
Credentialing

Credentialing is the process by which the appropriate peer review bodies of the Plan evaluate each individual applicant's demonstrated ability, training, background, education, experience, patient admitting capabilities, licensure, regulatory compliance, and health status, by means of primary source verifications obtained in accordance with regulatory, accreditation and Plan policy and procedure. Credentialing may be conducted by the Plan or delegated to an organization with oversight by the Plan.

The Plan will complete credentialing activities and notify providers within 90 days of receiving a completed application. The notification to the provider will inform them as to whether they are credentialed, whether additional time to complete the credentialing process is needed, or that additional providers are not needed at the time. When additional information is needed to complete a provider application, the Plan will make the request from the provider as soon as possible, and no later than 90 days from the receipt of the application. The Plan will also communicate with providers within these time frames throughout the provider re-credentialing process.

No participating physician, allied health practitioner, or organization may provide services to members unless credentialed by the Plan, or an entity approved for delegated credentialing. An applicant response to any reasonable request by the Plan for additional information is required.

A satisfactory site survey is required for each primary care and OB/GYN specialist physician office.

For newly licensed health care professionals or health care professionals relocating from another state who are joining a contracted group practice, they will be considered a 'provisionally credentialed' provider on the ninety-first (91st) day after submitting a completed application to the Plan if the Plan does not approve or decline the application within 90 days.

If the application is untimely denied, the applicant will

revert back to non-participating status. If the group practice wishes to include the newly licensed or relocated provider the practice must agree to refund any payments made by the Plan for in-network services delivered by the provisionally credentialed provider that exceed any out-of-network benefit. In addition the provider group must agree to hold the member harmless from payment of any services denied during the provisional period except for collection of co-payments that would have been payable had the member received services from an in-network provider.

Baseline Criteria

Baseline criteria for continued participation in the provider network requires:

License to Practice

Practitioners must have a current valid license to practice in the State of New York.

Board Certification

It is desirable that participating physicians (M.D., D.O., D.P.M.) maintain Board Certification in the specialty being practiced as a provider for the Plan; or have accredited training that renders a physician eligible to sit for the board certification examination.

Hospital Admitting Privileges

Practitioners are required to have valid admitting privileges at a Plan participating hospital, or a formal agreement to admit members with another Plan participating practitioner who has admitting privileges at a Plan participating hospital.

Professional Liability Insurance

Plan providers (all disciplines) shall be required to carry and continue to maintain professional liability insurance in the minimum limits of \$1.3 million/\$3.9 million.

Covering

Primary Care Physicians in solo practice must have a

Physician	Plan-participating covering physician.
Medical Staff	<p>Providers with the following professional degrees are credentialed by the Plan:</p> <p>MD; DO; DPM; DDS; DMD; DC; PsychD; PhD; OD</p>
Allied Health Professionals	<p>The following are examples of allied health professionals credentialed by the Plan:</p> <p><i>Dependent Practitioners</i> Dependent practitioners are required to have a Supervision or Collaborative Practice Arrangement; or in the case of New York licensed midwives, the requirement is to have a collaborative relationship with a licensed physician who practices Obstetrics-Gynecology; the collaborative relationship must be documented and made available to the midwife’s patients:</p> <ol style="list-style-type: none"> 1) Advanced Registered Nurse Practitioner (ARNP) 2) Certified Nurse Midwife (CNM) 3) Physician Assistant (PA) 4) Osteopathic Assistant (OA) <p><i>Independent Practitioners</i> Acupuncturist Audiologist Dietitian Licensed Clinical Social Worker (LCSW) Licensed Mental Health Counselor (LMHC) Occupational/Physical/Speech Therapist</p>
Re-credentialing	In accordance with regulatory, accreditation and Plan policies and procedures, provider re-credentialing shall be conducted at least once every three years.
Updated Documentation	Providers must furnish copies of their current license, DEA certificate and professional liability insurance certificate to the Plan. Expiration dates must be

included with the documentation.

**Office of Inspector General
Medicare/Medicaid
Sanctions Report**

On a regular and ongoing basis, the Plan accesses the listings from the *Office of the Inspector General Medicare/Medicaid Sanctions (exclusions and reinstatements report)*, for the most current available information. This information is crosschecked against the network of providers. If providers are identified as being currently sanctioned, such providers are subject to immediate suspension and notification of termination of contract, in accordance with Plan Policy and Procedure.

A practitioner whose provider status with the Plan is recommended for termination for reason(s) that may require a report to be made to the National Practitioner Data Bank shall be entitled to a hearing and appellate review.

**Hearing and
Appellate Review**

Notification of the termination recommendation, together with reasons for the action, hearing and appellate review rights, and the process for obtaining a hearing and appellate review, shall be provided to the practitioner within 30 days of the date of the termination recommendation. Notification to the practitioner is to be mailed by certified return receipt mail.

The practitioner shall have a period of 30 days in which to file a written request for a hearing and appellate review. The request must be mailed via certified return receipt mail.

Upon timely receipt of the request, the Chief Executive Officer or his designee shall notify the practitioner of the date, time and place of the hearing. Such hearing shall not take place less than thirty (30) days from the date of the notice of the hearing.

The practitioner requesting the hearing and appellate review is required to appear in person or by telephone. The practitioner and the Plan are entitled to legal

representation at the hearing.

A practitioner who fails, without good cause, to appear and proceed at such hearing, shall be deemed to have waived their rights to a hearing and appellate review.

The practitioner has the burden of proving by clear and convincing evidence that the reason for the termination recommendation lacks any factual basis, or that such basis, or the conclusion(s) drawn from them, are either arbitrary, unreasonable or capricious.

The Hearing and Appellate Review Committee considers and decides the case objectively and in good faith.

Within 30 days after final adjournment of the hearing and appellate review, the Committee makes a written report and forward its decision to the QI Committee.

Notification of the Plan's final decision will be provided to the practitioner within 30 days.

Delegated Entities

All participating providers or entities delegated for Credentialing are to use the same standards as defined in this section. Compliance is monitored on a monthly basis and formal audits are conducted annually.