Excellus

SUBJECT: CREDENTIALING COMMITTEE SECTION: CREDENTIALING POLICY NUMBER: CR-12	EFFECTIVE DATE: 1/01
Applies to all products administered by the Plan except when changed by contract	

Policy Statement: The Credentialing Committee ("Committee") is responsible for reviewing and approving all Health Plan's recommendations concerning all providers to whom the Plan's credentialing policies apply; for example, applications for credentialing and recredentialing, revocation of credentials, and for the development, review and revision of all credentialing and recredentialing policies and protocols.

The Committee shall ensure, by the administration of the credentialing and recredentialing processes defined in its policies, that providers are qualified for membership, show evidence of current competence to provide quality care that promotes health, and satisfies member and plan expectations, and demonstrate good moral character and professional conduct.

Structure:

The Committee shall be composed of no fewer than 16 nor more than 19 members (each a "Member"). By definition a member is credentialed with the Plan or a current non credentialed provider. In limited circumstances at the SVP/CMO discretion, a committee member may maintain membership without credentials by demonstrating clinical competence and commitment to educational excellence. (This may be demonstrated by continued board certification and MOC participation or commitment to 50 CME credits per year and a board review course completed once triennially). Members not credentialed with the Plan may have terms limited at the discretion of the SVP/CMO.

Members shall be nominated by the Medical Directors representing the Plans regions and appointed by the Plan's Senior Vice President/Chief Medical Officer ("SVP/CMO"). Committee members will hold a minimum term of 3 years, with a maximum of 2 terms. Based on exceptional credentials and/or Plan needs, a member may serve on Committee for extended periods based on the discretion of the Plan's SVP/CMO. The Plan's SVP/CMO may appoint one non-healthcare practitioner to the Committee. In the event this seat is vacant, the Committee Chairperson shall have the discretion to fill this vacancy with a designated staff member of the Plan. The staff member shall serve the Committee at the pleasure of the Chairperson.

There shall be at least four voting members from each of the Plan's regions. In addition, the Plan's Senior Medical Director and Medical Directors are considered voting members. The Plan's SVP/CMO, Chief Medical Officer, Senior Medical Director, who will serve as Vice Chairperson and Medical Directors are standing committee members.

Members are expected to attend at least half of all scheduled and special meetings. Members may be removed from the committee by the governing authority for non- participation or disruption of the committee in the conduct of its business.

Members shall, as a condition precedent to participation on the Committee, each individually execute the Committee Member Affirmation attesting to the Plan's Committee and Conflicts of Interest Policy, upon admission to the Committee and annually thereafter. A copy of the individual Member's affirmation is retained during the Member's participation on the Committee and for ten years thereafter. A Member's failure to execute the above affirmation annually, or to comply with the terms of the Committee and Conflicts of Interest Policy, shall result in a termination of his/her participation on the Committee.

The Credentialing staff and Medical Directors will be responsible for assuring appropriate geographic and institutional representation on the committee.

The committee may meet no less than ten meetings per calendar to consider and/or act on the following:

Process:

The Committee shall:

1. Collect and confirm source verifications (done by the Plan's Credentialing Staff on behalf of, and with oversight from, the Credentials Committee.)

2. Review and evaluate the qualifications of each applicant for credentialing or recredentialing. Decisions are not based on race, ethnic/national identity, gender, age, sexual orientation, or patient type (e.g, Medicaid) in which the practitioner specializes.

3. Seek additional information and clarification necessary to make an informed recommendation regarding the issue presented.

4. Decide whether the applicant has the requisite credentials and character for appointment and reappointment, and the duration of the appointment.

5. Determine if conditions or restrictions are attached to the granting of credentials.

6. If the qualifications for appointment are met, determine the category listing for the applicant is qualified.

7. Review practitioners out of cycle when triggered in accordance with credentialing policies, conditions of appointment, or referral to the credentials committee by the governing authority or Plan Medical Director.

8. Develop, implement, review and revise the credentialing policies.

9. Take into consideration recommendations provided by the Plan and external practitioner feedback during the review process.

10. Review, revise, and implement the list of specialties that are required to be credentialed by the Plan prior to participation in its network. For physicians, the list of specialties/sub- specialties shall be those solely as defined by ABMS, AOA, and/or RCPSC, and the qualifications for a physician to be listed and given specialty shall be consistent with the current qualifications for sitting the certifying examination.

11. The specialty listing and qualifications for non- physician providers shall be determined by the Credentials Committee and consistent with each profession's national certifying body.

12. Initiate pertinent directives or assistance from Credentialing Committee to other Committees.

Nondiscrimination:

The Health Plan does not base credentialing decisions, participation in its network, or otherwise discriminate against practitioners on the basis of the applicant's race, color, ethnic/national origin, gender, sexual orientation, age, disability of applicant or patient type. To prevent discriminatory practices, all Committee members are required to sign the "Committee Member Affirmation Statement" attesting adherence to the Plan's "Credentials Committee Confidentiality and Conflicts of Interest Policy" on an annual basis. Credentialing staff shall monitor the credentialing and recredentialing processes and committee decisions for discriminatory practices, by annually compiling a report of all application denials and assessing for trends based on applicant's race, ethnic/national identity, gender, age, sexual orientation or patient type. In the event discriminatory practices are identified, the Health Plan will take appropriate action to track and eliminate those practices as defined in the Health Plan's Credentialing Policy (CR-32) Monitoring Credentialing Denials.

Cross Reference: Adopted from BlueCross BlueShield of the Rochester Area MCO Policy and Procedure #CR-12 Dated 1/99, HMO-CNY Corporate Policy, Standard and Procedure # Administrative Appointment/Reappointment Workgroup Dated 4/6/99, HMO-CNY Corporate Policy, Standard and Procedure # Medical Advisory Board Dated 1/99, HMO-CNY Corporate Policy, Standard and Procedure # HMO-CNY Board of Directors Credentialing Accountability Dated 1/16/98,BCBSUW HMOBlue Credentialing/Recredentialing Policy and Procedures # CR-X Dated 4/99

Committee Approvals: Corporate Credentialing Committee: 3/15/04, 8/3/05, 7/25/07, 7/15/09, 4/21/10, 4/18/12, renewal 4/2014, 5/21/2014 revision, 5/25/16 rev, 11/19/16 rev, 4/19/17 rev, 12/19/18 rev; 10/21/20 rev; 9/21/22 rev; 6/26/24 rev
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