3.0 General Provider Information

3.1 Provider Participation Agreement Highlights (Rev. for 1/1/06)

All providers sign a participation agreement in order to participate in the Health Plan. An agreement signed by both the provider and the Health Plan is the only acceptable evidence that the provider currently participates with the Health Plan. The agreement contains provisions governing the provider’s relationship with the Health Plan.

In addition, many providers belong to Independent Physician Associations (IPAs) or Independent Provider Organizations (IPOs) that have agreements with the Health Plan. These agreements may override some of the terms given below.

Several basic provisions apply to all direct participation agreements. (Some are listed below.

- **Agreement covers all products.** The participation agreement enables the provider to participate in all product lines.

- **Provider Reimbursement.** The Health Plan’s basis for paying a provider is defined in his/her participation agreement. A provider must accept the reimbursement methodology as specified in his/her participation agreement as full payment. It is the Health Plan’s policy to provide fee information to any participating provider relative to his or her practice.

- **Hold Member Harmless.** Under no circumstances, including insolvency of the Health Plan, may a provider look to a subscriber, his/her family members or any other person (other than the Health Plan) acting on the member’s behalf for payment for covered services, except for deductible, coinsurance or copayments and member penalties where applicable. This means that balance billing is not permitted.

The agreement to accept the Health Plan’s fees as payment in full extends to all Health Plan members. Providers are not required to see patients covered by programs in which they do not participate, but, when they do, the agreement applies. When a provider sees any of the Health Plan’s members and benefits are payable, it is expected that the provider will accept direct payment from the Health Plan under the agreement. For example, if a Utica provider renders services to a patient covered by a product offered in Rochester, the Utica provider will accept the same fees that he or she accepts from the Health Plan for a similar product offered in Utica.

- **Term.** The term of a provider’s participation in the Health Plan is specified in his/her participation agreement. In a standard participation agreement, the agreement is designed to remain in effect until such time that either the Health Plan or the provider intentionally terminates the agreement under the provisions outlined in the agreement. (Written notice is required.)
- **Liability Insurance.** As required by the Health Plan, a provider shall maintain, at his/her cost and expense, policies of comprehensive general liability insurance and medical professional liability insurance as specified in the participation agreement.

- **PCPs.** For members with contract benefits requiring the oversight of a primary care physician (PCP), the PCP shall make all necessary arrangements with other participating providers to provide covered services to members.

- **Coverage.** A primary care physician or specialist participating in managed care networks or in plans with managed care features shall provide or arrange covered services by a physician 24 hours a day, seven days per week.

- **Participation in UM, QM, and Other Health Plan Processes.** Providers shall, as applicable, cooperate in utilization management, quality management, credentialing and member grievance processes, and in clinical encounter data collection programs related to these processes.

- **Records Retention.** Providers shall maintain medical, financial and administrative records concerning services provided to members and shall retain those records for six years or for a period consistent with requirements of federal or state rule or regulation, whichever is longer. Medical records of enrollees shall be retained for six years after the date services were rendered to enrollees, and, in the case of a minor, for six years after the age of majority.

- **Medical Record Standards.** A provider shall maintain adequate medical records in a format that is easily retrievable; that conforms with all federal, state and local laws, rules and regulations applicable to medical records; and that meets Health Plan documentation standards for all covered services rendered to members. (Health Plan medical record documentation standards are included in Section 2 of this manual.) The provider shall maintain the confidentiality of such medical records as required by state and federal statutes and regulations. The provider shall also obtain authorization from a member to release confidential health and financial data as required for the purpose of providing timely, quality care and appropriate reimbursement.

- **No Charge for Release of Medical Records.** Providers shall release members’ medical records at no cost to the Health Plan and, pursuant to Health Department regulations, to the New York State Department of Health. The Health Plan’s policy is to be judicious in any such requests for medical records.

- **Open Communication.** Physicians may communicate openly with members or with the Health Plan regarding any treatment alternatives that the physician believes are appropriate or medically necessary, regardless of benefit coverage limitations.

- **Timely Submission of Itemized Claims.** A participating provider shall submit claims for services within the timeframe stipulated in his/her participation agreement.
- **Reciprocity with other BlueCross BlueShield Plans.** Provider agrees to accept and treat members of other plans affiliated with the BlueCross BlueShield Association who seek treatment outside their service area, provided their plans participate in reciprocity programs. Provider shall also agree to bill the Health Plan, accept the Health Plan’s rate of reimbursement as payment in full, and collect from the member any copayment, coinsurance, permitted deductibles or member penalties applicable under the member’s health benefit program. This includes members from other regions of the Health Plan.

- **Non-Discrimination.** The provider agrees to accept member patients without regard to an individual patient’s health history or current type of illness or condition, and without discrimination against members on the basis of source of payment, gender, age, race, color creed, sexual orientation, religion, marital status, place or origin, economic status, state or federal entitlement program status, medical diagnosis or disability. Provider may reserve the right to not accept as a patient any person with whom the provider believes a satisfactory provider-patient relationship cannot be established, or if the patient’s medical care is beyond the scope of the provider’s license or practice. Providers are not required to see patients covered by programs in which they do not participate.

- **Regulatory Clauses.** Provider acknowledges that New York regulatory contracting guidelines require the Health Plan to incorporate New York State Department of Health (NYSDOH) Standard Clauses in provider participation agreements, and that such clauses are incorporated in all Health Plan provider participation agreements as applicable. These Standard Clauses are maintained by the NYSDOH on the NYSDOH Web site. Printed copies of these clauses are available from the Health Plan. If there are any inconsistencies between the Standard Clauses and the terms and provisions of the agreement, the provisions in the Standard Clauses will control as applicable. In addition, the provider agreements also incorporate certain contractual clauses supporting the federal Medicare Advantage programs as applicable.

- **HIV Confidentiality.** Providers must comply with the HIV confidentiality provisions of the New York State Public Health Law.

### 3.2 Credentialing and Recredentialing

This section provides summarizes of the Health Plan’s credentialing and recredentialing policies. Copies of the complete policies are available upon request from Provider Service. (For Health Plan phone numbers and addresses, see the Contact List in Section 2 of this manual.)

#### 3.2.1 Overview

Providers who participate in the Health Plan’s managed care programs, including Medicare Advantage programs, must meet the Health Plan’s credentialing requirements. The Health Plan credentials primary care physicians, most specialty physicians, certain allied health professionals and specific types of facilities.
The Health Plan does not currently credential the following specialty physicians:

- Anesthesiologists who provide only basic anesthesia services. (Anesthesiologists who provide pain management services must be credentialed: see Section 3.2).
- Emergency Room (ER) physicians
- Hospitalists
- Pathologists

At the time of this writing, the process of applying for credentialing or recredentialing with the Health Plan differs depending on the type of provider. All must complete a credentialing application. For many, this is a paper form received from the Provider Relations Representative or the Credentialing Department. Physicians, Podiatrists and Chiropractors use either a paper or electronic form submitted to a national credentialing organization. (See Section 3.2.2.)

The Health Plan is responsible for assuring the provision of accessible, cost-efficient, quality care to its members. To that end, the Health Plan’s Credentialing Committee reviews the credentials of all providers who apply for participation in managed care provider networks. The Credentialing Committee is composed of community providers, a medical director, and other such members as the Health Plan may appoint who, as a peer group, make decisions or recommendations to the governing body.

**Note:** The Health Plan will not credential a trainee who does not maintain a separate practice from his/her training practice. Nor does the Health Plan credential providers practicing on a limited permit. The Health Plan may not accept for credentialing a provider who practices exclusively within an inpatient setting or freestanding facility, and who supplies health care services to a Health Plan member only as a result of the member being admitted to the facility.

The Health Plan makes credentialing decisions without regard to the applicant’s race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or types of patients in whom the provider specializes. The Health Plan does not discriminate against providers who serve high-risk populations or who specialize in treating costly conditions.

**Note:** The Health Plan reserves the right to disapprove credentials in accordance with federal and state law and regulation.

The applicant has the burden of providing complete information sufficiently detailed for the Credentialing Committee to act. An applicant has the right upon request to be informed of the status of his/her application. The method of communication used by the applicant will determine the method of response (e.g., a phone inquiry will receive a phone response, a letter inquiry will receive a response by letter).

A provider may not serve members of the Health Plan’s managed care programs until the Credentialing Committee notifies him/her of the Health Plan’s approval. Until he/she has received
such an approval in writing, a provider is not a member of the managed care network. Providers are recredentialed at least every three years.

**Provider’s Right to Review Credentialing Information**

A provider has the right to review certain information the Health Plan uses when credentialing him or her. The information available for review is that obtained from primary source organizations such as the National Practitioner Data Bank, state licensing boards, medical professional insurance carriers and hospitals. Any provider wishing to review his/her personal information obtained from these primary sources must submit a signed (original signature of requestor), written request to the Credentialing Department. (For Health Plan phone numbers and addresses, see the Contact List in Section 2 of this manual.)

The provider has the right to correct erroneous information submitted by another party. The provider must notify Credentialing Staff in writing within 30 days of discovering the erroneous information. The Health Plan will include the explanation and/or correction as part of the provider's application when it is presented to the Credentials Committee for review and recommendation.

### 3.2.2. Credentialing and Recredentialing for Physicians, Chiropractors and Podiatrists

**Overview**

The Health Plan participates in a Web-based system that providers use to submit credentialing and recredentialing information. The system incorporates a nationwide universal credentialing application offered through the Council for Affordable Healthcare (CAQH). Called the Universal Credentialing DataSource, the system enables a provider to complete his/her credentialing application online, store the information in a database he/she controls and can update, and authorize participating health plans to read the data. As of this writing, the Health Plan is using the system to obtain credentialing and recredentialing information of physicians, podiatrists and chiropractors.

**Note:** For more information about the CAQH system, contact CAQH, Provider Service or Provider Relations. (For Health Plan phone numbers and addresses, see the Contact List in Section 2.)

Among the requirements of the credentialing process, physicians, chiropractors and podiatrists must:

- Maintain a practice within the Health Plan’s service area.
- Demonstrate attainment of the Health Plan’s specialty-specific requirements, including copies of all applicable certificates regarding training, licensure, specialty certification and medical professional liability insurance.
- Possess and maintain at all times medical professional liability insurance in amounts specified by the Health Plan. The provider must have a certificate of medical professional liability insurance that names the provider, documents the limits of liability and specifies the effective date and the
expiration date. The Health Plan may act immediately when it learns of a lapsed or expired certificate.

- Possess and maintain at all times a valid state license and current registration. The Health Plan may act immediately when it learns of a lapsed or expired registration.
- Possess and maintain at all times a valid Drug Enforcement Agency (DEA) Certificate, if applicable to the provider’s specialty. The Health Plan may act immediately when it learns of a lapsed or expired DEA certificate.
- Be a member in good standing with a Health Plan-affiliated Article 28 or Article 40 facility, if applicable. Exemptions to this requirement may be available upon request. All providers are required, by contract, to notify the Health Plan of any changes in their hospital privileges.
- Authorize release of information.
- Provide and update on an ongoing basis historical information regarding: physical or mental capacity impairments; criminal charges or convictions; loss, limitation or restriction of license; loss or limitation of DEA certification; loss or limitation of privileges in a hospital, facility, or managed care organization; professional disciplinary actions; or medical professional liability claims, among other information.
- Permit a site review of his/her office, if requested. (See the Office Site Review paragraph in Section 2.)
- Provide 24-hour coverage. Primary care physicians and specialists must provide continuous care of their patients through on-call coverage arrangements with other participating credentialed providers. (See the After-Hours Care paragraph in Section 2.)

**Physician, Podiatrist and Chiropractor Credentialing**

1. When a physician, podiatrist or chiropractor contacts the Health Plan’s Provider Relations Department with a request to participate with the Health Plan, if participation is to include the managed care network, the Health Plan will send the provider a Provider Information Form (for a sample, see Section 3.10), which the provider must complete and fax or mail to Provider Relations. The address and fax number are included on the form. (For Health Plan contact information, see the Contact List in Section 2.)

2. After processing the Provider Information Form, the Health Plan will send the provider a letter with his/her CAQH ID number and the address of the CAQH Web site where he/she must start the application process. The letter also will explain that CAQH will soon be mailing the physician a welcome kit.

The Health Plan then will forward the provider’s name to CAQH. This service is provided at no cost to the provider.
3. The provider should receive the CAQH welcome packet within 10 days after receiving the letter from the Health Plan. If the provider has not received the packet in that time, he/she should call CAQH at the number listed on the Contact List (Section 2).

4. The CAQH welcome kit will include detailed instructions for creating an electronic application on the CAQH Web site. The kit will also include information about how to request and submit a paper application.

5. Once the application is approved, the provider's information will be available online through the Universal Credentialing DataSource.
   a. If the provider seeks to participate with another health plan that participates with the CAQH system, the provider may authorize that plan to view his/her information, thus eliminating the need to complete another credentialing application.
   b. Quarterly, CAQH will ask the provider to update his/her information as necessary. A provider may also contact CAQH to update the information at any time. Providers must continue to notify the Health Plan directly in writing of changes to information, such as remit address, tax ID, etc. to keep claims processing systems accurate. This is done using the Provider Information Update Form, available on the Web site or by calling Provider Service. (See Section 2 of this manual for a sample form.)

**Physician, Podiatrist and Chiropractor Recredentialing**

The Health Plan may recredential providers at any time, but in no circumstances less frequently than every three years. When a provider is due for recredentialing, the Health Plan will send him or her an information packet explaining what the provider must do to be eligible for recredentialing. The packet will include:

- Detailed instructions for updating information on CAQH
- A form on which to report Continuing Education Credits. Each physician must submit 50 Clinical Category One credit hours per year, annualized, to coincide with the recredentialing date. For the number of continuing credit hours required for other providers, contact the Credentialing Department. (See the Contact List in Section 2.)

**3.2.3 Credentialing and Recredentialing of other Non-Physician Providers**

This section provides a brief overview of the credentialing and recredentialing processes the Health Plan uses for the providers specified below. For more information—including specialty-specific requirements—call the Credentialing Department. (For Health Plan phone numbers and addresses, see the Contact List in Section 2.)
This overview applies to all non-physician health care providers (except chiropractors and podiatrists) for whom the Health Plan, for its managed care products, has credentialing responsibilities, including:

- acupuncturists
- audiologists
- certified diabetic educators
- certified social workers
- enterostomal therapy practitioners
- nurse midwives
- occupational therapists
- optometrists
- oral maxillofacial surgeons
- physical therapists
- psychologists
- speech and language therapists

**Credentialing Non-Physician Providers**

As a first step in becoming a participating provider in the Health Plan’s managed care network, each type of provider listed above must contact the Health Plan to indicate intention to join the network. The Provider Relations Representative will send the provider a letter and a *Managed Care Organization Credentials Application*, required to begin the credentialing process.

Among the requirements of the credentialing process, the providers listed above must:

- Maintain a practice within the Health Plan’s service area.
- Submit the completed application, and all its attachments, waivers and releases updated by the applicant within 90 days of Health Plan receipt.
- Submit copies of all documents listed in the letter from the Provider Relations Representative, including certificates demonstrating the completion of training, degree and specialty certification to meet the current, minimum requirements as defined by the provider’s specialty board.
- Possess and maintain at all times medical professional liability insurance in amounts specified by the Health Plan. The provider must submit a certificate of medical professional liability insurance that names the provider, documents the limits of liability and specifies the effective date and the expiration date. The Health Plan may act immediately when it learns of a lapsed or expired certificate.
- Possess and maintain at all times a valid state license and current registration. The Health Plan may act immediately when it learns of a lapsed or expired registration.
- Possess and maintain at all times a valid Drug Enforcement Agency (DEA) Certificate if applicable to the provider’s specialty. The Health Plan may act immediately when it learns of a lapsed or expired DEA certificate.
- Be a member in good standing with a Health Plan-affiliated Article 28 or Article 40 facility, if applicable. Exemptions to this requirement may be available upon request. All providers are required, by contract, to notify the Health Plan of any changes in their hospital privileges.

- Sign an authorization to release information (part of the application form).

- Complete a Confidential Information Questionnaire (part of the application form). The questionnaire asks for historical information regarding physical or mental capacity impairments; criminal charges or convictions; loss, limitation or restriction of license; loss or limitation of DEA certification; loss or limitation of privileges in a hospital, facility, or managed care organization; professional disciplinary actions; or medical professional liability claims, among other information. Providers also must update this information on an ongoing basis.

- Permit a site review of his/her office, if requested. See Section 2.5.1.

- Behavioral health providers must offer “live” on-call coverage 24 hours a day, seven days a week to answer emergency calls (see Section 2.5.7).

**Recredentialing Non-Physician Providers**

The Health Plan may recredential providers at any time, but in no circumstances less frequently than every three years. At least five months before a non-physician provider is due for recredentialing, the Health Plan will send him or her an information packet explaining what the provider must do to be eligible for recredentialing.

Among the requirements for recredentialing, a non-physician provider must:

- Submit a completed Recredentialing Application Form, provided and approved by the Health Plan, and all its attachments, waivers and releases updated by the applicant within 90 days of Health Plan receipt.

- Submit copies of all certificates demonstrating the completion of training, degree and specialty certification to meet the current, minimum requirements as defined by the provider's specialty board.

- Possess and maintain at all times medical professional liability insurance in amounts specified by the Health Plan. The provider must submit a certificate of medical professional liability insurance that names the provider, documents the limits of liability and specifies the effective date and the expiration date. The Health Plan may act immediately when it learns of a lapsed or expired certificate.

- Possess and maintain at all times a valid state license and current registration. The Health Plan may act immediately when it learns of a lapsed or expired registration.

- Possess and maintain at all times a valid Drug Enforcement Agency (DEA) Certificate, if applicable to the provider’s specialty. The Health Plan may act immediately when it learns of a lapsed or expired DEA certificate.
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- Be a member in good standing with a Health Plan-affiliated Article 28 or Article 40 facility, if applicable. Exemptions to this requirement may be available upon request. All providers are required, by contract, to notify the Health Plan of any changes in their hospital privileges.

- Sign an authorization to release information.

- Complete a Confidential Information Questionnaire. A provider must certify his/her history since the last recredential date of pending and/or resolved issues such as physical or mental capacity impairments; criminal charges or convictions; loss, limitation or restriction of license; loss or limitation of DEA certification; loss or limitation of privileges in a hospital, facility, or managed care organization; professional disciplinary actions; and medical professional liability insurance claims, among other information. Providers also must update this information on an ongoing basis.

- Permit a site review of his/her office, if requested. See Section 2.5.1.

- Behavioral health providers must offer “live” on-call coverage 24 hours a day, seven days a week to answer emergency calls (see Section 2.5.7).

- As required, submit continuing education credit hours per year, to coincide with the recredentialing date. For the number of continuing credit hours required for a given specialty, contact the Credentialing Department. (See the Contact List in Section 2.)

3.2.4 Credentialing and Recredentialing Facilities

This section provides a brief overview of the Health Plan's facility credentialing process. For more information, call the Credentialing Department. (See the Contact List in Section 2.)

The Health Plan is committed to providing quality care and services to its members. To help support this goal, the Health Plan credentials and recredentials health delivery organizations with which it contracts. Health delivery organizations (hospitals, surgicenters, skilled nursing facilities, home health agencies and behavioral health facilities) requesting participation in the Health Plan shall be required to meet established credentialing criteria based on service type. The Health Plan will not contract with health delivery organizations that do not meet the criteria for that provider type. Health Plan staff will review health delivery organizations at least every three years. The Health Plan will credential only licensed, regulated facilities.

Each health delivery organization must meet the criteria listed below. In situations where an organization does not meet the criteria, the Health Plan may reconsider the organization for participation following an on-site review.

A. Acute General Hospitals. Must provide inpatient, outpatient and emergency services and must have:
   a. Operating License and Certificate.
   b. Accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).
   c. Medicare Certification as issued by the Centers for Medicare & Medicaid Services (CMS).
   d. Medicaid Certification as issued by the Department of Health, Education and Welfare.
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e. Certification from the Office of Mental Health for Acute Care General Hospitals with Mental Health Services.

f. Certificate of Insurance: general and medical professional liability insurance in amounts specified by the Health Plan.

B. Home Health Agencies, including Certified Home Health Agencies and Licensed Home Health Agencies. At a minimum, an agency must make available the services of registered and licensed practical nurses, certified home health aides, as well as occupational, physical and speech therapists. The agency also must have:

a. Operating License and Certificate.
b. Medicare and/or Medicaid Certification.
c. JCAHO Accreditation: Organizations not accredited are requested to submit their most recent Department of Health Survey.
d. Certificate of Insurance: general and medical professional liability insurance in amounts specified by the Health Plan. (Exceptions to limits may be approved by the Health Plan’s Corporate Risk Manager on a case-by-case basis.)

C. Skilled Nursing Facilities. Must provide discharge planning services; nursing supervision and services by registered or licensed practical nurses, nurses’ aides and occupational, physical and speech therapists; routine medical supplies; and semi-private room and board. At minimum, the facility must have:

a. Operating License and Certificate.
b. Medicare and Medicaid Certification.
c. Accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Continuing Care Accreditation Commission (CCAC). Organizations that are not accredited are requested to submit their most recent Department of Health Survey.
d. Certificate of Insurance: general and medical professional liability insurance in amounts specified by the Health Plan. (Exceptions to limits may be approved by the Health Plan’s Corporate Risk Manager on a case-by-case basis.)

D. Free-Standing Surgicenters/Ambulatory Care Organizations. At a minimum, the facility must have:

a. Operating License and Certificate.
b. Medicare and Medicaid Certification.
c. Accreditation from a recognized accrediting body [e.g., JCAHO or the Accreditation Association for Ambulatory Health Care (AAAHC)].
d. Certificate of Insurance: general and medical professional liability insurance in amounts specified by the Health Plan.

E. Chemical Dependency Treatment Centers. Must provide evaluation, intensive outpatient treatment and be medically supervised by a participating physician. At a minimum, the facility must have:
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- Operating License and Certificate.
- Certification from NYS Office of Alcoholism and Substance Abuse Services (OASAS).
- Certificate of Insurance: general and medical professional liability insurance in amounts specified by the Health Plan. (Exceptions to limits may be approved by the Health Plan’s Corporate Risk Manager on a case-by-case basis.)
- Medical Director must be (re)credentialed and participate with the Health Plan.
- List of qualified individuals providing services and a statement of their credentials.

F. **Community Mental Health Centers.** Must provide evaluation, short-term treatment, and medical management services. At a minimum, the facility must have:
- Operating License and Certificate.
- Medicare and Medicaid Certification.
- Certificate of Insurance: general and medical professional liability insurance in amounts specified by the Health Plan. (Exceptions to limits may be approved by the Health Plan’s Corporate Risk Manager on a case-by-case basis.)
- Medical Director must be (re)credentialed and participate with the Health Plan.
- List of qualified individuals providing services and stated credentials.

G. **Inpatient Substance Abuse Facilities.** At a minimum, the facility must have:
- Operating License and Certificate.
- Medicare and Medicaid certification.
- Certification from NYS Office of Alcoholism and Substance Abuse Services (OASAS).
- Certificate of Insurance: general and medical professional liability insurance in amounts specified by the Health Plan.
- JCAHO Accreditation.

H. **Inpatient Mental Health Facilities.** At a minimum, the facility must have:
- Operating License and Certificate.
- Medicare and Medicaid Certification.
- Certificate of Insurance: general and medical professional liability insurance in amounts specified by the Health Plan.
- JCAHO Accreditation.
- Certification from Office of Mental Health (OMH).

The Health Plan will conduct an on-site review if the above criteria are not met. On-site reviewers will verify that the organization:
- Has a current, active Quality Management Program
- Has a current, active Policy and Procedure Manual
- Holds Quality Management meetings appropriate to the organization
- Has indicators in place to address the measurement, action and frequency of reports/monitoring
- Monitors/reports member complaints and takes appropriate action
- Performs outcome studies
- Demonstrates that the individual member’s plan of care corresponds to that prescribed by the member’s physician

The Health Plan also conducts an interview with the organization’s Director of Quality Program at the time of the on-site visit.

### 3.2.5 Provider Profiling

As part of the recredentialing process, provider profiling involves collecting and reporting information about provider performance on a variety of measures. The Health Plan develops profiles for physicians and, for other providers, groups or individuals at its discretion.

**Note:** Evaluations or initiatives that involve provider profiling comply with requirements of the provider profiling statute set forth in the New York State Public Health Law, Section 4406-d(4).

The information reported in the profile assists with recredentialing decisions and with identifying opportunities for improvement. The measures reported may include but are not limited to member satisfaction, clinical quality concern review, complaint review, medical record review, and use of preventive health services.

Data related to individual measures is collected by the Health Plan and reported at various intervals. The following measures are included:

- **Member Satisfaction Survey.** A periodic survey of member satisfaction with PCPs and specialists. The appropriate quality committee determines an acceptable overall satisfaction score.

- **Clinical Care Concerns.** The Health Plan records concerns about the quality of clinical care and coordinates case reviews. A Medical Director reviews individual concerns as they are received and when patterns and trends are identified. The Medical Director determines when additional review and/or action are required.

- **Member Complaints.** Health Plan staff record member complaints received by phone or in writing. Complaints are categorized as they are received and the data analyzed and reported quarterly. The Medical Director may take action based on annual review of provider complaints or upon identification of patterns or trends.

- **Medical Record Reviews.** The Health Plan conducts Medical Record Reviews for PCPs with 50 or more members and other high-volume specialists. Medical record reviews are done on a rolling schedule based on recredentialing date, and additional reviews are performed as necessary. Scores are calculated and reported as reviews are finished. The minimum acceptable score and the acceptable range are determined every year by the appropriate quality committee. (For information about the Health Plan’s medical record documentation standards, see Section 2.6.1.)
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- **Mammography Rates.** Each quarter, the Health Plan assesses the mammography rates for PCPs' female patients in all member populations aged 50 to 69 years. Minimum acceptable rate, low acceptable range, and commendable rates are determined each year by the appropriate quality committee.

For more detailed information about provider profiles, contact Provider Service. (See the Contact List in Section 2.)

### 3.2.6 Credentialing Locum Tenens

A *locum tenens* is a health care professional who temporarily covers for a participating physician to accommodate the physician’s leave of absence, vacation, or emergency situation. A *locum tenens* health care professional:

- Has privileges limited in time and/or location,
- Is not listed in the provider directory and
- May not be selected by a member as his/her primary care physician.

In the event a credentialed physician arranges for a *locum tenens* to cover his/her practice (for various reasons), the Health Plan has adopted this policy so that all physicians who treat the Health Plan members have been credentialed by the Health Plan. A *locum tenens* may provide care only for the timeframe approved by the Health Plan.

1. A *locum tenens* is approved for a maximum of six months, with one six-month renewal for a maximum of 12 months. A physician who plans to remain as a *locum tenens* for longer than one year must apply for full approval as any other applicant. For a planned leave of absence or vacation, the Health Plan must receive the application for a *locum tenens* 60 days in advance of the requested start date. The *locum tenens* must be board certified in the same or comparable specialty as the provider he/she is replacing and demonstrate current competence to care for Health Plan patients.

2. Each *locum tenens* physician must provide:
   - Completed Credentials Application
   - Evidence of unrestricted NYS license and signed registration certificate
   - DEA Certificate, if applicable
   - Medical Professional Liability Insurance Certificate in accordance with current standards
   - Verification of the *locum tenens* physician’s participating hospital privileges or a letter from a participating physician that states he/she will admit patients of the *locum tenens*
   - Letter from the participating physician for whom the *locum tenens* has been retained, stating the reason for the physician’s leave and his/her intended date of return
   - Confidential Information Questionnaire
   - Authorization for release of information
   - Training and/or Board Certificates
The Health Plan Credentialing Staff will verify the sources of the information the *locum tenens* provides and make an inquiry to the National Provider Data Bank as applicable.

3. The Health Plan may not require the *locum tenens* to attend a New Provider Orientation session. However, Provider Relations staff may provide an overview of the organization.

The *locum tenens* will not have to undergo a site visit, unless he/she is practicing at an office that has never had a site visit. The practice of the *locum tenens* will be limited to the site of employment.

For emergency situations, a Health Plan Medical Director and/or the applicable delivery system Medical Director will make a decision on credentialing status. If the Medical Director has concerns with the *locum tenens* applicant, the Medical Director may address the concerns and/or present them to the Credentialing Committee.

4. The Health Plan Staff will notify the *locum tenens*, the participating physician and the delivery system(s) of the credentialing decision.

### 3.3 About Physician Extenders (NPs and PAs)

With the exception of a few pilot programs involving nurse practitioners (NPs) who are not employed by physician practices, as of this writing, Excellus BlueCross BlueShield, Central New York, CNY Southern Tier and Utica Regions, does not currently have participation agreements with most nurse practitioners (NPs or physician assistant (PAs) as participating providers, although they may be employed by and provide services as employees of participating providers.

### 3.4 Rendering Provider ID Number

The Health Plan assigns a unique Rendering Provider ID number (RPI) to each individual practitioner. The term “rendering provider” means the individual actually providing the service. The rendering provider number must be included on professional claims for all lines of business. (See Section 8 of this manual for information on billing.)

### 3.5 Provider Support

#### 3.5.1 Provider Service

The Health Plan encourages providers to call the Provider Service Department first whenever they have questions. Provider Service telephone and fax numbers are listed on the *Contact List* in Section 2.) Representatives are available Monday through Thursday, 8:00 a.m. to 5:00 p.m., and Friday, 9:00 a.m. to 5:00 p.m.
Provider Service representatives can answer most questions a provider might ask and, in situations where they can’t provide an answer, they will direct a provider to the appropriate department. Call Provider Service to inquire about:

- Provider ID numbers
- Medical Policies
- Member eligibility and benefits
- Copayment and coinsurance information
- Referral and preauthorization status
- Fee schedules
- Claim status
- Request for claims adjustment
- Request for appeal
- Coordination of Benefits (COB)
- Health Plan printed materials such as provider bulletins, provider newsletter or provider manual
- Any other provider-related issue

### 3.5.2 Provider Relations

Provider Relations Representatives are liaisons between provider offices and the Health Plan. The Health Plan assigns a Provider Relations Representative to each provider based on geographical territory. The name and telephone number of the assigned Provider Relations representative is included in the letter each provider receives welcoming him/her to the network of participating providers and informing the provider of his/her Rendering Provider ID number.

There is a list of Provider Relations Representatives and their respective geographical territories included in the contact information in Section 2 of this manual. This list is provided for reference and is subject to change.

Provider Relations representatives:

- Facilitate establishing contracts with individual providers
- Hold orientation sessions for participating providers and staff
- Educate providers on Health Plan policies and protocol
- Answer provider inquiries regarding provider participation agreements, reimbursement, incentive programs, etc.
- Assist providers with other complex problems or concerns
- Train office staff on use of available electronic tools
- Visit provider sites
- Host provider seminars

### 3.5.3 Provider Satisfaction Surveys

The Health Plan conducts hospital, physician and provider office manager satisfaction surveys at least annually. The surveys assess satisfaction with the Health Plan and are used to identify opportunities to improve Health Plan services to the provider community and to members. The Health Plan develops action plans based on survey results, and assesses these plans to determine effectiveness.

### 3.6 Provider Decredentialing, Termination, Non-Renewal and Suspension

This Health Plan credentials policy regarding decredentialing, termination, non-renewal, and suspension of providers is designed to supply providers with all notice and hearing rights afforded by the New York State Public Health Law, the New York State Insurance Law, and the federal Health Care Quality Improvement Act. In cases where a provider has a participation agreement with the Health Plan, to the extent that the agreement contains any additional rights with respect to terminations, suspensions, or non-renewals not set forth in the policy, such additional rights shall apply to the extent they are not contrary to applicable law.

#### 3.6.1 Cases Involving Imminent Harm to Members

Where the Health Plan Medical Director or his/her designee determines, at his or her sole discretion, that permitting a provider to continue to provide patient care services to members poses a risk of imminent harm to members, the Health Plan shall:

- Immediately suspend the provider's right to provide patient care services to members, and subsequently afford the provider the hearing procedures set forth in Section 3.6.5. A provider's status as participating shall remain suspended until the conclusion of the hearing procedure and the provider is either reinstated, reinstated with conditions, or terminated/decredentialing.

OR

- Immediately terminate the provider's participation agreement and/or revoke the provider's credentials, as applicable, without affording the provider the hearing procedures described in Section 3.6.5.
3.6.2 Cases Involving Fraud (as defined by the state in which the provider is licensed)

In cases involving fraud, where the Health Plan Medical Director or his/her designee determines, at his or her sole discretion, that permitting a provider to continue to provide patient care services to members poses a risk of imminent harm to members, the Health Plan shall proceed as in Section 3.6.1.

Where the Health Plan determines, at its sole discretion, that the fraudulent conduct does not pose a risk of imminent harm to members and that no determination of fraud has occurred, the Health Plan may recommend termination of the provider’s participation agreement or revocation of the provider’s credentials, as applicable, by referral to the Credentials Committee. If the Credentials Committee terminates/decredentials a provider, the Health Plan shall afford the provider the hearing procedure set forth in Section 3.6.5.

When a criminal conviction has occurred, the Health Plan will terminate the provider’s participation agreement or revoke provider’s credentials, as applicable. The Health Plan shall afford the provider the hearing procedures set forth in Section 3.6.5 unless the state suspends or revokes licensure. In that case, the Health Plan immediately will terminate the provider’s participation agreement and/or will revoke the provider’s credentials without affording the provider the hearing procedures.

3.6.3 Cases Involving Final Disciplinary Actions by State Licensing Boards or Other Governmental Agencies

Where a final disciplinary action has been rendered by any state licensing board or other governmental agency that restricts the provider’s ability to practice, the Health Plan shall proceed in accordance with one of the following, as applicable:

- Where the Health Plan determines, at its sole discretion, that the conduct of provider that resulted in the applicable disciplinary action poses a risk of imminent harm to members, the Health Plan shall proceed in accordance with Section 3.6.1.

OR

- Where the Health Plan determines, at its sole discretion, that the conduct that resulted in the applicable disciplinary action does not pose a risk of imminent harm to members, and did not result in a determination of fraud, the Health Plan may terminate the provider’s participation agreement and/or revoke the provider’s credentials, as applicable. In such cases, the Health Plan shall afford provider the hearing procedures set forth in Section 3.6.5.
3.6.4 Termination for Other Reasons

Where the Health Plan proposes to terminate a provider’s participation agreement or revoke a provider’s credentials, as applicable, for any reason other than those set forth in the previous sections (e.g., failure to comply with the Health Plan’s utilization management or quality management policies and procedures, failure to satisfy the Health Plan’s credentialing/peer review/quality review standards), the Health Plan shall afford the provider the hearing procedures set forth in Section 3.6.5.

Before any such termination, suspension or non-renewal may occur, the Health Plan may implement an action or range of actions including but not limited to: corrective action plans with monitoring as recommended by Quality Management; conditional, time-limited credentialing as approved by the Credentials Committee; required continuing medical education; or mentoring by an appropriate peer.

3.6.5 Notice and Hearing Procedures

Any hearing afforded a provider pursuant to this Policy shall be conducted in accordance with the following:

Notices

The Health Plan will send a provider a written notice of any proposed termination/decredentialing. The written notice of proposed termination/decredentialing shall be personally delivered - or mailed by U.S. mail with return receipt requested - to the provider. The notice shall include:

1. A written explanation of the reasons for the proposed termination.
2. Notice that the provider has the right to request a hearing before a hearing panel appointed by the Health Plan.
3. A summary of the provider’s rights at the hearing.
4. A time limit of no less than 30 days or more than 45 days within which to submit a written request for a hearing.
5. A time limit for a hearing date which must be held in not less than 30 days or more than 60 days after the date of receipt of a request for a hearing.

Hearing Requests

1. Any request for a hearing must be in writing, and be personally delivered or mailed by U.S. mail with return receipt requested, to the Medical Director.
2. The provider is entitled to only one hearing.
3. If the provider does not request a hearing in compliance with these rules, a proposed termination will be final, and the provider will have waived any right to a hearing or review under any applicable law.

**Notice of Hearing**

1. If the provider submits a written request for a hearing in compliance with these rules, the Health Plan shall give the provider a “Notice of Hearing”, which shall be in writing and shall state the place, time and date of the hearing, which date shall be not less than 30 days or more than 60 days after the date of receipt of the hearing request. The Notice of Hearing shall be personally delivered—or mailed by U.S. mail with return receipt requested—to the provider.

2. The Notice of Hearing shall also state a list of the witnesses, if any, expected to testify at the hearing against the provider and that the right to a hearing will be forfeited if the provider fails to appear at the hearing without good cause. The provider shall also provide a list of witnesses and representatives to the Health Plan no less than three days prior to the scheduled hearing.

**Conduct of the Hearing**

1. If the provider submits a written request for a hearing in compliance with these rules, the Health Plan will appoint a hearing panel composed of three persons as follows: one clinical peer in the discipline and in the same or similar specialty as the provider under review and two other persons appointed by the Health Plan. The hearing panel may consist of more than three persons provided that the number of clinical peers on the panel shall constitute one-third or more of the total membership of the panel.

   **Note:** For providers who participate in Medicare Advantage products, the hearing panel must be composed of a minimum of three members, the majority of whom shall be clinical peers.

2. The provider may be represented at the hearing by an attorney or other representative of his/her choice.

3. The provider may submit a written statement to the hearing panel.

4. The hearing panel will issue its written decision in a timely manner, which shall include a statement of the basis for the decision. The decision may include reinstatement of the provider, provisional reinstatement of the provider subject to conditions set by the Health Plan, or termination of the provider.

5. A copy of the hearing panel’s written decision shall be personally delivered or mailed to the provider by U.S. mail with return receipt requested.
Effective Date of Termination

1. If the provider does not request a hearing, the contract termination will become effective 60 days from the date the provider received the original notice of intent to terminate/decredential (i.e., written notice of proposed contract termination/decredentialing).

2. If the provider requests a hearing, the contract termination/decredentialing will become effective 30 days after the date the provider receives written notice of the hearing panel’s decision, or 60 days after the date when the provider received the original notice of intent to terminate (i.e., written notice of proposed contract termination), whichever is later.

Reporting the Results of the Hearing

The decision of the hearing panel shall be reported to the Credentials Committee. The minutes of the Credentials Committee shall be reported to the Board of Directors.

3.6.6 14-Day Summary Suspensions to Conduct Investigations

The Health Plan Medical Director, upon receiving information that a provider has engaged in activities related to professional competence or professional conduct that may adversely affect the health or welfare of a member, may summarily suspend the appointment of the provider for a period not longer than 14 days during which an investigation will be conducted to determine the need for further action. The summary suspension shall be effective immediately upon notice to the provider.

If the Medical Director determines that, based upon the investigation, termination/decredentialing is warranted, the Health Plan shall proceed in accordance with sections 3.6.2, 3.6.3, and 3.6.4, as applicable.

3.6.7 Non-Renewal

Upon 60 days notice to the provider, or as otherwise set forth in a Health Plan provider participation agreement, the Health Plan may exercise a right of non-renewal at the expiration set forth in the participation agreement or at the expiration of the credentialing period, whichever is applicable. In cases where the participation agreement does not specify an expiration date, the Health Plan may exercise a right of non-renewal 60 days prior to January 1 of each year, provided that the agreement has been in effect for at least one year.

When a provider’s participation agreement or credentials are not renewed, the Health Plan shall afford provider the hearing procedures set forth in Section 3.6.5.
3.6.8 No Retaliatory Terminations/Non-Renewals

The Health Plan will not terminate or refuse to renew a participation agreement solely because the provider has: (a) advocated on behalf of an enrollee, (b) filed a complaint against the Health Plan, (c) appealed a decision of the Health Plan, (d) provided information or filed a report to an appropriate governmental body regarding the policies or practices of the Health Plan which provider believes may negatively impact upon the quality of, or access to, patient care, or (e) requested a hearing or review.

3.6.9 Reporting To Regulatory Agencies

To the extent required by all applicable state and federal laws and regulations, the Health Plan shall report terminations/decredentialings or suspensions for cause of greater than 30 days to the appropriate regulatory agency, including without limitation, the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, the New York State Department of Health’s Office of Professional Medical Conduct, and the New York State Department of Education’s Office of Professional Discipline.

The report must include the name, address, profession, and license number of the person being reported. The report shall also include a description of the action taken by the Health Plan with the specific reason for and date of the action. A Health Plan Medical Director will sign the report.

Causes for termination/revocation or suspension of greater than 30 days include but are not limited to:

- Termination of a provider for mental or physical impairment, misconduct, or impairment of patient safety
- Voluntary or involuntary termination to avoid imposition of disciplinary action
- Termination for a determination of fraud or imminent harm to patient care
- Information that reasonably appears to show a professional is guilty of misconduct

3.6.10 Transitional Care (Rev. for 1/1/06)

**Note:** The transitional care rights described in this section apply to patients of a provider who leaves a Health Plan network. However, they do not apply to patients of a provider who leaves a Health Plan network without a right to a hearing under the provisions of the New York State Managed Care Law.

Except for terminations/decredentialings effected in accordance with sections 3.6.2, 3.6.3, 3.6.4, above, the Health Plan shall permit a member to continue an ongoing course of treatment with a provider during a transitional period of (i) 90 days from the last day of the provider’s contractual obligation, or (ii) if the member has entered the second trimester of pregnancy at the time of the
provider’s disaffiliation, for a transitional period that includes the provision of post-partum care directly related to the delivery.

The Health Plan will authorize the transitional care described above only if the provider agrees to continue to accept the reimbursement rates in effect prior to the start of the transitional period as payment in full, and to comply with all of the Health Plan’s policies and procedures including, without limitation, quality management and utilization management programs.

3.7 Provider-Initiated Departure from the Health Plan

- Providers who elect to terminate their participation agreement with the Health Plan must follow the guidelines set forth in the participation agreement.
- Providers who plan to retire must notify the Health Plan within 60 days of the date they intend to stop seeing patients.
- Upon the death of a provider, his/her representative should notify the Health Plan as soon as possible.

Send the notification on office letterhead to the Health Plan. (For Health Plan phone numbers and addresses, see the Contact List in Section 2.)

3.7.1 Reentry into Health Plan following Resignation

Providers who no longer are credentialed by the Health Plan but who wish to be considered for reentry to the network of providers permitted to treat managed care Health Plan members must contact the Provider Relations Department to make that request. The Health Plan will consider readmittance based on established policy. Copies of this policy are available upon request from the Credentialing Department. (For Health Plan phone numbers and addresses, see the Contact List in Section 2.)

3.8 Notifying Members Following Provider Departure

3.8.1 Health Plan Responsibilities

Within 10 days after a provider acting as a primary care physician has disaffiliated with the Health Plan, the Health Plan will send a letter to managed care members under that provider’s care, to the extent that the Health Plan can ascertain that information. The letter shall inform the member of the date on which the provider’s contract was terminated and encourage the member to select a new provider.
3.8.2 Specialist Responsibilities

When an individual specialist physician or a specialty group terminates participation in the Health Plan, the specialist or specialty group must notify affected members of the termination prior to the effective date of the termination. (This notification is in addition to the notification to be made by the Health Plan, as explained in Section 3.8.1.)

In the event an individual specialist is terminated from a specialty group, the group must notify affected members prior to the effective date of the termination. “Termination” shall include termination of the agreement between us and the physician or group for any reason, or any other situation in which the physician or group is no longer available to see an affected member. “Affected members” refers to members enrolled in the Health Plan who are receiving ongoing treatment from the specialist physician or specialty group.

3.9 Provider Reimbursement

Reimbursement is based on arrangements the Health Plan has made with an individual provider, provider group or IPA. Specific reimbursement is determined from the member’s benefit package and the product lines in which the provider participates. Inquiries regarding the reimbursement terms of a provider’s participation agreement should be directed to Provider Relations. (See the Contact List in Section 2 of this manual.)

3.9.1 Fee Schedule

The Health Plan pays a participating provider for covered services provided to Health Plan members on the basis of a fee schedule pursuant to the terms and conditions of the provider’s participation agreement.

The Health Plan deducts copayments, coinsurance, and deductibles from the amount to be reimbursed, as applicable. These amounts are determined from the member’s benefit package, the product lines in which the provider participates, and the terms established in the provider’s participation agreement with the Health Plan.

3.10 Forms

These forms are reproduced on the following pages:
- Form: Provider Information Form
Provider Information Form

1) Provider Name: ____________________________________ Professional Title _________

2) Gender:  Male ☐  Female ☐  Date of Birth ____________________

3) Name of Group or Employer (if applicable): __________________________________________
   Tax ID #: __________________________ Effective date of group affiliation ________________

4) Provider’s License Number: __________________________________ State __________

5) What specialties do you practice? _________________________________________________

6) Board Certified  Yes ☐  No ☐  Name of Board: ______________________________________

7) Office Address: street address _________________________________________________
   city ____________________________________________________________
   state _____  zip code _________ county _________________________
   phone ______________________  fax _________________________
   Handicap accessible? ☐ Yes  ☐ No

Second Office Address: street address ________________________________________________
(if applicable)
   city ____________________________________________________________
   state _____  zip code _________ county _________________________
   phone ______________________  fax _________________________
   Handicap accessible? ☐ Yes  ☐ No

8) Billing address: street address _________________________________________________
   city ____________________________________________________________
   state _____  zip code _________ county _________________________
   phone ______________________

9) DEA # __________________ Medicare # __________________ Worker’s Comp # __________
3.0 Provider Information

Medicaid # ____________ Social Security # ____________ CLIA Cert # ____________

10) What languages other than English do you speak? _____________________________________

11) Hospital affiliations:

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<th>Hospital Name</th>
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12) Office Contact Person: Name ________________________________ Phone ______________

Signature of person completing form: _______________________________ Title ______________

Date __________________

PLEASE ATTACH W-9 FORM WITH THIS INFORMATION.

Please return this form by mail or fax to one of the following addresses/fax numbers:

For Utica, Watertown & VT areas
    Provider Relations
    12 Rhoads Drive
    Utica, NY 13502
    Fax Number: 315-731-2530

For Central NY, So. Tier & PA areas:
    Provider File Maintenance
    344 South Warren Street
    Syracuse, NY 13202
    Fax Number: 315-671-6781