Excellus

SUBJECT: PRIMARY CARE AND SPECIALTY PHYSICIAN RECREDENTIALING SECTION: CREDENTIALING POLICY NUMBER: CR-02	EFFECTIVE DATE: 1/01
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 at intervals not exceeding 36 months to assure the practitioner continues to meet all credentialing criteria. 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 but not limited to, Medical Doctors (MD) and Doctors of Osteopathic Medicine (DO) *("Practitioners").*

The Plan requires all practitioners credentialed by the Plan, maintain a completed and maintain a current CAQH application ("*application*").

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 applicant specializes. The Plan may consider an applicant's age as part of the credentialing process. 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 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 practitioner has the burden of providing complete information sufficiently detailed for Credentialing Committee to act.

The practitioner has the right upon request to be informed of the status of their application for recredentialing.

The method of communication used by the practitioner 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). 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 may be recredentialed at any time, but in no circumstance longer than a 36 month period.

Process:

1. CRITERIA

The Plan will notify the practitioner 180 days prior to the practitioner's recredential date. All practitioners must complete the recredential application in its entirety, for review. A completed application consists of at least the following copies of all documents, where applicable as required by the Plan. The Plan will notify the practitioner by telephone or in writing to request the missing information needed for completion.

A. SERVICE AREA - All practitioners 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 be considered for (re)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 practitioner 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.

C. TRAINING – The Plan requires all physician practitioners to notify the Plan of additional training/certification since their last credential date. Accredited training must meet the current minimum requirements as defined by the practitioner's specialty board and criteria requirements of the Plan. The Plan expects all physicians to maintain their board certifications. Please refer to Credentialing Policies # CR-22 and CR-22A.

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 – Practitioner must possess, and maintain at all times, a valid State license and current registration to practice as a physician. Practitioner's with a limited or restricted license generally do not meet the Plan's criteria for credentialing. A practitioner 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. Institutional DEAs and DEA exceptions may be considered on request.

G. FACILITY PRIVILEGES – Practitioners must attest to maintain active hospital privileges and are 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 QUESTIONNARIE – Practitioners must certify the practitioner's history since the last recredential date of pending and/or resolved:

1) Lack of conditions, which could impact their ability to deliver the care for which they are credentialed (e.g.: physical and mental capacity impairments, including substance use)
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
9) History of pending or resolved medical malpractice claims history
10) Signed attestation statement verifying the correctness and completeness of the application.

I. SITE REVIEW – 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 participating practitioners of the same or similar specialties or subspecialty as applicable.

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

J. CONTINUING MEDICAL EDUCATION CREDITS – Each practitioner will be required to complete 50 continuing education credits per year, annualized, to coincide with the recredentialing date. Credit hours do not always equal credits earned. Therefore, it is imperative that the practitioner assure that their documentation clearly documents credits earned.

- Physicians who are board certified and actively participating in the applicable Maintenance of Certification (MOC) process at the time of recredentialing will be deemed to have satisfied the Plan's CME requirements. Active participation in MOC will be accepted as evidence of compliance with the CME requirement, and a separate CME Attestation will not be required unless otherwise requested by the Plan.
- Physicians who are board certified but are not actively participating in the applicable MOC process at the time of recredentialing must submit a CME Attestation documenting completion of 50 CME credits annualized, of which at least 30 must be Category One CME credits.

- Physicians who are not board certified at the time of recredentialing must submit a CME Attestation documenting completion of 50 Category One CME credits annualized, all of which must be in their credentialed specialty. (CR-22A)

Physicians who fail to provide the acceptable 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. Mail a request for a current and completed recredential application*.
2. Collect and review incoming applications.
3. Call or send written reminder after two weeks.

**A completed application for Recredentialing 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. 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 a 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. (ie. 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. applicant's license.
   b) Specialty Board Certification – Verify board certification at a primary source (i.e. ABMS, AMA AOA, Royal College of Physicians and Surgeons). Refer to policy CR-22.
   c) National Practitioner Data Bank – Obtain a National Practitioner Data Bank (NPDB) inquiry within 180 days of practitioner review date. In the event the insurance carrier provides information which differs from NPDB, the practitioner will be contacted by Credentialing Staff and is obliged to explain or resolve the discrepancy.
   d) New York State Department of Health – For all practitioners licensed in New York State, the Plan will conduct a search for any Office of Professional Medical Conduct (OPMC) action against the practitioner. 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.

e) Medicare/Medicaid Disciplinary Action (CMS) – In addition to reviewing 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, the plan will query the Office of Inspector General Database (OIG), Office of Medicaid Inspector General (OMIG) and The System for Award Management (SAM) websites for program exclusions. The application may be rescinded if an exclusion from any of these sources is reported.
f) 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.
g) DEA Certificate – Verify the active, current DEA Certificate. Practitioners who do not maintain a DEA certificate must request an exception. Exceptions are considered for practitioners who will not prescribe narcotics in their practice.
h) Social Security Death Master File (DMF) – Validate the applicants Social Security number is not listed on DMF list.
i) National Plan and Provider Enumeration System (NPPES) – Validate NPI number of the applicant.

3. Site review – Any practitioners may be required to undergo a site review at the time of recredentialing. These site reviews are conducted by the plan staff. Refer to Credentialing Policy CR-18.

4. 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 practitioner is notified in writing by the Credentialing Staff within 10 business days of discovering the discrepancy. The practitioner must respond within 10 business days to the Credentialing Staff with a written explanation of the discrepancy. Please refer to Credentialing Policy #CR-29.

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

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

6. Review practitioner file for Quality Issues and/or Member Complaints.

7. Present the completed practitioner recredentialing application to a Medical Director for recommendation.

8. Prepare and mail the Credentialing Committee agenda one week prior to the scheduled meeting.

9. 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 practitioner'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 practitioner's entire recredentialing packet, inclusive of the information obtained through the source verification work sheet of each practitioner.
2) Determine whether the practitioner meets the Plans requirements of a Clean File as defined in CR-03.
3) Identify practitioners requiring further review of consideration by the Credentialing Committee.
4) Make a recommendation. If the recommendation is adverse to the practitioner, 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 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 determination on each application.
4) If the determination is adverse to the practitioner, the reasons for the adverse determination shall be stated in writing and included with the notice to the practitioner.

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 committee within 30 days.
2) All approved practitioner criteria such as education, training (including Fellowship, if applicable) and designated specialty are added to the credentialing data base. 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. NONCOMPLIANCE

Practitioners must provide their completed recredential application in time for full review and verification and no less than four months prior to the expiration date of current privileges. The Plan issues reminder letters before the expected date of return. For those practitioners who do not provide a recredential application or provide an incomplete recredential application, they will be issued a certified letter advising them that they have to complete the recredentials application within the specified time frame, otherwise their ability to treat Plan members may expire.

7. 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 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.

8. SANCTIONED PRACTITIONER PROCESS

The Plan is prohibited from including in its network any practitioner 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.

Practitioners 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 during the recredentialing process that practitioners applying to continue to participate in the network do not fall into either of these categories. On an ongoing basis, 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 an action/restriction will be individually evaluated by the Plan and the credentialing committee. The reason for the license action/restriction will be considered as part of the overall recredentialing process, and

may contribute to a decision to propose 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 Primary Care and Specialty Care Physician Credentialing refer to #CR-01 For Facility Privileges refer to #CR-16
For On-Site Program refer to #CR-18.
For Competency Requirements for Credentialing/Recredentialing of Physicians and Osteopathic Physicians refer to #CR-22
For Unsolved Conflicts refer to #CR-29

Adopted from BlueCross BlueShield of the Rochester Area MCO Policy and Procedure #CR-3 Dated 5/99, BlueCross BlueShield of Central New York HMO-CNY Corporate Policy # Physician Appointments/ Reappointments, BlueCross BlueShield of Utica/Watertown HMOBlue Policy # CR-V

Committee Approvals:

Corporate Credentialing Committee: 6/16/03, 6/20/05, 03/22/06, 6/20/07, 6/17/09, 11/17/10, 4/13/11, 9/21/11, 2/15/12, 2/12/14, 4/16/14 CMS rev, 6/18/14 20 day rev, 4/20/16 rev, 5/25/16 rev; 5/16/2018 rev, 6/19/2019 rev; 4/21/2021 rev; 11/16/2022 rev; 3/15/2023 rev; 8/21/2024 rev; renewed 3/29/2025; 11/19/2025 revised; 1/21/2026 revised; 8/19/2026 revised

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