



Administrative Manual

Provider Responsibilities

Chapter 2



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Provider Responsibilities

HealthLink Standards of Participation

As part of the contracting process each healthcare professional/provider must satisfy the applicable selection standards before he or she is eligible to apply for participation in one or more of HealthLink's programs/networks.

If any applicant does not meet the selection standards outlined below, the applicant's request to participate in HealthLink programs/networks will not be processed.

1. The healthcare professional/provider must enter into the then current written provider agreement and abide by and comply with all terms and conditions of the provider agreement and fulfill all obligations imposed on the healthcare professional/provider under such provider agreement. Concurrent with HealthLink's periodic recredentialing, the healthcare professional/provider must enter into the then current written participation agreement.
2. The healthcare professional/provider who participates in the networks/programs of any other corporate affiliate in the WellPoint family of companies must be in good standing with such affiliates, abiding by and complying with all terms and conditions of the affiliate's provider agreement and fulfill all obligations imposed on the healthcare professional/provider under the affiliate's such provider agreement.
3. The healthcare professional/provider's primary office location must be located within the HealthLink service area.
4. The healthcare professional/provider must not be restricted from participating in one or more of HealthLink's programs/networks by an exclusive or other arrangement with any person or entity other than HealthLink.
5. In certain geographical areas, the healthcare professional/provider may be required to participate in one or more of the HealthLink programs/networks through an intermediary with whom HealthLink has an exclusive or other restrictive arrangement.
6. Active hospital privileges must be maintained by the healthcare professional/provider with at least one or more of the network hospitals pertaining to HealthLink's specific programs/networks of interest, where applicable. The healthcare professional/provider may also provide for hospital coverage by using the services of in-network hospital-based providers.
7. The healthcare professional/provider practice must not consist of a boutique, concierge, or retainer-type arrangement with its patients.

8. The healthcare professional must not receive, give, provide or condone any incentives or kickbacks, monetary or otherwise, in exchange for the referral of a covered person to other healthcare professionals or facilities.
9. The healthcare professional/provider must maintain professional liability insurance coverage, on per occurrence basis, in the amount of \$500,000, and \$1,000,000 in the aggregate. The healthcare professional/provider is encouraged to maintain professional liability insurance coverage, on a per occurrence basis, in the amount of \$1,000,000, and \$3,000,000 in the aggregate.
10. If the healthcare professional is a primary care physician or OB/GYN, he or she must be available to treat patients at least twenty (20) hours per week.
11. The healthcare professional/provider must provide or arrange for twenty-four (24) hours, seven days per week coverage for members who participate in HealthLink's programs/networks.
12. The healthcare professional/provider agrees that he or she may be excluded from participation if the professional/provider's application or other information obtained as part of the application or review process:
 - a. is found to be incomplete,
 - b. contains unacceptable information,
 - c. is believed or determined to contain untrue, misrepresented or fraudulent statements, or
 - d. contains information or is determined to be unacceptable by HealthLink, for any reason(s) listed above, or for any other reason, including, without limitation, the following reasons:
 - i. the healthcare professional/provider's liability claims history or outcomes of litigation raises questions regarding the care that may be provided by the healthcare professional or provider;
 - ii. the healthcare professional/provider's background raises questions regarding the ethical conduct of the healthcare professional/provider;
 - iii. the healthcare professional/provider's application was previously denied by HealthLink or one of its affiliates within the past thirty-six (36) months;
 - iv. the healthcare professional/provider's provider agreement or participation under a provider agreement with HealthLink was previously suspended or terminated;

- v. review of the healthcare professional/provider's practice indicates that the healthcare professional/provider practices, or provides services, in a manner that might unreasonably increase HealthLink's cost of providing health care services to its member;
- vi. the healthcare professional is joining a professional practice or a professional group practice that is currently being investigated by the Special Investigations Unit and/or the Clinical Investigations Unit; or
- vii. the healthcare professional is joining a professional practice or a professional group practice that has demonstrated continued non-compliance with HealthLink policies and procedures and/or the policies and procedures of any other corporate affiliate in the WellPoint family of companies.

Credentialing Scope

HealthLink credentials the following health care practitioners: medical doctors, doctors of osteopathic medicine, doctors of podiatry, chiropractors, and optometrists providing services covered under the Health Benefits Plan and doctors of dentistry providing Health Services covered under the Health Benefits Plan including oral maxillofacial surgeons.

HealthLink also credentials behavioral health practitioners, including psychiatrists and physicians who are certified or trained in addiction psychiatry, child and adolescent psychiatry, and geriatric psychiatry; doctoral and clinical psychologists who are state licensed; master's level clinical social workers who are state licensed; master's level clinical nurse specialists or psychiatric nurse practitioners who are nationally and state certified and state licensed; and other behavioral health care specialists who are licensed, certified, or registered by the state to practice independently. In addition, Medical Therapists (e.g., physical therapists, speech therapists and occupational therapists) and other individual health care practitioners listed in HealthLink's Network directory will be credentialed.

HealthLink credentials the following Health Delivery Organizations (HDOs): hospitals; home health agencies; skilled nursing facilities; (nursing homes); free-standing surgical centers; lithotripsy centers treating kidney stones and free-standing cardiac catheterization labs if applicable to certain regions; as well as behavioral health facilities providing mental health and/or substance abuse treatment in an inpatient, residential or ambulatory setting.

Credentials Committee

The decision to accept, retain, deny or terminate a practitioner's participation in a Network or Plan Program is conducted by a peer review body, known as HealthLink Credentials Committee (CC).

The CC will meet at least once every forty-five (45) days. The presence of a majority of voting CC members constitutes a quorum. The chief medical officer, or a designee appointed in consultation with the vice president of Medical and Credentialing Policy, will chair the CC and serve as a voting member (the Chair of the CC). The CC will include at least two participating practitioners, including one who practices in the specialty type that most frequently provides services to HealthLink Covered Individuals and who falls within the scope of the credentialing program, having no other role in HealthLink Network Management. The Chair of the CC may appoint additional Network practitioners of such specialty type, as deemed appropriate for the efficient functioning of the CC.

The CC will access various specialists for consultation, as needed to complete the review of a practitioner's credentials. A committee member will disclose and abstain from voting on a practitioner if the committee member (i) believes there is a conflict of interest, such as direct economic competition with the practitioner; or (ii) feels his or her judgment might otherwise be compromised. A committee member will also disclose if he or she has been professionally involved with the practitioner. Determinations to deny an applicant's participation, or terminate a practitioner from participation in one or more Networks or Plan Programs, require a majority vote of the voting members of the CC in attendance, the majority of whom are Network Providers.

During the credentialing process, all information that is obtained is highly confidential. All CC meeting minutes and practitioner files are stored in locked cabinets and can only be seen by appropriate Credentialing staff, medical directors, and CC members. Documents in these files may not be reproduced or distributed, except for confidential peer review and credentialing purposes.

Practitioners and HDOs are notified that they have the right to review information submitted to support their credentialing applications. In the event that credentialing information cannot be verified, or if there is a discrepancy in the credentialing information obtained, the Credentialing staff will contact the practitioner or HDO within thirty (30) calendar days of the identification of the issue. This communication will specifically notify the practitioner or HDO of the right to correct erroneous information or provide additional details regarding the issue in question. This notification will also include the specific process for submission of this additional information, including where it should be sent. Depending on the nature of the issue in question, this communication may occur verbally or in writing. If the communication is verbal, written confirmation will be sent at a later date. All communication on the issue(s) in question, including copies of the correspondence or a detailed record of phone calls, will be clearly documented in the practitioner's credentials file. The practitioner or HDO will be given no less than fourteen (14) calendar days in which to provide additional information.

HealthLink may request and will accept additional information from the applicant to correct or explain incomplete, inaccurate, or conflicting credentialing information. The

CC will review the information and rationale presented by the applicant to determine if a material omission has occurred or if other credentialing criteria are met.

Nondiscrimination Policy

HealthLink will not discriminate against any applicant for participation in its Plan Programs or Networks on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Additionally, HealthLink will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities that are provided to the Covered Individuals to meet their needs and preferences, this information is not required in the credentialing and re-credentialing process. Determinations as to which practitioners/ HDOs require additional individual review by the CC are made according to predetermined criteria related to professional conduct and competence as outlined in HealthLink Credentialing Program Standards. CC decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process.

Initial Credentialing

Each practitioner or HDO must complete a standard application form when applying for initial participation in one or more of HealthLink Plan Programs or Networks. This application may be a state mandated form or a standard form created by or deemed acceptable by HealthLink. For practitioners, the Council for Affordable Quality Healthcare (“CAQH”), a Universal Credentialing Datasource is utilized. CAQH is building the first national provider credentialing database system, which is designed to eliminate the duplicate collection and updating of provider information for health plans, hospitals and practitioners. To learn more about CAQH, visit their web site at www.CAQH.org.

HealthLink will verify those elements related to an applicants’ legal authority to practice, relevant training, experience and competency from the primary source, where applicable, during the credentialing process. All verifications must be current and verified within the one hundred eighty (180) calendar day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards.

During the credentialing process, HealthLink will review verification of the credentialing data as described in the following tables unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

Practitioners Verification Element

- License to practice in the state(s) in which the practitioner will be treating Covered Individuals.
- Hospital admitting privileges at a TJC, NIAHO or AOA accredited hospital, or a Network hospital previously approved by the committee.

- DEA, CDS and state controlled substance certificates
- The DEA/CDS must be valid in the state(s) in which practitioner will be treating Covered Individuals. Practitioners who see members in more than one state must have a DEA/CDS for each state.
- Malpractice insurance
- Malpractice claims history
- Board certification or highest level of medical training or education
- Work history
- State or Federal license sanctions or limitations
- Medicare, Medicaid or FEHBP sanctions
- National Practitioner Data Bank report

HDOs Verification Element

- Accreditation, if applicable
- License to practice, if applicable
- Malpractice insurance
- Medicare certification, if applicable
- Department of Health Survey Results or recognized accrediting organization certification
- License sanctions or limitations, if applicable
- Medicare, Medicaid or FEHBP sanctions

Recredentialing

The recredentialing process incorporates re-verification and the identification of changes in the practitioner's or HDO's licensure, sanctions, certification, health status and/or performance information (including, but not limited to, malpractice experience, hospital privilege or other actions) that may reflect on the practitioner's or HDO's professional conduct and competence. This information is reviewed in order to assess whether practitioners and HDOs continue to meet HealthLink credentialing standards.

During the recredentialing process, HealthLink will review verification of the credentialing data as described in the tables under Initial Credentialing unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

All applicable practitioners and HDOs in the Network within the scope of HealthLink Credentialing Program are required to be recredentialed every three years unless otherwise required by contract or state regulations.

Health Delivery Organizations

New HDO applicants will submit a standardized application to HealthLink for review. If the candidate meets HealthLink screening criteria, the credentialing process will commence. To assess whether participating HealthLink Network HDOs, within the scope of the Credentialing Program, meet appropriate standards of professional conduct and competence, they are subject to credentialing and recredentialing

programs. In addition to the licensure and other eligibility criteria for HDOs, as described in detail in HealthLink Credentialing Program Standards, all Network HDOs are required to maintain accreditation by an appropriate, recognized accrediting body or, in the absence of such accreditation, HealthLink may evaluate the most recent site survey by Medicare or the appropriate state oversight agency for that HDO.

Recredentialing of HDOs occur every three years unless otherwise required by regulatory or accrediting bodies. Each HDO applying for continuing participation in Plan Programs or Networks must submit all required supporting documentation.

On request, HDOs will be provided with the status of their credentialing application. HealthLink may request, and will accept, additional information from the HDO to correct incomplete, inaccurate, or conflicting credentialing information. The CC will review this information and the rationale behind it, as presented by the HDO, and determine if a material omission has occurred or if other credentialing criteria are met.

Ongoing Sanction Monitoring

To support certain credentialing standards between the recredentialing cycles, HealthLink has established an ongoing monitoring program. Credentialing performs ongoing monitoring to help ensure continued compliance with credentialing standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the credentialing department will review periodic listings/reports within thirty (30) calendar days of the time they are made available from the various sources including, but not limited to, the following:

1. Office of the Inspector General (OIG)
2. Federal Medicare/Medicaid Reports
3. Office of Personnel Management (OPM)
4. State licensing Boards/Agencies
5. Covered Individual/Customer Services Departments
6. Clinical Quality Management Dept. (including data regarding complaints of both a clinical and non-clinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
7. Other internal HealthLink Departments
8. Any other verified information received from appropriate sources

When a practitioner or HDO within the scope of credentialing has been identified by these sources, criteria will be used to assess the appropriate response including but not limited to: review by the Chair of HealthLink CC, review by the HealthLink Medical Director, referral to the CC, or termination. HealthLink credentialing departments will report providers to the appropriate authorities as required by law.

Appeals Process

HealthLink has established policies for monitoring and re-credentialing practitioners and HDOs who seek continued participation in one or more of HealthLink's Plan Programs

or Networks. Information reviewed during this activity may indicate that the professional conduct and competence standards are no longer being met, and HealthLink may wish to terminate practitioners or HDOs. HealthLink also seeks to treat practitioners and HDOs and applying providers fairly, and thus provides practitioners and HDOs with a process to appeal determinations terminating participation in HealthLink's Networks for professional competence and conduct reasons, or which would otherwise result in a report to the National Practitioner Data Bank ("NPDB").

Additionally, HealthLink will permit practitioners and HDOs who have been refused initial participation the opportunity to correct any errors or omissions which may have led to such denial (informal/reconsideration only). It is the intent of HealthLink to give practitioners and HDOs the opportunity to contest a termination of the practitioner's or HDO's participation in one or more of HealthLink's Plan Programs or Networks and those denials of request for initial participation which are reported to the NPDB that were based on professional competence and conduct considerations. Immediate terminations may be imposed due to the practitioner's or HDO's suspension or loss of licensure, criminal conviction, or HealthLink's determination that the practitioner's or HDO's continued participation poses an imminent risk of harm to Covered Individuals. A practitioner/HDO whose license has been suspended or revoked has no right to informal review/reconsideration or formal appeal.

Reporting Requirements

When HealthLink takes a professional review action with respect to a practitioner's or HDO's participation in one or more Plan Programs or Networks, HealthLink may have an obligation to report such to the NPDB and/or Healthcare Integrity and Protection Data Bank ("HIPDB"). Once HealthLink receives a verification of the NPDB report, the verification report will be sent to the state licensing board. The credentialing staff will comply with all state and federal regulations in regard to the reporting of adverse determinations relating to professional conduct and competence. These reports will be made to the appropriate, legally designated agencies. In the event that the procedures set forth for reporting reportable adverse actions conflict with the process set forth in the current NPDB Guidebook and the HIPDB Guidebook, the process set forth in the NPDB Guidebook and the HIPDB Guidebook will govern.

HealthLink Credentialing Program Standards

I. Eligibility Criteria

Health Care practitioners

Initial applicants must meet the following criteria in order to be considered for participation:

- A. Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where he/she provides services to Covered Individuals;

- B. Possess a current, valid, and unrestricted Drug Enforcement Agency (“DEA”) and/or Controlled Dangerous Substances (“CDS”) registration for prescribing controlled substances, if applicable to his/her specialty in which he/she will treat Covered Individuals; the DEA/CDS must be valid in the state(s) in which the practitioner will be treating Covered Individuals. Practitioners who see Covered Individuals in more than one state must have a DEA/CDS for each state; and
- C. Must not be currently debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP.
- D. For MDs, DOs, DPMs and oral & maxillofacial surgeons, the applicant must have current, in force board certification (as defined by the American Board of Medical Specialties (“ABMS”), American Osteopathic Association (“AOA”), Royal College of Physicians and Surgeons of Canada (“RCPSC”), College of Family Physicians of Canada (“CFPC”), American Board of Podiatric Surgery (“ABPS”), American Board of Podiatric Orthopedics and Primary Podiatric Medicine (“ABPOPPM”) or American Board of Oral and Maxillofacial Surgery (“ABOMS”)) in the clinical discipline for which they are applying. Individuals will be granted five years after completion of their residency program to meet this requirement.
 - 1. As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training and certification requirement:
 - a. Previous board certification (as defined by one of the following: ABMS, AOA, RCPSC or CFPC) in the clinical specialty or subspecialty for which they are applying which has now expired AND a minimum of ten consecutive years of clinical practice. OR
 - b. Training which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in that clinical specialty or subspecialty. OR
 - c. Specialized practice expertise as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of their specialty AND a faculty appointment of Assistant Professor or higher at an academic medical center and teaching Facility in HealthLink Network AND the applicant’s professional activities are spent at that institution at least fifty percent (50%) of the time.
 - 2. Practitioners meeting one of these three alternative criteria (a, b, c) will be viewed as meeting all HealthLink education, training and certification criteria and will not be required to undergo additional review or individual presentation to the CC. These alternatives are subject to HealthLink review and approval. Reports submitted by delegate to HealthLink must contain

sufficient documentation to support the above alternatives, as determined by HealthLink.

- E. For MDs and DOs, the applicant must have unrestricted hospital privileges at a The Joint Commission (“TJC”), National Integrated Accreditation for Healthcare Organizations (“NIAHO”) or an AOA accredited hospital, or a Network hospital previously approved by the committee. Some clinical disciplines may function exclusively in the outpatient setting, and the CC may at its discretion deem hospital privileges not relevant to these specialties. Also, the organization of an increasing number of physician practice settings in selected fields is such that individual physicians may practice solely in either an outpatient or an inpatient setting. The CC will evaluate applications from practitioners in such practices without regard to hospital privileges. The expectation of these physicians would be that there is an appropriate referral arrangement with a Network/Participating Provider to provide inpatient care.

II. Criteria for Selecting Practitioners New Applicants (Credentialing)

- A. Submission of a complete application and required attachments that must not contain intentional misrepresentations;
- B. Application attestation signed date within one hundred eighty (180) calendar days of the date of submission to the CC for a vote;
- C. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies;
- D. No evidence of potential material omission(s) on application;
- E. Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to Covered Individuals;
- F. No current license action;
- G. No history of licensing board action in any state;
- H. No current federal sanction and no history of federal sanctions (per OIG and OPM report nor on NPDB report);
- I. Possess a current, valid, and unrestricted DEA/CDS registration for prescribing controlled substances, if applicable to his/her specialty in which he/she will treat Covered Individuals. The DEA/CDS must be valid in the state(s) in which the practitioner will be treating Covered Individuals. Practitioners who treat Covered Individuals in more than one state must have a valid DEA/CDS for each applicable state.

J. Initial applicants who have NO DEA/CDS certificate will be viewed as not meeting criteria and the credentialing process will not proceed. However, if the applicant can provide evidence that he has applied for a DEA the credentialing process may proceed if all of the following are met:

1. It can be verified that this application is pending.
2. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA certificate is obtained.
3. The applicant agrees to notify HealthLink upon receipt of the required DEA.
4. HealthLink will verify the appropriate DEA/CDS via standard sources.
5. The applicant agrees that failure to provide the appropriate DEA within a ninety (90) day timeframe will result in termination from the Network.

K. Initial applicants who possess a DEA certificate in a state other than the state in which they will be treating Covered Individuals will be notified of the need to obtain the additional DEA. If the applicant has applied for additional DEA the credentialing process may proceed if ALL the following criteria are met:

1. It can be verified that this application is pending and,
2. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA certificate is obtained,
3. The applicant agrees to notify HealthLink upon receipt of the required DEA,
4. HealthLink will verify the appropriate DEA/CDS via standard sources; applicant agrees that failure to provide the appropriate DEA within a ninety (90) calendar day timeframe will result in termination from the Network, AND
5. Must not be currently debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP.

L. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions;

M. No history of or current use of illegal drugs or history of or current alcoholism;

N. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.

- O. No gap in work history greater than six months in the past five years with the exception of those gaps related to parental leave or immigration where twelve (12) month gaps will be acceptable. Other gaps in work history of six to twenty four (6 – 24) months will be reviewed by the Chair of the CC and may be presented to the CC if the gap raises concerns of future substandard professional conduct and competence. In the absence of this concern the Chair of the CC may approve work history gaps of up to two years.
- P. No history of criminal/felony convictions or a plea of no contest;
- Q. A minimum of the past ten years of malpractice case history is reviewed.
- R. Meets Credentialing Standards for education/training for specialty/specialties in which practitioner wants to be listed in a HealthLink Network directory as designated on the application. This includes board certification requirements or alternative criteria for MDs and DOs and board certification criteria for DPMs and oral & maxillofacial surgeons;
- S. No involuntary terminations from an HMO or PPO;
- T. No "yes" answers to attestation/disclosure questions on the application form with the exception of the following:
 - 1. Investment or business interest in ancillary services, equipment or supplies;
 - 2. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
 - 3. Voluntary surrender of state license related to relocation or nonuse of said license;
 - 4. A NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria.
 - 5. Non-renewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
 - 6. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five (5) year post residency training window.
 - 7. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;

8. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

Note: the CC will individually review any practitioner that does not meet one or more of the criteria required for initial applicants.

Practitioners who meet all participation criteria for initial or continued participation and whose credentials have been satisfactorily verified by the Credentialing department may be approved by the Chair of the CC after review of the applicable credentialing or recredentialing information. This information may be in summary form and must include, at a minimum, practitioner's name and specialty.

III. Currently Participating Applicants (Recredentialing)

- A. Submission of complete re-credentialing application and required attachments that must not contain intentional misrepresentations;
- B. Re-credentialing application signed date within one hundred eighty (180) calendar days of the date of submission to the CC for a vote;
- C. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies;
- D. No evidence of potential material omission(s) on re-credentialing application;
- E. Current, valid, unrestricted license to practice in each state in which the practitioner provides care to Covered Individuals;
- F. *No current license probation;
- G. *License is unencumbered;
- H. No new history of licensing board reprimand since prior credentialing review;
- I. *No current federal sanction and no new (since prior credentialing review) history of federal sanctions (per OIG and OPM Reports or on NPDB report);
- J. Current DEA, CDS Certificate and/or state controlled substance certification without new (since prior credentialing review) history of or current restrictions;
- K. No current hospital membership or privilege restrictions and no new (since prior credentialing review) history of hospital membership or privilege restrictions; OR for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting there exists a defined referral relationship with a Network/Participating Provider of similar specialty at a Network hospital who provides inpatient care to Covered Individuals needing hospitalization;

- L. No new (since previous credentialing review) history of or current use of illegal drugs or alcoholism;
- M. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field;
- N. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;
- O. Malpractice case history reviewed since the last CC review. If no new cases are identified since last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of last five (5) years of malpractice history is evaluated and criteria consistent with initial credentialing is used.
- P. No new (since previous credentialing review) involuntary terminations from an HMO or PPO;
- Q. No new (since previous credentialing review) "yes" answers on attestation/disclosure questions with exceptions of the following:
 - 1. Investment or business interest in ancillary services, equipment or supplies;
 - 2. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
 - 3. Voluntary surrender of state license related to relocation or nonuse of said license;
 - 4. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
 - 5. Nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
 - 6. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five year post residency training window;
 - 7. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
 - 8. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

- R. No QI data or other performance data including complaints above the set threshold.
- S. Recredentialed at least every three years to assess the practitioner's continued compliance with HealthLink standards.

*It is expected that these findings will be discovered for currently credentialed Providers and Facilities through ongoing sanction monitoring. Providers and Facilities with such findings will be individually reviewed and considered by the CC at the time the findings are identified.

Note: the CC will individually review any credentialed Provider or Facility that does not meet one or more of the criteria for recredentialing.

IV. Additional Participation Criteria and Exceptions for Behavioral Health Practitioners (Non Physician) Credentialing.

- A. Licensed Clinical Social Workers (LCSW) or other master level social work license type:
 - 1. Master or doctoral degree in social work with emphasis in clinical social work from a program accredited by the Council on Social Work Education (CSWE) or the Canadian Association on Social Work Education (CASWE).
 - 2. Program must have been accredited within three years of the time the practitioner graduated.
 - 3. Full accreditation is required, candidacy programs will not be considered.
 - 4. If master's level degree does not meet criteria and practitioner obtained PhD training as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. To meet the criteria, the doctoral program must be accredited by the APA or be regionally accredited by the Council for Higher Education ("CHEA"). In addition, a doctor of social work from an institution with at least regional accreditation from the CHEA will be viewed as acceptable.
- B. Licensed professional counselor ("LPC") and marriage and family therapist ("MFT") or other master level license type:
 - 1. Master's or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or doctoral degrees in education are acceptable with one of the fields of study above.

2. Master or doctoral degrees in divinity do not meet criteria as a related field of study.
3. Graduate school must be accredited by one of the Regional Institutional Accrediting Bodies and may be verified from the Accredited Institutions of Post-Secondary Education, APA, Council for Accreditation of Counseling and Related Educational Programs (“CACREP”), or Commission on Accreditation for Marriage and Family Therapy Education (“COAMFTE”) listings. The institution must have been accredited within three (3) years of the time the practitioner graduated.
4. If master’s level degree does not meet criteria and practitioner obtained PhD training as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. To meet criteria this doctoral program must either be accredited by the APA or be regionally accredited by the CHEA. In addition, a doctoral degree in one of the fields of study noted above from an institution with at least regional accreditation from the CHEA will be viewed as acceptable.

C. Clinical nurse specialist/psychiatric and mental health nurse practitioner:

1. Master’s degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing. Graduate school must be accredited from an institution accredited by one of the Regional Institutional Accrediting Bodies within three years of the time of the practitioner’s graduation.
2. Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing or other license or certification as dictated by the appropriate State(s) Board of Registered Nursing, if applicable.
3. Certification by the American Nurses Association (“ANA”) in psychiatric nursing. This may be any of the following types: Clinical Nurse Specialist in Child or Adult Psychiatric Nursing, Psychiatric and Mental Health Nurse Practitioner or Family Psychiatric and Mental Health Nurse Practitioner.
4. Valid, current, unrestricted DEA Certificate, where applicable with appropriate supervision/consultation by a Provider as applicable by the state licensing board. For those who possess a DEA Certificate, the appropriate CDS Certificate if required. The DEA/CDS must be valid in the state(s) in which the practitioner will be treating Covered Individuals.

D. Clinical Psychologists:

1. Valid state clinical psychologist license.

2. Doctoral degree in clinical or counseling, psychology or other applicable field of study from an institution accredited by the APA within three years of the time of the practitioner's graduation.
3. Education/Training considered as eligible for an exception is a practitioner whose doctoral degree is not from an APA accredited institution but who is listed in the National Register of Health Service Providers in Psychology or is a Diplomat of the American Board of Professional Psychology.
4. Master's level therapists in good standing in the Network, who upgrade their license to clinical psychologist as a result of further training, will be allowed to continue in the Network and will not be subject to the above education criteria.

E. Clinical Neuropsychologist:

1. Must meet all the criteria for a clinical psychologist listed in C.4 above and be Board certified by either the American Board of Professional Neuropsychology ("ABPN") or American Board of Clinical Neuropsychology ("ABCN").
2. A practitioner credentialed by the National Register of Health Service Providers in Psychology with an area of expertise in neuropsychology may be considered.
3. Clinical neuropsychologists who are neither board-certified nor listed in the National Register will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by one or more of the following:
 - a. Transcript of applicable pre-doctoral training OR
 - b. Documentation of applicable formal one (1) year post-doctoral training (participation in CEU training alone would not be considered adequate) OR
 - c. Letters from supervisors in clinical neuropsychology (including number of hours per week) OR
 - d. Minimum of five years' experience practicing neuropsychology at least ten hours per week

V. Health Delivery Organization (HDO) Eligibility Criteria

All Health Delivery Organizations must be accredited by an appropriate, recognized

accrediting body or in the absence of such accreditation; HealthLink may evaluate the most recent site survey by Medicare or the appropriate state oversight agency. Non-accredited HDOs are subject to individual review by the CC and will be considered for Covered Individual access need only when the CC review indicates compliance with HealthLink standards and there are no deficiencies noted on the Medicare or state oversight review which would adversely affect quality or care or patient safety. HDOs are recredentialed at least every three years to assess the HDO's continued compliance with HealthLink standards.

A. General Criteria for HDOs:

1. Valid, current and unrestricted license to operate in the state(s) in which it will provide services to Covered Individuals. The license must be in good standing with no sanctions.
2. Valid and current Medicare certification.
3. Must not be currently debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP.
4. Liability insurance acceptable to HealthLink.
5. If not appropriately accredited, HDO must submit a copy of its CMS or state site survey for review by the CC to determine if HealthLink's quality and certification criteria standards have been met.

B. Additional Participation Criteria for Health Delivery Organizations by Provider Type:

Medical Facilities

1. Acute Care Hospital
 - a. Must be accredited by the TJC, HFAP or NIAHO;
2. Ambulatory Surgical Centers
 - a. Must be accredited by the TJC, HFAP, AAPSF, AAAHC, AAAASF or IMQ;
3. Free Standing Cardiac Catheterization Facilities
 - a. Must be accredited by the TJC or HFAP (may be covered under parent institution);
4. Lithotripsy Centers (Kidney stones)

- a. Must be accredited by the TJC;
- 5. Home Health Care Agencies
 - a. Must be accredited by the TJC, CHAP or ACHC;
- 6. Skilled Nursing Facilities
 - a. Must be accredited by the TJC or CARF;
- 7. Nursing Homes
 - a. Must be accredited by the TJC;
- 8. Behavioral Health Facilities
 - a. The following behavioral health facilities must be accredited by the TJC, HFAP, NIAHO or CARF as indicated:
 - i. Acute Care Hospital – Psychiatric Disorders; TJC, HFAP or NIAHO;
 - ii. Residential Care – Psychiatric Disorders; TJC, HFAP, NIAHO or CARF;
 - iii. Partial Hospitalization/Day Treatment – Psychiatric Disorders; TJC, HFAP, NIAHO or CARF for programs associated with an acute care facility or Residential Treatment Facilities;
 - iv. Intensive Structured Outpatient Program – Psychiatric Disorders; TJC, HFAP or NIAHO for programs affiliated with an acute care hospital or health care organization that provides psychiatric services to adults or adolescents; CARF if program is a residential treatment center providing psychiatric services;
 - v. Acute Inpatient Hospital – Chemical Dependency/Detoxification and Rehabilitation; TJC, HFAP or NIAHO;
 - vi. Acute Inpatient Hospital – Detoxification Only Facilities; TJC, HFAP or NIAHO;
 - vii. Residential Care – Chemical Dependency; TJC, HFAP, NIAHO or CARF;
 - viii. Partial Hospitalization/Day Treatment – Chemical Dependency;

TJC, NIAHO for programs affiliated with a hospital or health care organization that provides drug abuse and/or alcoholism treatment services to adults or adolescents; CHAMPUS or CARF for programs affiliated with a residential treatment center that provides drug abuse and/or alcoholism treatment services to adults or adolescents;

- ix. Intensive Structured Outpatient Program – Chemical Dependency; TJC, NIAHO for programs affiliated with a hospital or health care organization that provides drug abuse and/or alcoholism treatment services to adults or adolescents; CARF for programs affiliated with a residential treatment center that provides drug abuse and/or alcoholism treatment services to adults or adolescents.

Provider Record Updates

All providers are responsible for notifying HealthLink with any of the following changes:

- Ownership Changes
- Name Change
- Business Address
- Hospital Staff Association
- Federal EIN/TIN
- National Provider Identifier (NPI)

Physicians, hospitals and other health care professionals can submit the above listed changes:

- On-line at *ProviderInfoSource.HealthLink.com*
- Fax to 314-925-6627, Attention: Network Representative
- Contact your Network Consultant

Coordination of Benefits

HealthLink does not direct how coordination of benefits is performed. Coordination of benefits may vary and procedures are specified in the Payor health plan document. To verify which health plan is primary when a patient has two or more health plans, the physician should contact the claims administrator listed on the enrollee's ID card.

Physician Availability and Accessibility

Ongoing Availability

Primary care physicians (i.e., specialties of Family Practice, General Medicine, Internal Medicine and Pediatrics) participating in the HealthLink network agree to be available or to arrange for medical coverage/consultation to patients enrolled in a HealthLink program 24 hours a day, seven days a week for consultation on medical concerns.

Availability of Services

Participating physicians and hospitals cooperate with HealthLink in working toward timeliness in performing medical services and mental health treatment. HealthLink's guidelines for physician appointments are as follows:

TYPE OF CARE	GUIDELINE
Emergency	Within four hours on the basis of medical need
Urgent	Within 24 hours on the basis of medical need
Routine Care with Symptoms	Within one week on the basis of medical need
TYPE OF CARE	GUIDELINE
Baseline Physical Exams	Within 30 days
Well Child Care (< age one)	Within three weeks
Well Child Care (> age one)	Within six weeks
Prenatal Care	
First Trimester	Within one week
Second Trimester	Within one week
Third Trimester	Within three days
High Risk Pregnancy	Within three days or immediately for emergency care
Wait Time in Physician Office	
Scheduled	Within 30 minutes in waiting room; 15 minutes in exam room
Unscheduled (worked in)	Within 60 minutes in waiting room or exam room
Telephone Response	
After Hours	Within 30 minutes
Emergency	Immediate
Urgent	Within one hour
Non-Urgent	Same day

Covering Physicians

All participating physicians are required to make arrangements for coverage in their absence, and must disclose this information to patients by telephone or answering service. HealthLink urges physicians to use HealthLink participating physicians for coverage, since patient benefits are typically reduced if patients utilize non-participating practitioners.

Behavioral Health Treatment

Participating behavioral health inpatient facilities are available for individuals who are in acute distress and require the close observation that is only available in an acute inpatient psychiatric setting. Participating behavioral health outpatient providers are available for individuals who can be safely and effectively treated in an office or outpatient hospital setting.

Patient Selection and Transfer of Care

Acceptance of Enrollees as New Patients

A physician must accept a reasonable number of enrollees of health plans accessing HealthLink's programs, as mutually agreeable at the time the physician applies for participation in HealthLink programs, and as notified thereafter. If a primary care physician participating in HealthLink programs is no longer able to accept new enrollees from health plans accessing the HealthLink network programs, the primary care physician must provide written notice to HealthLink 30 days in advance of the effective date so that HealthLink can update its records for health plan enrollees and applicants seeking physician selection. The intent of this provision is to accommodate the participating physician's practice needs and to accurately reflect availability of care within HealthLink's networks.

Physician and Enrollee Transfer Requests

Participating physicians, hospitals and other health care professionals in HealthLink programs should notify HealthLink of a request for the transfer of patient care to another physician. Health plan enrollees electing to transfer from one primary care physician to another may notify HealthLink Customer Service by phone or in writing. The change of physician will be effective on the first day of the month following such notice.

Referrals and Other Requirements

Providers shall admit or arrange for the admission of patients at Participating Hospitals and shall refer patients in need of specialty, ancillary and other health care services to Participating Providers, except in cases of medical emergency.

Confidentiality of Patient Information

Federal and state law as well as generally accepted medical practice standards require that contracted physicians must maintain a medical record for each patient accessing HealthLink's networks and programs. The physician and physician's employees must treat the medical records of enrollees as confidential and comply with all federal and state confidentiality laws. The following is a link to access more information regarding the standard HIPAA-Business Associate guidelines.

HealthLink HIPAA – Business Associate Guidelines

Enrollee Records Inspection

Contracted physicians, hospitals and other health care professionals must document all services provided to health plan enrollees accessing HealthLink's networks and programs. Upon the request of any federal or state governmental agency that has jurisdiction or authority over HealthLink, physicians must permit inspection of the books, records and information regarding the provision of health care services to health plan enrollees. In addition, physicians must comply with requests from HealthLink or its affiliated Payors to provide information contained within the medical record for purposes

related to health care operations and benefit consideration. HealthLink will make reasonable efforts to secure this information. Physicians participating in HealthLink's networks and programs agree to supply necessary information at no copying costs to HealthLink, its affiliated Payors or patients.