

# Chapter 3. Credentialing and Re-credentialing

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## 3.1 Introduction

Mountain State credentials and regularly re-credentials providers participating in the Mountain State's 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.

Commercial PPO credentialing and re-credentialing standards, policies, and procedures are reviewed by two committees comprised of practicing Mountain State network physicians of various specialties who make recommendations to Mountain State regarding the adoption of provider credentialing standards. FreedomBlue® network credentialing standards, policies and procedures are reviewed by Highmark's Credentials Policy Committee, which includes two members of the Mountain State Credentials Committees. 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 or Highmark decline to include a given provider in their networks, the Plan(s) will furnish written notice to the affected provider of the reason for their decision.

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## 3.2 Types of Providers Credentialed

Mountain State currently credentials the following types of providers:

<b>Physicians</b>	<b>Facilities / Organizational Providers</b>	<b>Allied Health Practitioners</b>
Medical Doctors (MD)	Acute Care Hospitals	Audiologists
Doctors of Osteopathic Medicine (DO)	Ambulance Services	Clinical Social Workers
Oral and Maxillofacial Surgeons (DDS/DMD)	Ambulatory Surgical Centers	Counselors and Therapists
Podiatrists (DPM)	Behavioral Health Centers	Occupational Therapists
Chiropractors (DC)	Critical Access Hospitals	Optometrists
	Durable Medical Equipment (DME) Providers	Physical Therapists
	Federally Qualified Health Centers	Physician Assistants
	Hearing Aid Vendors	Psychologists
	Home Health Agencies	Registered Dietitians
	Home Infusion Therapy Providers	Registered Nurse Anesthetists
	Hospices	Registered Nurse Midwives
	Portable X-ray Suppliers	Registered Nurse Practitioners
	Psychiatric Hospitals	Speech Pathologists and Therapists
	Rehabilitation Hospitals	Acupuncturists
	Renal Dialysis Centers	Massage Therapists
	Laboratories	Certified Diabetic Educators
	Rural Health Clinics	
	Skilled Nursing Facilities	
	Specialty Hospitals	

### 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.

A listing of Mountain State's credentialing policies and selection criteria are posted on our website at [www.msbcbs.com](http://www.msbcbs.com). If you would like to obtain copies of policies or have any other questions, please call the Network Credentialing Department 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;
- Active Drug Enforcement Agency (“DEA”) certificate;
- 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;
- 24/7 member availability;
- Completion of required continuing education for non-board certified physicians.

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 (“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”) exam.

MDs and DOs must have completed at least one year of postgraduate training.

Oral surgeons 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 only 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.

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### **3.3.2 Facilities and Organizational Providers**

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

- Current state license (if required) or state business registration;
- Medicare or Medicaid participation for the commercial networks 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.\*\*

Laboratories must provide evidence of CLIA certification only.

\*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 many provider types, proof of an acceptable CMS on-site review or proof of Medicaid participation may be substituted for accreditation.

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### 3.3.3 Allied Health Practitioners

#### a. *General Criteria*

- Active license;
- For Registered Nurses and Physician Assistants active advanced practice certification by a recognized entity;
- 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;
- Written proof of Medicare eligibility for the FreedomBlue® network
- 24/7 member availability;
- For the FreedomBlue® network, cannot have opted out of the Medicare Part B program.

Physician assistants, 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.

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

### 3.3.4 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 Credentials Committees

Mountain State maintains two Credentials Committees, one in the northern part of the state (Weirton) and the other in the south-central region (Charleston). The voting members of the Credentials Committees are practicing physicians of various specialties who participate in Mountain State's networks.

Each 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 Health Services Department executive staff serve on the Committees as non-voting members.

A listing of current Mountain State Credentials Committee members is posted on the Mountain State website.

The Mountain State Credentials Committees' primary responsibilities are to:

- Approve or disapprove all credentialing/re-credentialing applications;
- Request additional information if needed to review an application;
- Review and make recommendations regarding credentialing policies and procedures;
- Impose 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 Mountain State Credentials Committees meet monthly and keep minutes of their proceedings. The Committees are formally-constituted peer review bodies, which meet 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.

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### 3.4.2 Network Credentialing Department

The Mountain State Network Credentialing Department and Highmark Provider Data Services Department perform day-to-day administration of the credentialing program and provide staff support for the Credentials Committees.

Practitioners should contact Highmark's Provider Data Services Department at 866-763-3224, if they have any questions regarding the status of their credentialing/re-credentialing applications.

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

Questions regarding the Mountain State credentialing program should be directed to the Network Credentialing Department.

<p>Mountain State Blue Cross Blue Shield          Network Credentialing Department          900 Pennsylvania Avenue          P.O. Box 1353          Charleston, WV 25325          Phone: 888-475-2391          Fax: (304) 347-7740</p>
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<p>Highmark's Provider Data Services Department          P.O. Box 898842          Camp Hill, PA 17001          Phone: 866-763-3224          Fax: 866-507-6567</p>
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### 3.4.3 Applications

To initiate the credentialing process, West Virginia physicians and allied health practitioners must complete the State of West Virginia *Uniform Credentialing Form* (application). Mountain State also accepts uniform credentialing applications from other states (i.e. Ohio, Maryland). The West Virginia uniform credentialing and re-credentialing forms are available on the West Virginia Insurance Commissioner's website at [www.wvinsurance.gov](http://www.wvinsurance.gov). All

initial credentialing applications for practitioners are to be returned to Highmark's Provider Data Services Department for primary source verification at the above address.

Presently, there is no formal application for facility and organizational providers. When the contracting process is initiated, Mountain State will send a letter or form detailing the types of credentialing information the provider must submit. Facility and organizational providers are to submit requested credentialing documentation to Mountain State's Office of Network Credentialing.

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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 malpractice information will be scored using criteria set forth in the Malpractice Scoring Policy and Procedure.

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### **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 application, upon written request to the Network Credentialing Department. A provider may submit additional or corrected information, prior to review by the Credentials Committee (or if requested by the Committee or Mountain State), if there is incomplete, inaccurate, or conflicting information in the file.

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### **3.4.6 On-site Reviews**

Mountain State performs office site and medical record documentation reviews for all initial, new and relocated PCPs, OB/GYNs, independently practicing certified registered nurse practitioners and nurse midwives, and for initial potential high volume behavioral health sites. Reviews will be conducted triennially for dual credentialed practitioners. The reviews assess the following general elements:

- ▶ CPR Certification
  
- ▶ Office Site Evaluation
  - Handicapped parking;
  - Physical appearance of the office;
  - Adequate exam rooms;

- Fire extinguishers;
- Emergency/evacuation plan;
- Handicapped accessibility;
- Adequate waiting rooms;
- Secure medical/treatment records;
- Marked exits;
- Proper handling of bio-hazardous waste;
- Proper sterilization of equipment;
- Properly secured medication and prescription pads;
- Proper storage of medications and lab specimens; and
- Confidentiality.

► Office Accessibility

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

► Medical Records Documentation

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

- ▶ Treatment Record Documentation for Behavioral Health Practitioners
  - Personal biographical data;
  - Psychiatric history;
  - Developmental history;
  - Mental status exam;
  - Risk factors;
  - Identification of DSM-IV diagnoses; and
  - Treatment plan and goals.

All office site reviews will be scored in the aggregate for each component of the comprehensive site visit tool used by Mountain State. A score of at least 80 percent of the Environmental Assessment, Medical Record Documentation and Preventive Services evaluation must be met.

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

Practices not meeting Mountain State's compliance standards on office site, medical/treatment record or preventive services evaluations are expected to correct to the deficiencies and will be re-evaluated within six months. The re-evaluation will be a reassessment of the non-compliant elements from the previous site review. Practices failing to detect deficiencies may be sanctioned. Practices with office deficiencies on repeated re-evaluations may be terminated from network participation.

### 3.4.7 Time Frames

Mountain State's credentialing procedures are designed to facilitate prompt review and decision regarding a provider's credentialing application, once all required information is received. The process may take up to 120 days for initial credentialing, or up to three months longer if delays in primary source verification occur.

The Network Credentialing Department will not submit for Credentials Committee review any credentialing or re-credentialing application that is signed and dated more than one year prior, or that contains any primary or secondary source verification information received more than 180 days prior, to initial review by the Committee. In such cases, the provider may be asked to re-sign the application and information may need to be re-verified.

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## 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 Credentials Committees.

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## 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 Committees may direct that an individual provider be re-credentialed at a shorter interval, based on quality of care or other concerns.

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### 3.6.1 Physicians and Allied Health Providers

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 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.

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### 3.6.2 Facilities and Organizational Providers

As with initial credentialing, Mountain State will send the provider a letter 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 Credentials Committee.

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### 3.6.3 Ongoing Monitoring

The Network Credentialing Department 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 Credentials Committee (or the medical director in urgent situations) for appropriate action.

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## 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 Credentialing Department.

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

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### 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.

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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.

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### 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 Credentials Committees 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.

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### 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/Highmark 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 Credentials Committees 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.

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### 3.7.5 Reconsideration

A provider who has been notified that he/she is subject to corrective action may request reconsideration if the action to be imposed: (i) is not based on the competence or professional conduct of the provider; and (ii) does not reduce, restrict, suspend or revoke the provider's clinical privileges or status as a network provider. A change in specialty by which a provider is listed in the Mountain State provider directories may also be the basis of a request for reconsideration.

A provider must request reconsideration in writing within 30 days after receipt of a notice of corrective action. The request must include the basis for disagreeing with the action and any supportive documentation that was not previously considered.

The request for reconsideration and any supporting material will be considered by Mountain State Credentials Committee for commercial PPO providers and the Highmark Credentials Committee for FreedomBlue® network providers. The Committees will review the corrective action proposed and determine whether it is reasonable and warranted or whether an alternative corrective action or no corrective action is more appropriate. The decision of the Credentials Committees is final. The applicable Committee will notify the provider of its decision in writing.

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### 3.7.6 Hearings and Appeals

A provider who has been notified of an impending termination from the Mountain State/Highmark networks may request a hearing. A provider who has been subject to corrective action may also request a hearing if the action: (i) is based upon the competence or professional conduct of the provider (and the conduct affects or could adversely affect the health or welfare of a patient); or (ii) may reduce, restrict, suspend or revoke the provider's clinical privileges or status as a network provider.

If a hearing is available to the provider, Mountain State will send a written notice so informing the provider. The provider must request a hearing in writing within 30 days of receipt of the notice, or forfeit the right.

The hearing will be held before a peer review body consisting of at least three members. Mountain State may also appoint a hearing officer to conduct the hearing. The peer review body will review the proposed termination or corrective action and determine whether it is reasonable in light of the facts in their entirety as a whole. The body will issue a written decision to the provider.

A provider may appeal this decision to a second-level peer review body, which will consist of at least three members not involved in the initial action or the first-level hearing. The second-level peer review body will be the Highmark Quality Improvement Committee. The provider has 30 days from receipt of the hearing body's decision to request an appeal in writing.

No new evidence or witnesses will be presented at the appeal hearing. The second-level body will review the record made below and may reduce or modify the first-level peer review body's decision only if the decision: was clearly unreasonable, wrong or arbitrary; was not made in substantial accordance with Mountain State or Highmark policies and procedures; did not afford the provider a reasonable opportunity to address or respond to issues; or was affected by bias or conflict of interest.

The second-level body will issue a written decision, which is final and not subject to further appeal.

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## 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 National Practitioner Data Bank, and/or the Health Integrity and Protection Data Bank.

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

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