialed and listed in the provider directories in a specialty recognized by the American Board of Oral and Maxillofacial Surgery (“ABOMS”) if they have completed an accredited residency program in that specialty.

Podiatrists may be credentialed and listed in the provider directories in a specialty recognized by either the ABPS or the ABPOPPM, if they have completed an accredited residency program in that specialty.

D. Board Certification

Mountain State does not require board certification for participation in our networks. However, we will indicate in our electronic provider directories posted on our website that a physician is board certified if he/she is currently certified in a specialty category and by a board recognized by the ABMS, AOA, ABOMS, ABPS or ABPOPPM.

3.3.2 Facilities and Organizational Providers

Facilities and organizational providers credentialed by Mountain State generally must satisfy the following requirements

- Current active state license (if required) or state business registration;
- Medicaid participation and proof of Medicare eligibility for the FreedomBlue® network.
- Professional liability insurance (\$1 million per occurrence, \$3 million aggregate for most provider types);* and
- Accreditation (as appropriate for provider type).**

Laboratories must provide evidence of CLIA certification only.

*Credentialing is only required for those freestanding Laboratories providing moderate or high complexity testing, and are required by CLIA to obtain a Certificate of Compliance or Certificate of Accreditation. A copy of the current certificate must be provided for credentialing. Providers who are only conducting waived testing and / or provider performed microscopy procedures (“PPMP”) are not required to be credentialed.

*Hearing aid vendors and DME companies are required to carry \$1 million per occurrence/\$2 million aggregate; skilled nursing facilities \$500,000 per occurrence/\$2 million aggregate; and ambulance services \$1 million per occurrence/\$1 million aggregate in professional liability coverage.

**For some provider types, proof of acceptable Centers for Medicare and Medicaid Services (“CMS”) on-site review or proof of Medicaid participation may be substituted for accreditation.

3.3.3 Allied Health Practitioners

A. General Criteria

- Active license in each state in which the practitioner provides services;
- For Registered Nurses active advanced practice certification by an entity approved by the state licensing board;
- Evidence of appropriate education and training. Licensure often verifies education;
- Acceptable 5-year work history for initial credentialing;
- Professional liability insurance (\$500,000 per occurrence, \$1.5 million aggregate)*;
- Acceptable malpractice history;
- No Medicare or Medicaid sanctions;
- The ability to directly or through on-call arrangements with other qualified Mountain State participating practitioners of the same or similar specialty to provide coverage 24 hours a day including a credentialed and contracted practitioner of the same network(s) who meets Mountain State's standards for care of children under 13 years of age if applicable, seven days a week for urgent and emergent care;
- Written proof of Medicare eligibility for the FreedomBlue® network
- FreedomBlue® network practitioners cannot have opted out of the Medicare Part B program.

Nurse practitioners and nurse midwives must also provide documentation that describes the scope of services to be provided, as agreed upon by his or her supervising physician (collaborative agreement) if required.

*Some registered nurses are required to maintain \$1 million per occurrence, \$3 million aggregate in professional liability coverage.

3.3.4 Locum Tenens

Mountain State credentials locum tenens physicians based on the length of time the physician will be providing care in Mountain State's network service area. Locum Tenens physicians who will be providing services for at least six months or longer will be required to undergo initial credentialing and, if applicable, recredentialing, at least every three years.

For billing requirements please refer to Chapter 7.5.5

3.3.5 Additional Criteria Applicable to all Provider Types

Mountain State will review and may take into consideration the following types of information (among others) in credentialing or re-credentialing decisions for all provider types:

- National Practitioner Data Bank (“NPDB”) reports;
- Licensing board or hospital disciplinary actions/ restrictions;
- Convictions, criminal and civil proceedings;
- Substance abuse impairment;
- Fraud, inappropriate or excessive billing;
- Complaints;
- Non-cooperation/non-compliance with Mountain State contract terms, administrative requirements or health services management programs;
- Completeness, timeliness and accuracy of credentialing/re-credentialing information; and
- Quality of care or utilization issues.

3.4 The Credentialing Process

3.4.1 Network Quality and Credentials Committee

The Highmark West Virginia Network Quality and Credentials Committee is a statewide committee that meets twice monthly. This allows expeditious processing of exception practitioners. It consists of practitioners from the northern and the south central regions of the state. The voting members of the Highmark West Virginia Network Quality and Credentials Committee are practicing physicians of various specialties who participate in Mountain State’s networks.

The Committee is chaired by a Mountain State medical director (also a practicing physician), who oversees the clinical aspects of the credentialing program. Other Mountain State executive staff serve on the Committee as nonvoting members.

The Highmark West Virginia Network Quality and Credentials Committee’s primary responsibilities are to:

- Review and make recommendations regarding credentialing/re-credentialing exception cases;
- Request additional information if needed to review a provider;
- Review and make recommendations regarding credentialing policies and procedures;
- Recommend corrective action or termination if a provider fails to meet reasonable standards of care or to comply with credentialing or contracting requirements; and

- Consult with appropriate specialists if needed to review a credentialing application or issue.

The Highmark West Virginia Network Quality and Credentials Committee meets twice monthly and keeps minutes of their proceedings. The Committee is a formally-constituted peer review body, which meets the definition of “review organization” under WV Code §30-3C-1. As such, their proceedings and records are confidential and privileged as provided by WV Code §30-3C-3.

3.4.2 Network Credentialing Area

The Mountain State Network Quality Management and Network Credentialing area and Highmark’s Provider Information Management department perform day-to-day administration of the credentialing program and provide staff support for the Highmark West Virginia Network Quality and Credentials Committee.

Practitioners:

Practitioners should contact Highmark’s Provider Information Management at 866-763-3224, if they have any questions regarding the status of their credentialing/re-credentialing applications.

Facility and Organizational Providers:

Facility and organizational providers should contact Mountain State’s Network Quality and Credentialing area at 888-475-2391, if they have questions regarding the status of their credentialing or recredentialing.

Questions regarding the Mountain State credentialing policies or criteria should be directed to the Quality and Credentialing area.

Mountain State Blue Cross Blue Shield Network Quality and Credentialing Area P.O. Box 1353 Charleston, WV 25325 Phone: 888-475-2391 Fax: (304) 347-7740
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Highmark Provider Information Management P.O. Box 898842 Camp Hill, PA 17001 Phone: 866-763-3224 Fax: 866-507-6567
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3.4.3 Applications

Practitioners:

To initiate the credentialing process, West Virginia physicians and allied health practitioners must complete the most recent version the State of West Virginia *Uniform Credentialing Form* (application) or may enter information into the Council for Affordable Healthcare's ("CAQH") database, as long as it is printed on the mandated West Virginia uniform credentialing form (application). Mountain State is not permitted to accept the CAQH application forms by law. The most recent version of the West Virginia uniform credentialing and re-credentialing forms are available on the West Virginia Insurance Commissioner's website at www.wvinsurance.gov. Mountain State will accept uniform credentialing applications from other states (i.e. Ohio, Maryland) if that is the primary location of practice. All initial credentialing applications for practitioners are to be returned to Highmark's Provider Information Management area for primary source verification at the above address.

Facility and Organizational Providers:

When the contracting process is initiated, Mountain State will send an application, if applicable and/or a letter detailing the types of credentialing information the provider must submit. Facility and organizational providers are to submit requested credentialing documentation to Mountain State's Network Quality and Credentialing Area.

Hospital Based Practitioners:

An abbreviated credentialing process is permitted for those practitioners who practice **exclusively** within the inpatient or outpatient setting and who provide care for Mountain State members only as a result of the members being directed to the hospital. This abbreviated process is conducted at Mountain State by the Office of Professional Provider Relations which can be contacted using the information below. Should the practitioner affiliation change and they are no longer practicing exclusively in an acute care setting (inpatient or outpatient), they will be required to undergo the full credentialing process.

<p>Mountain State Blue Cross Blue Shield Office of Professional and Provider Relations P.O. Box 1948 Parkersburg, WV 26101 Phone: 800-798-7768 Fax: (304) 424-7713</p>
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3.4.4 Review Process

Upon receipt of a credentialing application (or letter with required information from a facility or organizational provider), the information will be reviewed for completeness. Any practitioner malpractice information will be scored using criteria set forth in the Malpractice Scoring Policy and Procedure.

3.4.5 Opportunity to Review and Correct Information

Providers have the opportunity to review any information submitted to Mountain State in support of their credentialing or re-credentialing applications, upon written request to the Network Quality Credentialing area. A provider may submit additional or corrected information, prior to review by the Highmark West Virginia Network Quality and Credentials Committee (or if requested by the Committee or Mountain State), if there is incomplete, inaccurate, or conflicting information in the file.

3.4.6 On-site Reviews

Mountain State performs office site visits by identifying practices based on the following:

- Member Dissatisfaction;
- Random Sampling;
- Problems that were identified during Risk Adjustment Data Validation (“RADV”) audits;

The overall evaluation process may include the following:

- Practitioner office site quality evaluation;
- Medical/treatment record evaluation;
- Process improvement evaluation;

The office site evaluations include, but are not limited to an assessment of the following:

- Physical accessibility;
- Physical appearance;
- Adequacy of waiting and examining room space;
- Member access to services and availability of appointments;
- Policies and procedures;
- Adequacy of equipment;
- Confidentiality of medical information;
- Adequacy of medical/treatment record keeping/documentation.

The on-site review nurse will mail a comprehensive, written report to the practice, outlining the results of the evaluation and a corrective action plan if necessary.

Practices not meeting the compliance standards are expected to correct deficiencies and are subject to a re-evaluation six months after the initial visit. Failure to correct deficiencies could impact the practice's credentialing or network status.

Data Completeness Assessment:

Starting January 1, 2010, the data completeness evaluation process for all practitioners will be incorporated into the recredentialing process in the following manner:

- Year one: if a data completeness deficiency is noted by the Quality Management Consultants during a HEDIS or RADV chart audit, a feedback sheet will be placed on the chart detailing the deficiency found. If there are five or more unique deficiencies found, your practice will be "flagged" in Mountain State's database.
- Year two: if five or more feedback sheets are placed on the chart during the subsequent year, the practice will receive a letter that explains how the recredentialing outcome or decision could be affected if deficiencies are found the following year.
- Year three: if a practice receives five or more feedback sheets for three *consecutive* years, the practitioners at that office will be evaluated as "exceptions" at the time of their next recredentialing review. This could potentially lead to termination from the networks.

3.4.7 Time Frames

Mountain State's credentialing procedures are designed to facilitate prompt review and decision regarding a provider's completed credentialing application.

In accordance with the Love Settlement, MDs and DOs are required to be initially credentialed and notified of their credentialing status within 90 days of Mountain State receiving a complete credentialing application.

In accordance with the Ohio Healthcare Simplification Act, all practitioners who participate with Mountain State and whose primary site of service is located in Ohio are required to be credentialed and notified of their credentialing status within 90 days of Mountain State receiving a complete or incomplete credentialing application.

All other providers will be initially credentialed within 120 days of the submission of a credentialing application, in compliance with W.Va. Code § 30-45-2(11).

The Network Quality and Credentialing area will not submit for the Highmark West Virginia Network Quality and Credentials Committee's review any application that is signed and dated more than 180 days prior to the Committee date for initial or re-credentialing providers. These time frames also apply to any primary or secondary source verification information. In such cases, the provider may be asked to re-sign the application and information may need to be re-verified.

3.5 Initial Credentialing

Pursuant to accreditation and Medicare requirements, providers are not considered to be participating in the PPO, POS and FreedomBlue® networks and may not be listed in the provider directories until the credentialing process is completed and the provider is approved by the Highmark West Virginia Network Quality and Credentials Committee.

Non-Compliance with the Credentialing Process:

Providers who do not submit the required credentialing information, in the specified time frame, may have his/her application process discontinued. The provider will be notified to this in writing within the required notification time frame. The provider will be able to re-apply for credentialing, once he/she is able to comply with all initial credentialing requirements.

3.6 Re-credentialing

After initial credentialing, all physicians (MDs, DOs, DDS/DMDs, DPMs and DCs), allied health providers, facilities and organizational providers are re-credentialed at least every three years. The Credentialing Committee may direct that an individual provider be re-credentialed at a shorter interval, based on quality of care or other concerns.

Recredentialing providers should be considered recredentialed unless otherwise notified.

Non-Compliance with the Re-Credentialing Process:

Providers who do not submit the required re-credentialing information, in the specified time frame, may be viewed as voluntarily withdrawing from the Mountain State networks and/or HHIC's FreedomBlue®. Providers will be notified of this in writing. Providers will be required to re-apply as an initial applicant. A new provider contract may or may not be required.

3.6.1 Physicians and Allied Health Providers

Generally, six months prior to the re-credentialing due date, an application will be mailed to the practitioner for completion. Physicians and allied health providers must complete

the West Virginia *Uniform Re-Credentialing Form* (application), or other state mandated recredentialing application.

The general criteria for re-credentialing are the same as those for initial credentialing, except that education and training generally are not re-verified unless an issue or question arises or additional training has been obtained. Primary source verification is performed on the same types of information for which it was performed for initial credentialing.

In addition to the standard criteria, information presented to the Highmark West Virginia Network Quality and Credentials Committee may include information obtained through ongoing monitoring, quality and service reviews, onsite reviews, complaints, billing or other audits, and other performance-related information.

3.6.2 Facilities and Organizational Providers

As with initial credentialing, Mountain State will send the provider a letter well in advance of the re-credentialing due date, or form listing the types of information required for re-credentialing. The criteria are the same as for initial credentialing. Additional information from ongoing monitoring and other performance-related reviews may also be considered by the Highmark West Virginia Network Quality and Credentials Committee.

3.6.3 Ongoing Monitoring

The Provider Information Management and Network Quality and Credentialing areas routinely monitors the ongoing compliance of network providers with credentialing/re-credentialing criteria. Such monitoring includes, but is not limited to:

- U. S. Department of Health and Human Services, Office of Inspector General (“OIG”), List of Excluded Individuals/Entities (providers excluded from participation in Medicare, Medicaid and other Federal health programs) (monthly);
- Licensing Board queries (monthly); and
- Medicare Part B “Opt Out” List (quarterly).

If it is determined or suspected that a provider no longer complies with credentialing, re-credentialing or contracting requirements (e.g. revocation or suspension of a license, OIG sanction), the matter will be investigated and presented to the Highmark West Virginia Network Quality and Credentials Committee (or the medical director in urgent situations) for appropriate action.

3.7 Corrective Action, Termination and Appeals

3.7.1 Availability of Policies; Non-Contractual Nature

This section summarizes Mountain State's current policies and procedures governing corrective action and termination of network providers. This section also outlines a provider's ability to request reconsideration or a hearing and to appeal in certain circumstances.

For more detailed information, you may request copies of the Mountain State corrective action and termination policies from the Network Quality and Credentialing area.

These policies, and the procedures and rights described therein, are not contractual in nature and may, at Mountain State's discretion, be changed.

3.7.2 Network Compliance Policy

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

Providers who are not compliant are subject to corrective action. Non-compliance can be divided into three categories:

- Quality of care concerns;
- Unacceptable resource utilization; and
- Administrative non-compliance.

Quality of Care Concerns. A quality of care concern arises when an episode of care deviates from acceptable 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 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;
- Missed diagnoses;
- Medication errors;

- Delayed diagnosis/treatment;
- Unexpected operative complications;
- Invasive procedure complications;
- Inappropriate procedures;
- Unanticipated, unexplainable death of a patient; and
- Actions requiring a report to the NPDB or other adverse actions.

Unacceptable Resource Utilization. This 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 encounters per member per year; and
- Under-utilization (i.e. withholding) of necessary and appropriate medical services.

Administrative Non-Compliance. This is defined as behavior that does not comply with applicable laws, regulations or Mountain State policies or procedures, or that is detrimental to the successful functioning of Mountain State as a health plan or to its members' rights or benefits under their plan.

Examples of administrative non-compliance include, but are not limited to:

- Direct or unauthorized billing for services;
- Balance billing members for services;
- Failure to cooperate with Mountain State's administrative, quality management, utilization review, credentialing, member service, reimbursement and other procedures;
- Use of non-network providers (for supplies, devices, etc.);
- Conduct that is unprofessional toward members, family members and/or Mountain State staff;
- Failure to comply with contractual obligations; and
- Failure to comply with state or federal laws or regulations.

3.7.3 Corrective Action

A network provider who engages in practices inconsistent with reasonable standards of care or professional conduct, or who does not comply with Mountain State contractual or administrative requirements may become subject to corrective action.

Corrective action may be initiated by the medical director or the Highmark West Virginia Network Quality and Credentials Committee and may include, but is not limited to, the following:

- Discussions with the provider;
- Written warning or counseling;
- Monitoring of the provider's performance;
- Expedited re-credentialing;
- Requirement to complete continuing medical education;
- Limitation of authority to perform certain procedures; and
- Requirement to enter into a preceptor relationship with another provider.

Mountain State may immediately suspend the network participation status or restrict the clinical privileges of a provider who, in the opinion of the medical director, is engaged in conduct or is practicing in a manner that appears to pose a significant risk or imminent danger to the health, welfare or safety of a patient or other individual. In such cases, Mountain State will investigate the circumstances on an expedited basis.

If the suspension or restriction will last longer than 14 days, the provider will be notified that he/she can request a hearing. The request must be made in writing within 30 days of receipt of the notification.

3.7.4 Termination

It is recognized that Mountain State's provider agreements automatically terminate, or may be terminated immediately or upon specified notice, under certain specified circumstances. Nothing in this *Provider Manual* shall be deemed to abrogate or modify any such provisions or rights.

Under Mountain State credentialing policies, a network provider may be terminated from the PPO, POS and FreedomBlue® networks if the provider does not maintain compliance with credentialing/re-credentialing requirements, fails to provide an acceptable level of care, or engages in acts or omissions which adversely affect operation of the network or compliance with applicable regulatory requirements. Providers may not be terminated for advocating for necessary healthcare, initiating appeals or protesting policies, declining to provide services on moral or religious grounds, or discussing treatment options and Mountain State coverage/non-coverage of services with patients. Termination decisions are made by the Highmark West Virginia Network Quality and Credentials Committee or, in urgent situations, by the medical director. Termination from the PPO and POS networks will also result in termination from the traditional indemnity network. A provider who has not participated in Mountain State networks for more than 30 days will need to re-apply as an initial applicant.

Loss of license or an OIG/FEP sanction will result in an immediate termination. Providers will be afforded the opportunity to appeal after the termination has taken effect. Providers who are recommended for termination for other reasons are scheduled to be terminated 90 days after receiving the written notice of termination. The provider will be offered re-consideration and appeal rights as described below, prior to the final termination date.

3.7.5 Reconsideration

A provider, who has been notified of the Highmark West Virginia Network Quality and Credentials Committee decision for denial, termination, or specialty listing, may request reconsideration of the action to be imposed. The provider must request the reconsideration in writing within 30 days of notice of the credentialing decision the provider shall be given the opportunity to present information to the Highmark West Virginia Network Quality and Credentials Committee by one or any of the following options:

1. In writing, to the Highmark West Virginia Network Quality and Credentials Committee for consideration which shall take place during a Highmark West Virginia Network Quality and Credentials Committee meeting.
2. Appearing in person at a Highmark West Virginia Network Quality and Credentials Committee meeting.
3. Participating via a telephone conference call at a Highmark West Virginia Network Quality and Credentials Committee meeting.

Reconsiderations to Mountain State Commercial and HHIC FreedomBlue PPO network practitioners will be presented before the Highmark West Virginia Network Quality and Credentials Committee. Reconsiderations for practitioners who participate in Mountain State Commercial and HHIC FreedomBlue PPO networks as well as any Highmark networks will be presented before the Highmark Network Quality and Credentials Committee.

After the meeting, the provider shall receive written notice of the reconsideration decision from the applicable 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.

A contracted provider will remain in the network until the Highmark West Virginia Network Quality and Credentials Committee's final decision to terminate and an effective date of termination is established.

3.7.6 Hearings and Appeals

In the event of an appeal, Highmark Network Quality and 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 Mountain State's networks.

Practitioner appeals for Mountain State Commercial and HHIC FreedomBlue PPO network participants will be presented to the Highmark Network Quality and Credentials Committee.

Practitioner appeals for participants in any Highmark networks and Mountain State Commercial and/or HHIC FreedomBlue PPO networks will appeal before the Medical Review Committee (MRC).

The provider must request the appeal, in writing, within thirty-days (30) of receipt of written notification of an adverse decision. The provider remains in the network(s) 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.

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.

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.

All relevant documentation, including but not limited to, the provider's credentialing file and minutes of the Network Quality and Credentials Committee meeting(s); and all applicable recommendations and decisions will be presented at a meeting of the Highmark Quality and Credentials Committee or the Medical Review 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 organization'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.

The applicable Committee will decide whether to uphold or reverse the decision. The Committee's decision is final and not subject to further appeal.

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.

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 Network Quality and 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 included in the notification.

3.8 Reporting of Actions

Mountain State may be required by federal law to report certain corrective actions or terminations to the applicable state licensing board, the NPDB, and/or the HIPDB.

Once a final decision has been issued, a Mountain State medical director and the Network Quality and Credentialing area will review the action and determine whether and, if so, to whom, the action must be reported.