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Policy Name:	Termination Appeal Process for PPO Network Providers	BCBSIL Corporate Policy
Effective Date:	October 1, 2002	
Revision Date:	June 1, 2009	

**Approval
Signature:**



Vice President–Network Management

Review process for providers terminated for cause from BCBSIL Network

Policy Statement:

The Health Plan makes a procedure available to the provider for review of a decision by BCBSIL to terminate the Provider from the BCBSIL Network. This document describes, in general terms, the criteria under which a provider may be terminated from the PPO network for cause. This document also describes the policy and procedure by which a provider may request a review of an adverse decision regarding participation in the PPO network. This document does not supersede the terms and conditions of any particular provider's agreement with BCBSIL. In the event of a conflict between the terms set forth in this document and the terms of the provider's agreement, the terms of the provider's agreement shall govern.

Affected Areas:

- Credentialing
- Network Management
- Health Care Management

Acronyms/ Definitions:

The following are acronyms/definitions referenced in this document:

Term	Definition
ADC	Add/Delete/Change
Health Plan	Blue Cross and Blue Shield of Illinois
HMO	Health Maintenance Organization
PA	Provider Affairs
PREMIER	Mainframe system for professional provider information
PPO/POS	Preferred Provider Organization/Point of Service
Provider	Provider is defined as physician or professional practitioner
ISMD	Illinois Senior Medical Director
INM	Illinois Network Management
PSC	Provider Selection Committee
NPDB	National Practitioner Data Bank
HIPDB	Health Integrity and Protection Databank

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Provider Appeal of Termination with Cause:

The following are the required timeframes for submission of a review request and panel decision:

- Within five (5) business days of the INM/PSC decision to deny or terminate a provider's network participation, the ISMD, or his/her Designee, notifies the provider in writing of the denial/ termination including the reason(s) for the denial/termination. ISMD provides a copy of the denial/termination letter to PA.
- The provider may submit a written request for review of the adverse action to the ISMD or his/her Designee within 30 calendar days from the date of the denial/termination letter.
- The ISMD or his/her Designee and INM/PSC must review the request within 30 calendar days of receipt of the provider's letter requesting a review unless an extension is sought by INMD/PSC and a notice of such an extension is given to the provider.
- If the provider does not submit a written request within 30 calendar days from the date of the denial/ termination letter, no further review will be provided and the termination will be considered final.
- If the provider does submit a written request within 30 calendar, days the following process will occur:
 - The information submitted will be reviewed by the ISMD, or his/her Designee, and then submitted to the PSC for review.
 - The PSC, with its panel of community providers, will review the documentation submitted by the appealing provider and determine if sufficient information has been submitted for the review. Based on the review in the PSC, the Provider appeal may be upheld or overturned.
 - The provider has the right to be present in person or via other electronic means to discuss his/her case with the members of the PSC.
 - The final decision of the PSC will be communicated to the provider within 30 calendar days after the PSC has met.

The ISMD or his/her Designee, or the HIPDB Medical Director, will make the final determination on the reporting of the provider to the NPDB or HIPDB.

Note: A provider terminated for imminent harm to patient health, an action by state medical or dental board, other medical or dental licensing board, or other licensing board or other government agency that effectively impairs the provider's ability to practice, fraud or malfeasance, or for any quality of care issue will result in the provider's immediate departicipation from all product lines.

Documentation to provider file:

The following must be placed in the provider's file upon final decision:

- Letter outlining the final decision; if the provider is denied participation, the letter must include the reasons for the denial/termination.
- Provider's written request for review with supporting documentation.
- Correspondence signed by ISMD or designee following the INM/PSC decision.

Note: Minutes from INM/PSC meeting(s) are maintained separately from the provider's file.

Reapplication after final denial

A provider may not submit another application (either individually or through a group) for at least one year following the final notification of denial/termination.

**Attachment 1B for PPO
NOTIFICATION OF TERMINATION
NETWORK PROVIDER**

Current Date

Certified Mail Number
Returned Receipt Requested

<< First Name >> << Last Name >>, << Title >>
<< Address >>
<< City >>, << State >> << Zip Code >>

Dear <<Title>> << Last Name >>:

This is to inform you that your participation in the PPO network will be terminated effective << *scheduled termination date* >>. This date has been established in accordance with the provisions of your PPO Agreement. Please advise your patients immediately. Prior to << *scheduled termination date* >> you are contractually obliged to continue providing services according to your provider contract to Blue Cross and Blue Shield of Illinois PPO patients. However, in order to facilitate a relatively smooth transition for subscribers with as little disruption as possible, we ask that you please advise them of the following immediately and as appropriate.

As of <<*scheduled termination date*>> I will no longer be considered a participating provider in the BCBSIL PPO Network. You may continue to see me for medical treatment or services, however you will only be eligible to receive out-of-network benefits for any services I provide. Additionally, you will be financially responsible for any amounts billed that are over the allowed amount permitted under your benefit plan.

The reason(s) for this action << *is/are* >> due to:

- << *List all reasons for termination.* >>

Please be advised that the above may be reported to the National Practitioner Data Bank (NPDB) or the Health Integrity and Protection Databank (HIPDB).

Please be advised that the termination of your participation from the PPO network will be effective for at least one year. You may reapply for participation in the network one year after the termination date noted above.

If you wish to have this decision reviewed, upon receipt of this letter please submit in writing your request for a review. You may also submit any supporting documentation which you would like to be considered as part of the review process. Your letter must be received no later than 30 calendar days from the date of this notice. Please forward your request and all supporting documentation to:

Kim Reed, MD
Senior Medical Director
Blue Cross and Blue Shield of Illinois
300 E. Randolph, 24th Floor
Chicago, IL 60601

Sincerely,

Kim Reed, MD
Senior Medical Director

cc: PSC

Attachment 2B
ACKNOWLEDGEMENT OF REVIEW REQUEST
NETWORK PROVIDER

Current Date

Certified Mail Number
Returned Receipt Requested

<< First Name >> << Last Name >>, << Title >>
<< Address >>
<< City >>, << State >> << Zip Code >>

Dear <<Title>> << Last Name >>:

This is to acknowledge receipt of your letter dated << *Date of Letter* >> requesting a review of the decision to terminate participation in the << *PPO* >> network(s). Your request will be presented to << *Illinois Network Management Group or Provider Selection Committee* >> for consideration.

You will be promptly advised of the outcome of the review.

Sincerely,

Medical Director Name
Senior Medical Director

cc: PSC

Attachment 3B
NOTIFICATION OF TERMINATION REVERSAL
NETWORK PROVIDER

Current Date

Certified Mail Number
Returned Receipt Requested

<< First Name >> << Last Name >>, << Title >>
<< Address >>
<< City >>, << State >> << Zip Code >>

Dear <<Title>> << Last Name >>:

Thank you for your correspondence dated << *Date of Letter* >> regarding the review of your termination from the << *PPO* >> network(s). The << *Illinois Network Management Group or Provider Selection Committee* >> recently considered your letter and file. Based upon the additional information that you provided regarding your << *Review Information* >>, the decision of the committee was to continue your participation in the network(s).

We appreciate your help in providing additional information to assist with the deliberations. If you have any questions, please contact me at <<*phone #*>> or your network representative, << *Network Rep* >> at << *Phone #* >>.

Sincerely,

Medical Director Name
Senior Medical Director

cc: PSC

Attachment 4B for PPO
**NOTIFICATION OF UPHELD TERMINATION
NETWORK PROVIDER**

Current Date

Certified Mail Number
Returned Receipt Requested

<< First Name >> << Last Name >>, << Title >>
<< Address >>
<< City >>, << State >> << Zip Code >>

Dear <<Title>> << Last Name >>:

After careful consideration and review of your letter dated << *Date of Letter* >> and your entire file, the Illinois Network Management Group has reaffirmed the decision to deny your continued participation in the PPO network. The reason(s) for this action << *is/are* >> due to:

- << *List all reasons for denial.* >>

Please be advised that this action may be reported to the National Practitioner Data Bank (NPDB) or the Health Integrity and Protection Databank (HIPDB).

Your termination date will be effective << *termination date on the Notification of Termination letter (Attachment 1B)* >> as stated in the initial termination notification letter dated << *date of the Notification of Termination letter* >>. This date has been established in accordance with the provisions of your PPO Agreement. Prior to <<*termination date*>> you are contractually obliged to continue providing services according to your provider contract with Blue Cross and Blue Shield of Illinois PPO patients. However, in order to facilitate a relatively smooth transition for subscribers with as little disruption as possible, we ask that you please advise them of the following immediately and as appropriate:

As of <<*termination date*>> I will no longer be considered a participating provider in the BCBSIL PPO Network. You may continue to see me for medical treatment or services, however you will only be eligible to receive out-of-network benefits for any services I provide. Additionally, you will be financially responsible for any amounts billed that are over the allowed amount permitted under your benefit plan.

Please be advised that the termination of your participation from the PPO network will be effective for at least one year. You may reapply for participation in the network one year after the termination date noted above.

Sincerely,

Medical Director Name
Senior Medical Director

cc: PSC

Policy Name: PPO Hospital Accreditation Requirements
Effective Date: October 3, 2005
Revision Date:

**Approval
Signature:**



Vice President, Provider Affairs

Policy:

BCBSIL requires hospitals contracted under the Participating Provider Option (PPO) program to be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association (AOA). Further, hospitals are required to notify BCBSIL immediately of any change in accreditation status.

Under the PPO program, BCBSIL may issue a policy waiver to non-accredited hospitals based on the following.

- Services performed by the non-accredited hospital are unique and require special consideration.
- The non-accredited hospital is in a rural / outlying location and proximity to the nearest PPO contracted hospital exceeds 10 miles.
- The hospital has a pending JCAHO or AOA survey. *Note: BCBSIL will not issue a waiver to hospitals which have failed to meet the accreditation standards of JCAHO or AOA unless a survey is pending.*

Notification of a change in accreditation status and/or policy waiver requests should be directed to the Vice President of Provider Affairs.