Policy Statement: Excellus Health Plan, Inc. (the “Plan”) is responsible for assuring the provision of accessible, cost efficient, high quality care to its members. To assist the Plan to meet this goal, the Credentialing Committee reviews the credentials of all practitioners who apply for participation. The Credentialing Committee is a committee of community practitioners, Divisional Medical Directors, and other such members as the Plan may appoint, who as a peer group make decisions on practitioner applications.

This policy applies to all Primary Care Physicians and/or Specialty Care Physicians, for which the Plan has credentialing responsibility, including Medical Doctors (MD) and Doctors of Osteopathic Medicine (DO) (“Practitioners”). For purposes of this policy, Practitioners applying to the Plan for credentialing shall be an “applicant”.

The Plan will not credential trainees who do not maintain a separate and distinct practice from their training practice.

The Plan does not credential practitioners practicing on a limited permit. The Plan does not accept applications for credentialing as general practice.

Practitioners who practice exclusively within the inpatient setting or freestanding facilities and who provide care for our members only as a result of members being directed to the facility may not need to be credentialed by the Plan.

The Plan does not make credentialing decisions based solely on the applicant’s race, ethnic/national identity, gender, age, sexual orientation, the types of procedures or types of patients in which the practitioner specializes. The Plan reserves the right to request proof of identity and personal interviews during the credentialing process. The Plan does not discriminate against practitioners who serve high-risk populations or who specialize in treating costly conditions or who participate in other Plans.

The applicant has the burden of providing complete information sufficiently detailed for the Credentialing Committee to act. The Plan will not provide benefits for services that a provider renders to a member covered under a program that requires providers to be credentialed until the provider is notified of the Plan’s credentialing approval and execution of a participating provider agreement by both the provider and the Plan. Until he/she has received such an
approval in writing and a participating agreement has been executed by both parties, a provider is not a member of the network and is not eligible for reimbursement. Providers must hold a member harmless if care is rendered prior to approval of the Plan.

The applicant has the right upon request to be informed of the status of their application for credentialing.

The method of communication used by the applicant will determine the method of response (e.g. a phone inquiry will receive a phone response, a letter inquiry will receive a response by letter). Staff will share current status, date of the next committee meeting, as well as identify the missing items necessary to complete the file for presentation to the Credentialing Committee.

Practitioners are recredentialed at intervals not to exceed three years and may be required to re-apply before their term expires in accordance with credentialing policies.

1. **CRITERIA**

   All applicants for credentialing shall meet the following criteria as established by the Plan:

   A. Service Area: All practitioners must maintain a practice within the geographic areas where the Plan is licensed to sell its products (the “Plan Service area”) to be considered for credentialing. Refer to Credentialing Policy # CR-20.

   B. Application Form: All applicants must submit a completed application in its entirety, for review. Credentialing staff cannot finish an incomplete application, therefore, if any information is missing, the applicant will be notified as soon as possible by telephone or in writing to request the missing information. A completed application consists of at least the following copies of all documents, where applicable and other documents as required by the Plan:

      Application Form – provided by or approved by the Plan; and all its attachments, waivers and releases updated by the applicant within 180 days of presentation to the Corporate Credentialing Committee. If application is not finished within 180 days it will be considered incomplete.

   C. TRAINING – Accredited training must meet the current minimum requirements as defined by the American Osteopathic Association (AOA) or American Board of Medical Specialties (ABMS). The Plan expects all physicians to be board certified in the specialty or sub-specialty in which they intend to practice, and maintain their certifications. Please refer to Credentialing Policy # CR-22.

   D. MALPRACTICE INSURANCE – New York State Practitioners must possess, and maintain at all times amounts of at least $1 million per occurrence and $3 million common aggregate applicable to the practitioner’s specialty/sub-specialty, or as otherwise specified
by the Plan. For Practitioners who practice in a state other than New York State, the applicant must document the existence of professional liability coverage meeting the minimum required in his/her state.

The proof must:

1. Name the practitioner
2. Document the limits of liability.
3. Include effective date and expiration date.

Applicants must also complete the Named Insured Certificate which Credentialing Staff will issue to the carrier to obtain notification of changes in coverage.

E. NYS SIGNED REGISTRATION – Applicant must possess, and maintain at all times, a valid State license and current registration to practice as a physician.

Practitioners with restricted or limited licenses generally do not meet the Plan’s criteria for credentialing. An applicant with a limited or restricted license(s) who request their application be considered as exceptions shall provide proof to the Credentialing Committee that they exceed the qualifications for membership in professional competence and good character.

F. DEA CERTIFICATE – Applicants must possess, and maintain at all times, a valid Drug Enforcement Agency (DEA) Certificate. Institutional DEAs and DEA exceptions may be considered on request.

G. FACILITY PRIVILEGES – Applicants are expected to be a member in good standing with a Plan affiliated Article 28 or 40 facility except as permitted by Credentialing Policy CR-16. Practitioners are required, by contract, to notify the Plan of any changes in their privilege status. All practitioners are obligated to provide for the continuous care of their patients in accordance with law and contractual obligations to the Plan.

H. CONFIDENTIAL INFORMATION QUESTIONNAIRE – Applicants must complete the disclosure questions set forth in the Application, which includes:

1. Whether (s)he is free of any conditions, which could impact his/her ability to deliver the care for which they are credentialed (e.g.: physical and mental capacity impairments, including substance abuse)
2. History of charges or convictions of a crime
3. History of pending or resolved Medicare or Medicaid Sanctions.
4. History of loss, limitation, or restriction of licensure in any jurisdiction
5. History of loss or limitation of DEA
6. History of loss or limitation of hospital privileges
7. History of revocation or limitation of privileges, membership, association, employment or participation status in any hospital, health care facility, or managed care organization
8. History of any professional disciplinary actions
i) History of pending or resolved medical malpractice claims history  
j) Signed attestation statement verifying the correctness and completeness of the application

I. SITE REVIEW – New practitioners may undergo a Site Review. Please refer to Credentialing Policy # CR-18.

J. 24 HOUR COVERAGE – All credentialed practitioners are obligated to provide for the continuous care of their patients through on-call coverage arrangements with other Plan credentialed practitioners of the same or similar specialties or sub-specialty, as applicable.

Practitioners who fail to provide proof that they meet or maintain any of the above criteria may be subject to denial of their credentials at the Plan’s discretion.

2. CREDENTIALING PROCEDURE

A. The Credentialing Staff will:

a. Assist the practitioner in accessing a Plan accepted application.

b. In accordance with Chapter 551 amendments to Public Health Law 4406-d(1) and Insurance Law 4803(a), the Plan will complete review of the applicant’s application for credentialing and will, within 60 days of receiving a completed application, notify the applicant as to whether the application was granted or whether additional time is necessary to make a determination, e.g., as a result of lack of necessary documentation from a third party.

c. If an incomplete application is submitted to the Plan, or if the Plan is not currently accepting additional health care professionals of the applicant’s type, the Plan will respond to the applicant with such notice as soon as possible, but no later than 60 days from receipt of the application.

d. The Plan will follow all applicable Managed Care legislation for any provider’s credentialing application that is pending for more than 60 days.

B. Once the completed application is available, the Credentialing Staff will:

a. Perform primary source verification of:

1) New York State Department of Education, Office of Professional Licensing – The licensing agency indicates licensure and if there have been any disciplinary action taken against the applicant’s license. Each applicant must have a current license to practice in the state where the member is to receive care. If there has
been any disciplinary action, the Credentialing Staff requests the report from the appropriate state.

2) Education and Training – Verify the highest level of credentials obtained, i.e. medical school, residency, fellowship training unless board certified.

3) Specialty Board Certification – Verify board certification at a primary source, i.e. ABMS, AMA Physician Master File, contacting AOA or writing to the appropriate Board.

4) Malpractice Insurance – Verify active coverage meeting our minimum requirements.

5) National Practitioner Data Bank – Obtain a National Practitioner Data Bank (NPDB) inquiry. In the event the insurance carrier provides information which differs from NPDB, the applicant will be contacted by Credentialing Staff and is obliged to explain or resolve the discrepancy.

6) Current Facility Privileges – Contact the facility requesting status of privileges effective date, any restrictions/limitations and the department in which the applicant has privileges. Please refer to Credentialing Policy # CR-16.

7) New York State Department of Health – Conduct a search for any Office of Professional Medical Conduct actions against the applicant. OPMC releases reports of practitioners who have been professionally disciplined. The report details the effective date of the disciplinary action, nature of misconduct and action taken.

8) Medicare/Medicaid Disciplinary Action (CMS) – Review the Medicare/Medicaid Sanction and Reinstatement Report via the NPDB and/or Federation of State Medical Boards (FSMB) for previous sanction activity by Medicare/Medicaid. Review the Office of Inspector General Database as well. The application may be rescinded at anytime if a Medicaid exclusion is reported.

9) DEA Certificate – Verify the active, current DEA Certificate. Applicants who do not maintain a DEA certificate must request an exception. Exceptions are considered for applicants who will not prescribe narcotics in the practice.

10) Work History – Work history for the prior five years of professional activity must be detailed and all gaps greater than six months must be explained. The applicant may be obliged to provide the means to verify any or all of the time period for any gap the Credentialing Committee requests to be explained.

b. Identify Discrepancies – If the information obtained from any source differs substantially from what the applicant provided, the applicant is notified in writing by the Plan Credentialing Staff within 10 business days of discovering the discrepancy. The applicant must respond within 10 business days to the Credentialing Staff with a written explanation of the discrepancy.

In addition, the applicant has the right to correct erroneous information submitted by another party. The applicant must notify the Plan Credentialing Staff in writing within 10 business days of discovering the erroneous information. The Plan staff will include the explanation and/or correction as part of the applicant's application.
when it is presented to the Credentialing Committee for review and recommendation.

Right to Review - The applicant has the right to review information obtained by the Plan to evaluate their application including information from the primary areas identified in B. a. 1) through 10).

c. Verify Clinical Competency References:

1) For applicants who within the last three (3) years completed their residency program, Credentialing Staff may solicit a letter from the Residency or Fellowship Program Director regarding clinical competence.

2) For applicants who have had other affiliations, either in area or out of area, Credentialing Staff may solicit references regarding clinical competency from a department chair or other appropriate expert.

d. Present completed application to a Divisional Medical Director for recommendation.

e. Credentialing Staff is responsible for maintaining the confidentiality of practitioner-specific information related to the credentialing process in accordance with applicable law. All information obtained in the credentialing process is confidential. Practitioner files are maintained in secure, locked files.

3. REVIEW ACTIONS

A Divisional Medical Director will:

a. Review each applicant’s entire credentialing packet, inclusive of the information obtained through source verification or references.

b. Identify applicants requiring further review or consideration by the Credentialing Committee.

c. Make a recommendation. If the recommendation is adverse to the applicant, the recommendation and reasons shall be stated in writing. If the Divisional Medical Director recommends approval of the application, the recommendation would be presented to the Credentialing Committee for review and approval.

4. APPROVAL/REVIEW PROCESS

Credentialing Committee shall:

a. Review the recommendations made by the Medical Director and discuss any issues that have been identified by the Medical Director as requiring further review.
b. Make determinations regarding the applicant. If the determination is adverse to the applicant, the reasons for the adverse determination shall be stated in writing and included with the notice to the applicant.

5. NOTIFICATION PROCESS

Credentialing Staff shall:

a. Notify the individual applicant and/or IPA(s)/Delivery System(s) if applicable of the credentialing decision made by the Credentialing Committee within 30 days of such decision.

b. If approved, all of applicant’s relevant information, such as education, training, and designated specialty/sub-specialty are added to the credentialing database. This information is available to download for the provider directory, website and member materials to ensure the information published is consistent with the information obtained in the credentialing process.

6. REGULATORY NOTICE REQUIREMENTS

Pursuant to 42 CFR 455.106 the Plan requires Practitioner to disclose the identity of any person who: (1) has ownership or control interest in the provider, or is an agent or managing employee of the provider; and (2) has been convicted of a criminal offense related to that person’s involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs. The Plan requires the disclosure of the above information upon entering into an initial agreement or renewal of any agreement between the Plan and its Providers.

The Plan is required to notify the New York State Department of Health of any disclosures made above within 20 working days of receipt of such information.

7. SANCTIONED PROVIDER PROCESS

The Plan is prohibited from including in its network any provider who:

a. Has, over the previous five (5) year period, been sanctioned or prohibited from participation in Federal health care programs under either Section 1128 or Section 1128A of the Social Security Act; or

b. Has had his or her license suspended by the New York State Education Department or the State office of Professional Misconduct.
Providers who fall into either of these categories will not be permitted to participate with the Plan. Pursuant to the primary source verification steps outlined earlier in this policy, the Plan shall confirm at initial credentialing that providers applying to participate in the network do not fall into either of these categories. Subsequent to initial credentialing, the Plan shall review its provider network on a monthly basis to identify providers that require exclusion on this basis.

Please note that a provider whose license is subject to a licensure action will be individually evaluated by the health plan and credentialing committee. The reason for the license action/restriction will be considered as part of the overall credentialing or recredentialing process, and may contribute to a decision to propose denial/termination of the provider's participation with the health plan.

Note: Except as required by law, the Credentialing Committee reserves the right to grant exceptions to this policy for the good of the community.

Cross Reference:
For Primary Care and Specialty Care Physician Recredentialing refer to #CR-02
For Hospital Privileges refer to #CR-16
For Out of Area Providers refer to #CR-20
For Board Certification of New Physicians and Osteopathics refer to #CR-22
Adopted from BlueCross BlueShield of the Rochester Area MCO Policy and Procedure #CR-1
Dated 5/99, BlueCross BlueShield of Central New York HMO-CNY Corporate Policy #
Physician Appointments/ Reappointments, BlueCross BlueShield of Utica/Watertown HMOBlue Policy # III

Committee Approvals:
Corporate Credentialing Committee: 6/16/03, 9/20/04, 6/20/05, 6/20/07, 6/17/09, 10/21/09, 11/17/10, 4/13/11, 9/21/11, 2/15/2012, 2/12/14, 4/16/14 CMS rev, 6/18/14 20 day rev, 5/25/16 policy rev, 10/19/16 NCQA, DOH rev
Excellus Credentialing Committee: 6/25/01, 12/17/01, 3/14/02, 9/17/02,
MCOCC: 11/3/00, 4/9/01
HCBMC: 12/7/00