Standards for Participation

To become a THP provider, a physician must meet the standards of participation as developed by The Health Plan. Practitioners cannot provide medical care to our members until they are fully credentialed.

A physician must have the following credentials:

- Drug Enforcement Administration (DEA) registration number if the scope of practice would warrant the physician to have a DEA
- Professional liability – minimum amount of $1 million, any amount below minimum will be reviewed by the Credentials Committee
- Admitting privileges at a participating hospital
- Clear report from the National Data Bank
- Board-certified or board eligible. If not board-certified or board-eligible, the physician must demonstrate appropriate training for specialty listed
- Signed and dated agreement
- Office site survey for primary care physicians (PCP), OB/GYN and those providers designated by the plan as a high-volume specialist who provides service to Medicaid recipients.
- Proof of current medical license(s)
- Sufficient information concerning any malpractice actions.
- NPI number and UPIN or PTAN number
    - The Centers for Medicare and Medicaid (CMS) has made it their goal to increase the accuracy of provider directories and is requesting that providers review their demographic information in the National Plan and Provider Enumeration System (NPPES) registry and make necessary corrections to the data and then attest to the accuracy of the data.
- Completed application
- Proof of cultural competency training

Practitioners/providers eligible for participation with The Health Plan are:

- Medical doctor
- Doctor of osteopathy
- Doctor of podiatric medicine
- Doctor of dental surgery
- Doctor of chiropractic medicine
- Audiologist
- Certified nurse practitioner – must submit a copy of their collaborative agreement and/or prescriptive authority (if applicable) with a physician who is a participating practitioner with The Health Plan
- Certified nurse midwife – must have a collaborative agreement with an obstetrician
- Physician assistant – the collaborating physician must be participating with The Health Plan and the PA must submit a copy of the practice agreement with the collaborating physician
- Independent physical therapist
- Optometrist
- Fully licensed psychologist
- Clinical licensed master social worker

- Ambulance provider
- Durable medical equipment – must be accredited and possess a surety bond; if applicable
- Independent speech language pathologist
- Registered dietitian, diabetic educator and nutritionist
- Counselor therapists

Provider/facilities eligible for affiliation in The Health Plan network are:

- Ambulatory surgical centers – must be accredited
- End-stage renal disease facilities
- Federally qualified health centers
- Rural health clinics
- Home health care facilities
- Infusion therapy providers – must be accredited
- Hospitals – must be accredited
- Critical access hospitals
- Long-term acute care hospitals
- Outpatient physical therapy facilities
- Skilled nursing facilities
- Accredited behavioral health facilities

Providers and facilities must meet certain requirements to be a participating provider with The Health Plan. Please contact our contracting department or provider relations department for specific requirements by calling 1.800.624.6961.

The agreement will not be executed on behalf of The Health Plan until the credentialing process has been completed and the practitioner has been approved for participation. Practitioner cannot see members of The Health Plan until they are fully credentialed with the plan.

Notification of acceptance and/or rejection will be sent, in written form, within 60 days of the decision.

The Health Plan will complete the credentialing process within 90 days of receipt of the application or 180 days from the date of signature on the attestation statement of the application.

In addition to the above credentials, The Health Plan quality improvement committee has identified the following behaviors and expectations for The Health Plan physicians, who should:

- Have 24-hour availability, seven days a week, with backup coverage
- Accept members of any or all THP products, as required by The Health Plan
- Admit THP patients to participating hospitals
- Accept and support The Health Plan policies
- Allow medical records and office to be reviewed as part of a collaborative quality program
- Have records and office meet criteria established by The Health Plan and participating physician
- May not discriminate against The Health Plan patients or "de-market" The Health Plan
- Admit under own service to participating hospitals if patient's condition is within physician's range of expertise and scope of privileges
- Meet the CME requirement that is required for state licensure

The following guidelines are for PCPs only:

A PCP shall be required to provide a minimum of 20 hours per week of patient care availability in a county to be considered as a PCP in that county. The only exception shall be practitioners who provide services at multiple sites.

In the instance of multiple sites, these shall be acceptable providing the alternate location is within 30 miles or 60 minutes driving time of the primary location and the alternate location meets all the necessary requirements, as determined appropriate by the credentials committee and/or the executive management team. The PCP must also provide coverage 24 hours a day, seven days per week and have privileges at a provider facility or have arranged with a contracting provider/hospitalist group to handle all inpatient care for his/her patients.

The PCP maintains at least 50% primary care practice.

The following guidelines are for specialty providers (specialists and secondary care physicians):

Specialist practitioners who provide patient care access fewer than 20 hours per week in a THP county shall be considered as a practitioner in that region only if the specialty service of the physician is not otherwise available through sufficient plan practitioners residing in that region. Furthermore, the ability of the specialist to provide the necessary service locally including inpatient care, surgery and backup support shall be considered by the credentials committee and/or executive management team in making the determination of the acceptance of the practitioner as a plan provider.

The committee shall consider the specific needs of the specialty and how the physician will accommodate his/her patient needs. Practitioners who provide only limited services locally shall not be permitted to be accepted as a plan provider. In addition, if it is determined that the physician specialty requires the physician to be available locally, the practitioner shall not be accepted as a plan provider.

Practitioners Credentialing Rights

The practitioner has the right, upon request, to review information in support of his/her credentialing/recredentialing application by contacting The Health Plan credentialing department at 1.740.699.6279 or 1.800.624.6961, ext. 6279. The review will be at The Health Plan office and limited to the results of the primary verification of credentials. References, recommendations or other peer review protected information will not be shared with the practitioner.

The practitioner has the right to correct erroneous information. Any omissions, inconsistencies or erroneous information that is discovered during any of the listed verification processes will require further investigation by the director/manager of credentialing services. The director/manager of credentialing services will review the information to determine if it needs to go to the medical director for direction or select a course of action that may include:

- The manager of credentialing will send a written notice to the practitioner along with a copy of the application containing the discrepancy. The letter will state that the provider has 15 calendar days to respond in writing to the request for correction/update. If there is no written response received within the 15-calendar day timespan, a credentialing representative will contact the office via email or phone to ascertain why there has been no response. Once contacted, the practitioner is afforded an additional 15 calendar days to reply. The written explanation must be

returned by secure fax at 740.695.7883 or via postal mail to the manager of credentialing, or the credentialing representative listed on the letter, to 1110 Main Street, Wheeling WV, 26003.

If no response is received within 15 days of contact by the credentialing representative, the file will be placed in an inactive file and the practitioner will be notified of this status by letter.

- Once the information is received, the practitioner will be notified via email, fax, or telephone by the manager or a credentialing representative. The information will be taken to the medical director and/or blinded and taken to the credentials committee, along with the explanation from the practitioner, for the committee's acceptance, acceptance with restrictions, or rejection.

The practitioner has the right, upon request, to be informed of the status of their credentialing or recredentialing application. The information that will be afforded to the practitioner includes if the application is still in process, it is pending to the credentials committee or in review by the medical director awaiting sign-off. The practitioner may request status by contacting The Health Plan credentialing department at 1.740.699.6279 or 1.800.624.6961, ext. 6279 or via e-mail at hpecs@healthplan.org. The practitioner will be contacted by telephone or mail with the response to his/her request for application status. This response will be within 5 business days of the request.