Excellus

SUBJECT: NON-PHYSICIAN HEALTHCARE PRACTITIONER INITIAL CREDENTIALING SECTION: CREDENTIALING POLICY NUMBER: CR-01A	EFFECTIVE DATE: 9/26
Applies to all products administered by the Plan except when changed by contract	

Policy Statement: 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 Non-Physician Healthcare Practitioners, for which the Plan has credentialing responsibility, including but not limited to:

Applied Behavioral Analysts	Genetic Counselors	Pharmacists
Acupuncturist	Marriage & Family Therapists	Physical Therapists
Audiologist	Mental Health Counselors	Podiatrists
Certified Diabetic Educators	Midwifes	Psychologists
Chiropractors	Nurse Practitioners*	Registered Dieticians
Creative Arts Therapists	Occupational Therapists	Social Workers
Dentists *(specializing in oral maxillofacial surgery only)*	Optometrists	Speech Language Pathologists

*Independently practicing in Acute Care; Gerontology; Neonatal; Oncology; Psychiatric; Women's Health.

Specialty-specific credentialing and recredentialing criteria may be established for practitioner types identified in this policy. Such criteria shall be maintained in separate Credentialing (CR) documents and are incorporated herein by reference. Practitioners subject to specialty-specific criteria must satisfy both the requirements of this policy and the applicable specialty-specific credentialing and recredentialing criteria.

For purposes of this policy, practitioners applying to the Plan for credentialing shall be an "*applicant*".

The Plan requires all applicants credentialed by the Plan, to complete and maintain a current CAQH application (*"application*"). The applicant must list the Plan as an authorized entity to access the application information.

The Plan does not credential practitioners who practice on a limited permit. 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 are registered as agents of a credentialed facility and are not credentialed by the Plan.

The Plan will provisionally credential practitioners in accordance with this policy and the law.

The Plan's processes, strategies and methodologies for determining and applying credentialing requirements is comparable and no more stringently applied to mental health/substance use disorder providers as applied to medical/surgical providers.

The Plan does not base credentialing decisions on the applicant's race, ethnic/ national identity, gender, sexual orientation, the patient's insurance coverage (e.g. Medicaid) or the types of procedures in which the

However, age shall never be the sole determining factor in credentialing decisions.

The Plan reserves the right to require proof of identity and request 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 reimbursement for services rendered by an applicant, if the Plan requires the applicant to be credentialed, unless and until such applicant is notified of the Plan's credentialing approval and execution of a Participating Provider Agreement by both the applicant and the Plan. Until he/she has received such an approval in writing and a participating agreement has been executed by both parties, the applicant is not a member of the network and is not eligible for reimbursement. Applicants 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 practitioner will determine the method of response (e.g. a phone inquiry will receive a response by phone, a letter inquiry will receive a response by letter). The Plan 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 credentialed and recredentialed for a period not to exceed 36 months and may be required to re-apply before their term expires, in accordance with the Plan's policies.

Process:

1. CRITERIA

All applicants must submit a completed application in its entirety, for review and shall meet all criteria established by the Plan. The Plan will notify the applicant by telephone or in writing to request the missing information needed for completion.

A. SERVICE AREA: All applicants must maintain a physical practice location within the geographic areas where the Plan is licensed to sell its products (the "Plan Service area") and for which the applicant is physically present to treat our members to be considered for credentialing. All practice locations must meet the established applicable standards as defined in Credentialing Policy CR-18.

B. APPLICATION - All applications must be approved by the Plan. Applications, attachments, waivers and releases must be updated by the applicant and reattested at least 120 days prior to presentation to the Corporate Credentialing Committee. Any application and attestation dated greater than 120 days would be considered incomplete and will not be presented to the Corporate Credentialing Committee.

C. TRAINING – Accredited training must meet the current, minimum requirements as defined by the applicant's specialty board and criteria requirements of the Plan.

D. MALPRACTICE INSURANCE – New York State Practitioners must attest to maintaining current malpractice liability coverage in the 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 their state. (refer to Exhibit 1 for malpractice insurance requirements for Dentists).

The Plan reserves the right to request additional proof of malpractice liability coverage at any time during the credentialing process.

E. STATE LICENSE CERTIFICATE - Applicant must possess and maintain at all times, a valid State license and current registration to practice in their requested specialty. Applicants 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 – Practitioners must possess, and maintain at all times, a valid Drug Enforcement Agency (DEA) Certificate, if applicable for their specialty. Institutional DEAs and DEA exceptions may be considered on request.

G. FACILITY PRIVILEGES – Applicants must attest to maintain active hospital privileges and are a member in good standing with a Plan affiliated Article 28 or 40 facility, if applicable, except as permitted by Credentialing Policy CR-16. Applicants 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 the law and contractual obligations to the Plan.

H. CONFIDENTIAL INFORMATION QUESTIONNAIRE - Applicant's must document:

1) Lack of conditions that impact their ability to deliver the care for which they are
2) credentialed (e.g.: physical and mental capacity impairments, including substance use)
3) History of charges or conviction of a crime
4) History of pending or resolved Medicare or Medicaid Sanctions
5) History of loss, limitation, or restriction of licensure in any jurisdiction
6) History of loss or limitation of DEA
7) History of loss or limitation of hospital privileges
8) History of revocation or limitation of privileges, membership, association, employment or participation status in any hospital, health care facility, or managed care organization
9) History of any professional disciplinary actions
10) History of pending or resolved medical malpractice claims history
11) Signed attestation statement verifying correctness and completeness of the application.

I. 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 gaps the Credentialing Committee wants explained.

J. SITE REVIEW – New applicants may undergo a Site Review. Please refer to Credentialing Policy CR-18.

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

Applicants who fail to provide proof that they meet or maintain any of the above criteria may be subject to an administrative denial of credentials at the Plan's discretion.

2. **CREDENTIALING PROCEDURE**

A. The Plan will:

1) Assist the applicant in accessing an application.
2) Notify the applicant of missing or incomplete elements of the application.
3) Notify the applicant, within 60 days of receipt of a completed application, whether he/she is credentialed or whether additional time is needed to make a determination because a third party has failed to provide necessary documentation.
4) Where additional time is needed to make a determination due to the failure of a third party to provide necessary documentation, ensure that every effort is made to obtain such information as soon as possible, and shall make a final determination within 21 days of receiving the necessary information from a third party.
5) For applicants that are (1) newly licensed health care professionals or (2) a health care professional who has recently relocated to New York from another state and has not previously practiced in New York; and who are joining a participating group in which all members of the group currently participate with the Plan, and who have submitted a completed application which is neither approved nor declined within sixty (60) days, such applicant will be deemed "provisionally credentialed" on the 61st day, provided:
    i. The provisionally credentialed practitioner may not be designated as a member's primary care physician until such time as the practitioner has been fully credentialed;
    ii. The group practice in which the applicant will be joining notifies the Plan in writing that, should the application ultimately be denied, the group:
        a) shall refund any payments made by the Plan for in-network services provided by the provisionally credentialed practitioner that exceed any out of network benefits payable under the member's contract with the Plan; and
        b) shall not pursue reimbursement from the member, except to collect the copayment that otherwise would have been payable had the member received the services from a practitioner participating in the Plan's network.

**A completed application for Credentialing purposes includes: a complete and accurate CAQH application, re-attested to within the last 120 days, including all supporting documentation including, but not limited to malpractice insurance certificate, continuity of care arrangements that meet Plan criteria for specialty, explanation of any affirmative responses including malpractice suits, an explanation of any work history gaps of over six months. The practitioner is obliged to provide the Plan with information sufficiently detailed to render an opinion regarding any affirmative response. In addition, all verifications from third party source as listed under Section B. below.*

B. Once the completed application is available, the Plan will:

1. Review the application for completeness.

2. Perform primary source verification of:
    a) State Licensure - Verify that the applicant has a valid and current license to practice in all states where the practitioner provides care to members. License verifications are queried directly from the State licensing or certification agency. (e.g. New York State Department of

Education, Office of Professional Licensing) The licensing agency validates active licensure and may advise of any disciplinary action taken against the applicant's license. If there has been any disciplinary action, the Plan requests the report from the appropriate state.

b) Education and Training – Verify accredited training program for the specialty, via the applicable State licensing board.

c) Specialty Board Certification – Verify board certification at the primary source (i.e. ABPS, ABPOPPM, ABOMS, National Board of Chiropractic Examiners and/or American or International Chiropractic Board of Specialties), if applicable.

d) National Practitioner Data Bank – Query the National Practitioner Data Bank (NPDB) to identify any reports of malpractice settlements, adverse actions or sanctions imposed by any state or federal governing bodies. In the event the insurance carrier provides information which differs from NPDB, the applicant will be contacted by the Plan and is required to explain or resolve the discrepancy.

e) New York State Department of Education – For all applicants licensed in New York State, the Plan will conduct a search for any Office of Professional Discipline (OPD) actions taken against the applicant. Additionally, the Federation of Chiropractic Licensing Boards (e.g.: CINBAD) is also verified for chiropractors.

f) Medicare/Medicaid Disciplinary Action (CMS) – In addition to reviewing the Medicare/Medicaid Sanction via the NPDB for previous sanction activity by Medicare and/or Medicaid, the Plan will query the Office of Inspector General (OIG), Office of Medicaid Inspector General (OMIG) and the System for Award Management (SAM/EPLS) for program exclusions. The application may be denied if an exclusion from any of these sources is reported.

g) Office of Foreign Assets Control (OFAC) - Review OFAC's sanction lists to confirm that the applicant is not on any of those lists. Appearance on any of the lists will result in immediate denial of the application.

h) DEA Certificate –Verify the active, current DEA Certificate, if applicable or required. The application will be denied immediately if a debarment from this source is identified.

i) Social Security Death Master File (DMF) – Validate the applicant's Social Security number is not listed on DMF list.

j) National Plan and Provider Enumeration System (NPPES) – Validate NPI number of the applicant.

3. Identify Discrepancies – If the information obtained from any source (e.g., malpractice insurance carriers, hospital affiliation status, state licensing boards) differs substantially or determined to be inaccurate from what the applicant attested to on the application, the applicant is notified in writing by the Plan within 10 business days of discovering the discrepancy. The applicant must respond within 10 business days to the Plan with a written explanation of the discrepancy. Please refer to Credentialing Policy #CR-29.

   In addition, the applicant has the right to correct information submitted by another party. The applicant must notify the Plan in writing within 10 business days of discovering what they believe to be incorrect information. The Plan 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. See Credentialing Policy #CR-29.

4. Right to Review - the applicant has the right to review information obtained by the Plan to evaluate their application including information for the primary areas identified in B.2. a) through m). The Plan does not make available references, recommendations or peer review protected information.

5. Verify Clinical Competency References:

a) If applicable, for applicants who within the last year completed their training program, the Plan may solicit a letter from the training Program Director regarding clinical competence.
b) For applicants who have had other affiliations, either in area or out of area, Credentialing Staff may solicit references regarding clinical competency from an appropriate expert.

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

7. The Plan 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. All newly hired credentialing staff members are instructed on the importance of keeping the applicant's information confidential and secure, during on-boarding. All Credentialing materials and practitioner files are maintained in secure electronic files. In the event paper copies are generated, they are placed in locked bins, shredded and disposed of securely.

3. REVIEW ACTIONS

The Divisional Medical Director holds oversight responsibility for the credentialing review process. This role includes the comprehensive review of all completed practitioner files to ensure accuracy, completeness, and compliance with established standards. The Medical Director is also accountable for streamlining the review process, identifying opportunities for efficiency, and ensuring timely progression of files. Upon completion of the review, the Medical Director provides informed recommendations to the Credentials Committee for review, acceptance of the recommendation and final determination.

A. Role of the Divisional Medical Director:

1) Review each applicant's entire credentialing packet, inclusive of the information obtained through the source verification work sheet of each practitioner.
2) Determine whether the applicant meets the Plans requirements of a Clean File as defined in CR-03.
3) Identify applicants requiring further review of consideration by the Credentialing Committee.
4) Make a recommendation. If the recommendation is adverse to the applicant, the recommendation and reasons shall be stated in writing. If the Medical Director recommends approval of the application, the recommendation would be presented to the Credentialing Committee for review and approval.

4. APPROVAL PROCESS

A. Credentialing Committee shall:

1) Review all practitioners who were determined by the Plan to meet the Clean File criteria.
2) Review the recommendations made by the Medical Director and discuss any issues that have been identified by the Medical Director as requiring further review.
3) Make determinations regarding the applicants. 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

A. The Plan shall:

1) Notify the individual practitioner, and/or IPA(s)/Delivery System(s) if applicable, of the

credentialing decision made by the Credentialing Committee within 30 days.

2) All approved practitioner criteria such as education, training, and designated specialty are added to the credentialing database. This information is available to download for the practitioner directory, web site 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 new applicants to disclose the identity of any person who: (1) has ownership or control interest in the practitioner, or is an agent or managing employee of the practitioner; 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 practitioners.

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 PRACTITIONER PROCESS

The Plan is prohibited from including in its network any applicant 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.
c. Is included on any of OFAC's sanction lists

Applicants 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 practitioners applying to participate in the network do not fall into either of these categories. Subsequent to initial credentialing, the Plan shall review its practitioner network on a monthly basis to identify practitioners that require exclusion on this basis.

Please note that a practitioner whose license is subject to a license action/restriction will be individually evaluated by the Plan. 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 practitioner's participation with the 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 Non-Physician Healthcare Practitioner Recredentialing refer to #CR-02A
For Hospital Privileges refer to #CR-16
For Out of Area Providers refer to #CR-20
For Unresolved Conflicts refer to #CR-29

Adopted from BlueCross BlueShield of the Rochester Area MCO Policy and Procedure #CR-2 Dated 5/99, BlueCross BlueShield of Central New York HMO-CNY Corporate Policy # Non 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, 10/15/08, 7/09, 10/21/09, 11/17/10, 3/16/11, 2/15/12, 6/19/13 MT/GC, 10/16/13 Pharm, 4/16/14 CMS rev, 11/19/14 ABA, 9/16/15 LMC, Psych NP, 3/22/17 NYS Expedited Cred Law rev, 6/21/17 LMFT, 1/17/18 WHNP; 6/19/2019 rev; 4/21/2021 rev; 6/15/2022 rev; 7/20/22 rev; 11/16/2022 rev; 2/15/2023 rev; 3/15/2023 rev; 6/21/2023 rev; 8/21/2024 rev; 3/19/2025 renewed; 10/15/2025 revised; 11/19/2025 revised; 1/21/2026 revised

Excellus Credentialing Committee 6/25/01, 9/24/01, 3/14/02, 9/17/02
MCOCC: 11/3/00, 4/9/01
HCBMC: 12/7/00