univera HEALTHCARE

SUBJECT: **Primary Care Nurse Practitioners** SECTION: **CREDENTIALING** POLICY NUMBER: **CR-31**	EFFECTIVE DATE: **10/04**
Applies to all products administered by the Plan except when changed by contract	

Policy Statement: The Plan permits eligible Nurse Practitioners with full practice authority to be credentialed as Primary Care Practitioners, either as independent practitioners or as members of a group practice. Nurse Practitioners may be credentialed as Primary Care Practitioners in service areas where no contractual arrangement with a provider network prohibits such practice. This policy does not apply to Nurse Practitioners who practice in collaboration with, or under the supervision of, a physician or physician group and do not maintain their own patient panel. In such cases, members may continue to receive care from the Nurse Practitioner by selecting the affiliated physician as their primary care physician.

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 credentialing of all practitioners who apply for participation. The Credentialing Committee is a committee of community practitioners, regional Medical Directors, and other such members as the Plan may appoint, who as a peer group make decisions or recommendations.

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

The applicant has the burden of providing complete information sufficiently detailed for Credentialing Committee to act. The applicant has the right upon request to be informed of the status of their application. 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). 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.

Nurse Practitioners are recredentialed at intervals not to exceed 36 months and may be required to re-apply before their term expires in accordance with credentialing policies. In the event a credentialed Nurse Practitioner does not wish to be re-credentialed, they must, prior to the expiration of the credentialed term, register with the Plan as a Nurse Practitioner to continue to participate in the Plan's provider network.

Definition:

Full Practice Authority – A Nurse Practitioner providing the full scope of services in which they are educated and clinically trained to provide in accordance with the laws and regulations of the State. Primary Care

Nurse Practitioners must be licensed in the state in which they practice and provide primary care services in pediatric, adult medicine, or family medicine to patients either in a group practice or in an independent office setting.

Process:

Nurse Practitioners must agree that the first year of practice will be a provisional year. They must agree to immediately report any preventable adverse events of Excellus patients and medical errors to the regional Chief Medical Officer (CMO). In addition, the Plan reserves the right to perform medical record reviews. The Nurse Practitioner must consent to having no fewer than 10 records selected, or all Excellus patient records if less than 10 per quarter reviewed by Excellus on a quarterly basis for clinical content

All primary care Nurse Practitioners will be required to provide the following documentation:

1. Evidence of graduation from an approved nursing school
2. Evidence of a Master's degree as a Nurse Practitioner
3. Evidence of an unrestricted license to practice as a Nurse Practitioner with a current registration date
4. Nurse Practitioner certification from one of the following four nationally recognized organizations: American Academy of Nurse Practitioners Certification Board, American Nurses Credentialing Center, Pediatric Nursing Certification Board, or National Certification Corporation.
5. DEA registration and license number
6. Facility privileges or a written statement delineating an inpatient coverage arrangement, as well as coverage arrangements for ER and after-hours situations
7. Consistent with the New York Nurse Practitioners Modernization Act, evidence of more than 3,600 hours of experience practicing as a licensed or certified Nurse Practitioner in the specialty field in which the applicant Nurse Practitioner is seeking to participate in Plan's network.
8. New York State applicants must maintain professional liability coverage for a minimum of $1 million per occurrence /$3 million aggregate. For applicants who practice in a state other than New York State, the applicant must attest the existence of professional liability coverage meeting the minimum required in their state.
9. Disclosure of any liability history, judgements, settlements, or disciplinary actions of any type
10. Evidence of any specialized training, education or experience not otherwise evident
11. Complete summary of education and work history from entry into nursing school to present
12. Until July 1, 2026, a Nurse Practitioner with more than 3,600 hours of experience is not required to provide evidence of a collaboration with a physician, a written practice agreement and written practice protocols.
13. Minimum of three professional references, two of whom must be physicians in the same specialty.
14. At the time of recredentialing, Nurse Practitioners will be required to provide evidence of 50 hours of annualized CMEs.

In addition, all new applicants must complete a Plan approved application and either a) sign a participating provider agreement, or b) participate under the terms and conditions of a Group participating provider agreement.

1. CRITERIA

All practitioners must submit and maintain a completed application in its entirety, for review and shall meet all criteria established 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 Nurse 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 Nurse Practitioner is physically present to treat our members to be considered for credentialing and (re) credentialing. All practice locations must meet the established applicable standards as defined in Credentialing Policy CR-18 and be in compliance with all laws and regulations and meet all criteria applicable to Nurse Practitioners in New York state.

B. APPLICATION: All 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 practitioner's specialty board. Practitioners must submit copies of each and every certificate of completion of training, degree, specialty certification and designation.

D. MALPRACTICE INSURANCE – New York State Nurse 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 Nurse 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. Nurse Practitioner may also complete the Named Insured Certificate which Credentialing Staff will issue to the carrier to obtain notification of changes in coverage.

E. STATE LICENSE CERTIFICATE – Practitioners must possess, and maintain at all times, a valid State license and current registration to practice as a Nurse Practitioner. The Plan will act immediately when it learns of a lapsed or expired registration. practitioners with restricted or limited licenses are generally not qualified to be credentialed. Those with limited or restricted licenses who request their application be considered as exceptions have the burden of proof they are qualified, competent (current) and of good moral character.

F. DEA CERTIFICATE – Practitioners must possess, and maintain at all times, a valid Drug Enforcement Agency (DEA) Certificate. The Plan will act immediately when it learns of a lapsed or expired certificate. Institutional DEAs and DEA exceptions may be considered on request.

G. FACILITY PRIVILEGES – Practitioners must attest to maintain active hospital privileges and are in good standing with a Plan affiliated Article 28 or 40 facility, if applicable, 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 the law and contractual obligations to the Plan.

H. CONFIDENTIAL INFORMATION QUESTIONNAIRE - Practitioners must document:

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 conviction 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 correctness and completeness of the application.

I. AUTHORIZATION RELEASE FORM – Signed and unchanged.

J. SITE REVIEW – New Practitioners may undergo a Site Review.

K. 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.

L. NEW PRACTITIONER ORIENTATION – Upon receipt of the Credentials Application, credentialing staff will notify Provider Relations if there is a need to schedule a New Practitioner Orientation.

M. 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 wants explained.

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

2. CREDENTIALING PROCEDURE

A. The Plan will:
1. Assist the practitioner in accessing a Plan accepted application.
2. Notify practitioners of missing or incomplete elements of the application.
3. Notify the practitioner, within 60 days of receipt of a completed application, whether they are 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.

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 practitioner 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, if applicable.
c) Specialty Board Certification – Verify board certification at the primary source where applicable.
d) 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

practitioner will be contacted by Credentialing Staff and is obliged to explain or resolve the discrepancy.

e) New York State Department of Education – The Office of Professional Discipline (OPD) 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.

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 practitioner attested to on their application, the practitioner is notified in writing by Plan 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 Plan 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.

4. Right to Review - The practitioner 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 practitioners who within the last year completed their training program, Credentialing Staff may solicit a letter from the training Program Director regarding clinical competence.
   b) For practitioners 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 practitioner credentialing application to a 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 and approve all practitioners who were determined by the Plan to meet the Clean File criteria.
   2) Review all 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, group practice and/or IPA(s)/Delivery System(s) if applicable of the credentialing decision made by the Corporate Credentialing committee within 30 days, or such other time as required by applicable law.
   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 and the Corporate Credentialing Committee. The reason for the license action/restriction will be considered as part of the overall credentialing and/or recredentialing process, and may contribute to a decision to propose denial/termination of the practitioner's participation with the Plan.

Note: The Plan Credentialing Committee reserves the right to grant exceptions to this policy for the good of the community.

Cross Reference:
For Hospital Privileges refer to #CR-16
For On-Site Program refer to #CR-18
For Non-Physician Healthcare Practitioner Recredentialing refer to #CR-02A
For Unresolved Conflicts refer to #CR-29

Source: no previous formal policy

Committee Approvals:
Corporate Credentialing Committee 9/20/04, 5/17/06, 6/20/07, 6/18/08, 6/16/10, 4/13/11, 9/21/11, 2/15/2012, 2/12/14, 7/15/15 rev, 3/22/17 rev, 4/19/17 rev, 7/26/17 rev, 1/17/2018 rev; 5/15/19 rev; 5/19/21 rev; 6/15/2022 rev; 7/20/2022 rev; 3/15/2023 rev; 4/17/2024 rev; 11/19/2025 rev; 1/21/2026 rev