EmblemHealth

Chapter 3: Credentialing

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Chapter Summary

EmblemHealth, like all health plans, reviews and verifies a practitioner's training and qualifications prior to allowing the provider to participate in our network. This is called credentialing. Additionally, practitioners are required to be recredentialed every three years in accordance with National Committee for Quality Assurance (NCQA) guidelines. The recredentialing process ensures a provider's credentials remain up to date and accurate.

Credentialing and Recredentialing Forms

For credentialing and recredentialing forms required, refer to the Join Our Network section of EmblemHealth.com.

Emblemhealth Credentialing and Recredentialing Process

EmblemHealth follows New York State law for credentialing and recredentialing. The Credentialing department reviews initial applications within 60 days of receiving a fully completed application. If additional information is needed, the plan will respond within 21 days. Applicants are notified within that period if credentialing has been approved or if additional time is needed. We make our best effort to obtain any missing documentation from third parties in a timely manner.

Decision

Once the application and all applicable verifications are completed, the Credentialing/Recredentialing Committee (CRC), which is under the direction of the EmblemHealth Chief Medical Officer, considers all information gathered on the provider and evaluates the provider based on EmblemHealth credentialing criteria. The CRC decides to approve or deny the provider's application. The provider is then informed of their decision.

Providers are generally credentialed for a three-year period. However, the CRC may recommend credentialing for a shorter period based on the results of its review. If so, the provider is advised of the decision and the reason for the shorter approval period.

If a provider is denied and is providing care to EmblemHealth members, care for the members will transition in accordance with EmblemHealth Continuity of Care requirements. Please refer to the *Continuity of Care with Out-of-Network Providers* subsection in the Utilization and Care Management chapter.

Provider Data Validation

New York State and federal regulations require EmblemHealth to maintain the accuracy of its provider file data and ensure its Provider Directories meet basic information requirements. EmblemHealth validates the accuracy of a provider's service location data during both credentialing and recredentialing by reviewing the provider's data in CAQH Provider Data Portal and performing telephone outreach. Providers are also contractually obligated to update their information with EmblemHealth. For additional guidance, please click here.

Note: EmblemHealth periodically updates our directories to change the OB/GYN specialty designation to GYN (gynecology) for practitioners who have not submitted a claim for obstetric services in the prior 24 months. Let us know if you stopped practicing obstetrics less than two years ago and we will update our records accordingly.

Council for Affordable Quality Healthcare

EmblemHealth requires all applicants for all networks to complete the Council for Affordable Quality Healthcare (CAQH) Provider Data Portal credentialing application form. If you do not have a CAQH number, register with CAQH Provider Data Portal. If you have any questions about how to obtain a CAQH number, call CAQH at 888-599-1771.

State-Designated Providers

State designation of providers will suffice for EmblemHealth's credentialing process. When contracting with New York State (NYS)-designated providers, EmblemHealth will not separately credential individual staff members in their capacity as employees of these programs. EmblemHealth will still conduct program integrity reviews to ensure provider staff is not disbarred from Medicaid or in any other way excluded from Medicaid reimbursement. EmblemHealth will still collect and accept program integrity-related information from these providers, as required in the Medicaid Managed Care Model Contract. This means we require such providers to not employ or contract with any employee, subcontractor, or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program.

Accrediting Bodies

Acceptable accrediting bodies include:

- The Joint Commission (TJC)
- Det Norske Veritas (DNV)
- The Accreditation Association for Ambulatory Health Care (AAAHC)
- The Commission on Accreditation of Rehabilitation Facilities (CARF)
- The Council on Accreditation (COA)
- The Community Health Accreditation Program (CHAP)
- The Continuing Care Accreditation Commission
- American Association of Diabetes Educators (AADE)
  American College of Radiology (ACR)
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- American Institute of Ultrasound in Medicine (AIUM)
- Intersocietal Accreditation Commission (IAC)
- American Association of Clinical Endocrinologists (AACE)
- Nuclear Medicine Technology Certification Board (NMTCB)
- American Academy of Urgent Care Medicine (AAUCM)
- Urgent Care Association of America (UCAOA)
- American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)

The Credentialing/Recredentialing Committee (CRC)

EmblemHealth's Credentialing/Recredentialing Committee (CRC) is charged with examining the qualifications of participating clinicians and facilities against the professional standards established by our Quality Improvement Committee (QIC).

The CRC performs the initial approval and credentialing of practitioners and facilities for participation with EmblemHealth networks. The CRC is assisted by the Credentialing department, which is responsible for reviewing and verifying completeness of every provider's application. This includes primary source verification of the provider's licensure and accreditation. The Centers for Medicare & Medicaid Services (CMS) requires primary source verification of education and training records and board certification. The CRC and the Credentialing department reassess practitioners and organizational providers every three years (at minimum) to assure all credentialed practitioners and organizations remain qualified and continue to meet EmblemHealth's criteria for participation.

Members of the CRC include the Medical Director (acting as the Committee Chair) or an EmblemHealth designee, and at least one physician from each primary care specialty and any high-volume specialists as designated by the Committee Chair. The Committee Chair ensures the CRC has a meaningful range of participating practitioners serving on the Committee, with additional specialties added on an ad-hoc basis. All practitioners in the voting membership of the Committee must be currently credentialed with EmblemHealth.

The Committee Chair leads discussions concerning potential quality issues and explains and/or clarifies credentialing policy and procedure when required.

For Medicare Advantage health care services, the provider must cooperate with EmblemHealth's credentialing and recredentialing process. The credentials of medical professionals covered by an agreement with one of EmblemHealth's companies are either reviewed by EmblemHealth directly or by a delegated entity. The credentialing process of a delegated entity is reviewed and approved by EmblemHealth and audited on an ongoing basis.

Reportable Actions

Actions reportable to the National Practitioner Data Bank (NPDB) include:

- Any professional review based on reasons related to professional competence or conduct that adversely affects EmblemHealth participation for a period longer than 30 days
- Voluntary surrender or restriction of clinical privileges while under, or to avoid, investigation

Actions reportable to the Healthcare Integrity and Protection Data Bank (HIPDB) include:

- Health care-related civil judgments entered in federal or state court
- Any other adjudicated actions or decisions the CMS Secretary shall establish by regulatizon

Actions reportable to the applicable state office with oversight of professional conduct (e.g., New York State Office of Professional Medical Conduct (NYS OPMC) includes:

- Termination of credentials based upon member complaints or peer review findings

Practitioner Language, Race, and Ethnicity

EmblemHealth asks all contracted practitioners to volunteer their own language and race/ethnicity information. This information is not used in contracting or credentialing decisions or for any discriminatory purpose. Data may be collected directly from practitioners or from sources such as, but not limited to, forms and the provider portal. If you prefer to not provide this information, please indicate "prefer not to provide" when this information is requested.

Languages available at a provider location are published in our provider directories. Members may request your language, race, and ethnicity. If the information is available, it can be provided to members by EmblemHealth Customer Service or by contacting your office.

Termination and Appeal

The CRC has the authority to terminate practitioners from serving EmblemHealth members. The Committee's decision is based on quality or credentialing issues arising at recredentialing and/or complaints about quality of care. The procedures for termination and appeal are managed through our Credentialing department.

EmblemHealth may terminate practitioner agreements upon 60 days prior written notice to Practitioner in the event of:

- a loss, suspension, or restriction of practitioner's hospital privileges;
- failure of practitioner to notify EmblemHealth of any changes in location in his/her practice;
- failure of practitioner to be available to provide services to members for a period in excess of thirty (30) days;
- failure of practitioner to timely supply requested information in connection with EmblemHealth's recredentialing process or failure to meet EmblemHealth's credentialing/recredentialing standards;
- failure of practitioner to comply with EmblemHealth's QI, Claims, Member Grievances, or UM Programs;
- failure of practitioner to continuously maintain (or the termination of any of) the types or amounts of insurance required to be continuously maintained by practitioner by this Agreement;
- failure of practitioner to remain a member in good standing of the staff of a designated participating facility; and in the event that practitioner's participation in the Medicare or Medicaid program is restricted, suspended or terminated, or there is a threat of such restriction, suspension, or termination.

EmblemHealth may terminate practitioner agreements immediately:

- if practitioner's Drug Enforcement Administration (DEA) number or license or certification to practice medicine is revoked, suspended, surrendered, or not renewed;
- upon a reasonable determination by EmblemHealth that the continued provision of services by practitioner under this Agreement may result in imminent harm to members; or
- upon a reasonable determination by EmblemHealth that practitioner has committed a fraud or has misrepresented a material fact.

EmblemHealth may terminate a practitioner's agreement, subject to any applicable reconsideration or hearing rights under applicable state or federal law, upon sixty (60) days' prior written notice to practitioner in the event of a breach of the agreement. Examples include:

- Practicing beyond the scope of the profession
- Being sexually or physically abusive
- Abandoning or neglecting a patient in need of immediate care

The CRC makes decisions, except for termination for egregious reasons or imminent harm concerns, at regularly scheduled

meetings. The practitioner receives a termination notice explaining the reason(s) for the proposed action, a termination date, and a detailed explanation of the appeal process. Termination shall be effective no earlier than 60 days from the practitioner's receipt of the termination notice. Termination for egregious reasons or for imminent harm concerns is immediate and does not require a CRC meeting to review.

Throughout the process, the CRC makes every effort to ensure the practitioner has an adequate opportunity to contribute to any discussion on recredentialing or quality of care, except when termination is due to egregious reasons or imminent harm.

Decisions of the practitioner's termination shall be effective no less than 60 days from the date of the termination notice.

Appeal of Disciplinary Decisions

The practitioner may appeal any formal CRC disciplinary action to a CRC Ad Hoc Appellate Board. Written notice of appeal must be sent to the CRC within 30 days of the date of the termination notice. If no appeal is submitted within 30 days, the action is reported to the NPDB.

If an appeal is requested, the practitioner is notified of the date and time of the appeal hearing once a date and time are confirmed. The hearing shall take place no later than 30 days from the date of receipt of the provider's request for a hearing.

The notice of hearing must be accompanied by copies of all documents, reports, cases, or materials on which the Ad Hoc Appellate Board intends to rely. The practitioner may submit additional information (in writing) for consideration by the Ad Hoc Appellate Board within 30 days of filing the appeal. Additional materials must be received before the scheduled date of the hearing.

The practitioner has the right to appear before the Ad Hoc Appellate Board through counsel.

This hearing may be postponed only once, unless there are extenuating circumstances. If the practitioner elects to postpone the second hearing without extenuating circumstances, the Ad Hoc Appellate Board convenes as scheduled and decides based upon the available information.

If the Ad Hoc Appellate Board upholds the original Committee's decision, EmblemHealth proceeds with reporting the action to the appropriate regulatory agencies.

Ad Hoc Appellate Board

The Ad Hoc Appellate Board is assembled by EmblemHealth credentialing staff and includes three credentialed practitioners, at least one of whom specializes in the field appropriate to the review. The Hearing Panel may consist of more than three credentialed practitioners, provided the number of clinical peers constitutes one-third or more of the total membership. Members of the CRC may serve on this Board. However, no physician can vote on both an initial decision and an appeal for the same practitioner.

The Ad Hoc Appellate Board may recommend reinstatement, provisional reinstatement with conditions set by the Board, or termination. The Hearing Panel renders a decision in a timely manner. The practitioner is notified by mail within five business days of the decision. A decision for termination is effective no less than 30 days after the practitioner's receipt of the Hearing Panel's decision.

EmblemHealth permits members to continue an ongoing course of treatment for a transition period of up to ninety (90) days, and postpartum care, subject to the provider's agreement, pursuant to PHL §4403(6)(e). See the Continuity of Care with Out-of-Network Providers subsection in the Utilization and are Management chapter.

Termination for Egregious Reasons

EmblemHealth can initiate an immediate termination in the event of:

- Knowledge of a member's imminent harm by a clinician
- Determination of fraud by EmblemHealth's Special Investigations Unit (SIU)
- Action by a state or federal agency, such as license suspension or revocation, CMS sanction, or other regulatory exclusion. Sources reviewed for those actions include but are not limited to:
  - Department of Health and Human Services Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE)
  - The United States Office of Personnel Management, Debarment Listing (OPM)
  - The General Services Administration (GSA) System for Award Management (SAM) Excluded Parties List System (EPLS)
  - The Social Security Administration Death Master File (SSDMF) or Limited Access Death Master File (LADMF)
  - The National Plan and Provider Enumeration System (NPPES)
  - The Office of Foreign Assets Control (OFAC)
  - Medicaid exclusions lists, which include: the New York State Office of the Medicaid Inspector General (OMIG), the State of New Jersey Office of the State Comptroller, Medicaid Fraud Division Debarment List, the TIBCO listing distributed by the Centers for Medicaid & Medicare Services (TIBCO) (collectively, "Exclusion/Sanction Lists")

A termination for any of the above reasons is reported to the NPDB and is not eligible for a hearing or a review.

EmblemHealth immediately removes any provider from the network who is unable to provide health care services due to a disciplinary action.

We recognize practitioners have the following rights that may not justify termination or decredentialing:

- Advocate on behalf of our members
- File a complaint against EmblemHealth
- Appeal any decision made by EmblemHealth
- Provide information or file a report to PHL §4406-c regarding prohibitions made by EmblemHealth
- Request a hearing or review

Medicaid Requirements

Providers sanctioned or excluded by the New York State Department of Health's (NYSDOH) Medicaid Program are excluded from participation in all EmblemHealth benefit plans.

All providers, professionals and facilities, inside and outside of New York, treating EmblemHealth Medicaid, HARP, and Child Health Plus members should be registered with the NYSDOH for the Medicaid Program. Registration does not obligate providers to see fee-for-service (FFS) Medicaid members. The NYSDOH offers an option for participation to be limited to Medicaid Managed Care.

Medicaid Compliance Program Certification

Social Services Law §363-d subd. 4 and 18 NYCRR §521.1(c) and 18 NYCRR §521.2(b) require EmblemHealth to validate each participating person, provider, or affiliate who receives, has received, or should be reasonably expected to receive, at least $500,000 in payments in any consecutive 12-month period, and has certified their mandatory compliance program with the New York State Office of the Medicaid Inspector General (OMIG). EmblemHealth validates certification during the initial

credentialing and recredentialing process by requesting the provider to either attest to not meeting the criteria for certification or providing proof of certification from the New York State OMIG for the previous year for initial credentialing, and the previous three years for recredentialing.

Medicare Preclusion

CMS requires EmblemHealth to ensure providers serving Medicare Advantage (MA) and Part D prescription drug plans (PDPs) are not on the Medicare Preclusion List.

In general, the Preclusion List includes providers or entities who have been revoked from Medicare, are under active re-enrollment bar, or have engaged in other inappropriate behavior regarding Medicare. The Preclusion List was assembled to replace the MA and prescriber enrollment requirement. Providers are notified of their potential inclusion on the list and their appeal rights. CMS adds the provider to the list only after an appeal is denied. CMS makes the Preclusion List available monthly for MA and PDP plans.

- Plans must remove any provider on the CMS list from their Part C and D networks, including any entities, providers/prescribers, and pharmacies. Removals must occur monthly as necessary.
- Plans are required to notify enrollees who have received care from one of these providers in the last 12 months. Members must be notified 60 days before payments to Preclusion List providers are denied. This means denials would begin starting 60 days after the effective date of the provider appearing on the listing. Providers receive a copy of the member notification.
- After the 60-day period, EmblemHealth may not reimburse or make payment for claims to any providers who appear on the Preclusion List, even for emergency or urgent services that may be in- or out-of-network. This includes any payments for prescriptions ordered by precluded providers.
- EmblemHealth uses the same process each month, including review of the Preclusion List, notification to impacted members (60 days before), and denial of payments/claims (after the 60-day period).

Practitioner Credentialing

Qualification Requirements

The minimum qualification requirements for participating in EmblemHealth networks include, but are not limited to, the following:

- A valid, unencumbered license to practice
- Ongoing maintenance of Board Certification as per specialty board requirements
- Admitting privileges in good standing with an EmblemHealth network participating hospital (as applicable)
- Current malpractice insurance coverage within acceptable limits
- Acceptable malpractice history
- Regulatory program participation status

The following types of practitioners require credentialing:

- Primary care physicians (MD, DO)
- Specialty care physicians (MD, DO)
- Podiatrists (DPM)
- Dentists (DDS, DMD)
- Oral and maxillofacial surgeons (OMS)
- Chiropractors (DC)
- Osteopaths
- Midwives (MW) – certified
- Optometrists (OD)
- Nutritionists
- Audiologists
- Physical, occupational, and speech/language therapists (PT, OT, SLP)
- Nurse practitioners (NP) – certified or advance registered or practicing independently
- Primary care nurse practitioners
- Physician assistants (PA)
- Home visit clinicians
- Acupuncturists
- Certified registered nurse anesthetists (CRNA)
- HIV specialists
- Lactation counselors
- Screening, brief intervention, and referral to treatment (SBIRT) providers

Independent Relationship Practitioners

Practitioners with an independent relationship with EmblemHealth must also be credentialed. The following credentialing requirements apply to Independent Relationship Practitioners providing care at an individual or group practice, facility, rental network, or telemedicine setting:

- Hospital-based practitioners providing care to EmblemHealth members because of their independent relationship with EmblemHealth
- Dentists providing care under EmblemHealth's medical benefits
- Non-physician practitioners with an independent relationship with EmblemHealth who provide care under EmblemHealth's medical benefits

Practitioners Excluded from Credentialing

The following types of practitioners are not credentialed:

- Contracted or hospital-employed practitioners practicing exclusively within the inpatient hospital setting (e.g., radiologists, pathologists, anesthesiologists, and emergency room physicians) and are providing care to EmblemHealth members at the facility
- Practitioners practicing exclusively within free-standing facilities and providing care for EmblemHealth members at the facility
- Pharmacists working for a pharmacy benefits management (PBM) organization to which EmblemHealth delegates utilization management (UM) functions
- Covering practitioners (e.g., locum tenens) who do not have an independent relationship with EmblemHealth
- Practitioners who do not provide care for members in a treatment setting

Practitioner Rights

During the credentialing process, practitioners maintain the following rights:

- To review information obtained in support of their credentialing applications, excluding references, recommendations, or other peer review-protected material
- To correct erroneous information, in writing, to the credentialing department within 10 days of receipt of EmblemHealth's notification
- To be informed of the status of his/her credentialing/recredentialing application (requests may be made to EmblemHealth via written or telephone inquiry)

Reporting Decredentialed Practitioners for Quality Issues

In the event a practitioner is decredentialed for quality issues by the CRC, the Recredentialing Committee, or an Ad Hoc Appellate Board, EmblemHealth is required by law to report such misconduct to the appropriate data collection service(s). Reporting will occur within 30 days of the decision date, unless the practitioner requests an appeal.

Practitioner Provisional Credentialing

In accordance with New York State Public Health Law, EmblemHealth allows newly licensed or recently relocated out-of-state practitioners to apply for provisional credentialing. This provisional status is available to practitioners who apply within six months of licensing or out-of-state relocation, who join a group practice that participates with EmblemHealth's HMO networks, and the group practice agrees to any necessary repayment noted below.

Provisionally credentialed practitioners may not be assigned to members as a primary care provider.

If an application for provisional credentials is denied, EmblemHealth considers any work performed by the provisional practitioner to be an out-of-network service, and the practitioner (or their group practice) shall repay EmblemHealth the difference between the in- and out-of-network fees payable under each member's coverage plan. Under no circumstances may the practitioner (or group practice) attempt to recover this difference from the member, except to collect copayment or coinsurance that would otherwise be payable had the member received services from a health care professional in the EmblemHealth network.

Practitioner Recredentialing

EmblemHealth requires all practitioners to undergo recredentialing every three years.

Practitioners must maintain the same minimum qualification requirements as applicable for the initial credentialing. The recredentialing process evaluates each practitioner on the following:

- Access and availability
- Under/overutilization data
- Quality of care
- Primary and secondary prevention
- Disease management
- Member satisfaction
- Site/medical record audit scores
- Member concerns
- Peer review
- ·Continuity of care

Six (6) months prior to the expiration of credentials, practitioners receive a letter from either EmblemHealth's Recredentialing Department or Aperture CVO (our contracted credentials verification organization). The letter directs the practitioner to update their CAQH Provider Data Portal application with the following:

- Malpractice claims history (if applicable)
- Updated copies of their curriculum vitae, state license, and Drug Enforcement Administration (DEA) certification
- Proof of malpractice insurance coverage

Refer to our CAQH Tips for guidance on updating your CAQH application.

Practitioners with a complete application on file with CAQH Provider Data Portal can advise EmblemHealth or Aperture CVO to retrieve all documentation from this source.

To ensure continued participation with EmblemHealth, it is important to return all recredentialing materials as soon as possible. Failure to respond in a timely manner may result in termination from EmblemHealth's provider networks. Reapplying to participate in EmblemHealth networks is then subject to network need.

The Recredentialing Department reviews the updated application for completeness and presents it to EmblemHealth's CRC for a determination. Occasionally, an EmblemHealth staff member may call the practitioner's office for missing or additional information. The practitioner is then notified of continued participation or termination.

Practitioner Reporting Responsibilities

The following events may affect the credentialing of a practitioner or practitioner's employee and shall be immediately reported to EmblemHealth:

- Any voluntary or involuntary diminishment, suspension, termination, or relinquishing of licensing and/or hospital privileges initiated by a hospital
- Any voluntary or involuntary diminishment, suspension, revocation, or relinquishing of a DEA certificate
- The initiation of any proceeding by a state licensing authority
- The initiation of any legal or criminal proceeding pertaining to the practitioner or any individual employed by the practitioner
- Any proceeding that could affect Medicaid or Medicare participation of either the practitioner or any licensed employee of the practitioner
- Any report made to the NPDB or other reporting agency concerning a licensed professional employed by the practitioner
- Any notice given regarding the commencement of a professional liability action involving the practitioner or any entity, other than a publicly traded company, in which the practitioner has an ownership interest
- Any member complaint concerning the covered services rendered

Behavioral Health Credentialing

To see the credentialing requirements for our Behavioral Health Network, see Carelon Behavioral Health (formerly Beacon

Health Options)'s Provider Handbook. The following provider types should contact Carelon Behavioral Health at 800-397-1630 to discuss participation:

- Caregiver/Family Supports and Services – behavioral health primary diagnosis
- Community Self-Advocacy Training and Support – behavioral health primary diagnosis
- Habilitation – behavioral health primary diagnosis
- HCBS/SPA services – behavioral health primary diagnosis
- NYS-designated providers of Children's Specialty Services – behavioral health primary diagnosis
- NYS-determined Essential Community Behavioral Health providers for children – behavioral health primary diagnosis
- OMH and OASAS licensed or certified providers
- Psychologists
- Prevocational Services
- Psychiatrists
- Respite – behavioral health primary diagnosis
- School-based mental health clinics
- Social Workers
- Supported Employment

Midwifery, Lactation Consultant, Nurse Practitioner, and Physician Assistant Services

MIDWIFERY SERVICES

EmblemHealth requires midwives to have a collaborative relationship with a participating physician practicing obstetrics and gynecology. Participation midwives, or those applying for participation with EmblemHealth, must document this collaborative relationship and make this information available to their patients. Failure to comply with this directive may result in professional misconduct charges. Refer to nysed.gov for New York State Midwifery definitions and requirements.

LACTATION CONSULTANT SERVICES

EmblemHealth adopts policy guidance from the New York State Medicaid program to ensure appropriate designation of participating practitioners as breast feeding, education, and lactation counselors. Physicians, Nurse Practitioners, Midwives, Physician Assistants, and Registered Nurses seeking this credential must have the following minimum requirements, as defined in the EmblemHealth Credentialing Policy:

- Current and valid medical license
- Current and valid Drug Enforcement Administration (DEA) certificate (as applicable)
- Current malpractice coverage within acceptable limits
- Hospital privileges in good standing with a plan-contracted facility
- Acceptable work history
- Acceptable malpractice history
- Acceptable adverse action history

In addition to these minimum credentialing requirements, applicants must possess one of the following certifications:

- International Board-Certified Lactation Consultant (IBCLC)

Certified Lactation Specialist (CLS)
- Certified Breastfeeding Specialist (CBS)
- Certified Lactation Counselor (CLC)
- Certified Lactation Educator (CLE)
- Certified Clinical Lactationist (CCL)
- Certified Breastfeeding Educator (CBE)

NURSE PRACTITIONER SERVICES

The professional services of a Nurse Practitioner (NP) may be covered in-network if he or she is contracted, meets qualifications for NPs, and is legally authorized to provide services in the state where the services are performed. Payments are allowed for assistant-at-surgery services and services provided in all areas and settings permitted under applicable state licensure laws.

Note: No separate payment is made to the NP when a facility or other provider charges or is paid any amount for such professional services. A facility or other provider includes a hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, ambulatory surgical center, community mental health center, rural health center, or federally qualified health center.

NP Qualification Requirements for Network Participation

An NP must meet all three of the following qualifications:

- Be a registered professional nurse authorized by the state in which the services are provided to practice as an NP in accordance with state law
- Be certified as an NP by a recognized national certifying body with established standards for NPs
- Possess a master's degree in Nursing

The following organizations are recognized national certifying bodies for NPs at the advanced practice level:

- American Association of Nurse Practitioners (AANP)
- American Nurses Credentialing Center (ANCC)
- National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties (NCC)
- Pediatric Nursing Certification Board (PNCB)
- Oncology Nursing Certification Corporation (ONCC)
- AACN Certification Corporation
- Hospice and Palliative Credentialing Center (HPCC)

Credentialing Application for NPs

Refer to the Join Our Network section of emblemhealth.com for the Credentialing Application for Nurse Practitioners.

Covered Services

Services are covered if they meet all four of the following criteria:

- Considered physician's services otherwise provided by a Doctor of Medicine or Osteopathy (MD/DO)
- Performed by a person who meets all NP qualifications and is legally authorized to perform the services in the state in which they are performed
- Performed in collaboration with an MD/DO
- Not otherwise precluded from coverage because of statutory exclusions

Collaborative Relationship

NPs with over 3,600 hours of total practice experience are no longer required to maintain a collaborative agreement and practice protocols with the Department of Education. Instead, NPs must execute and maintain, at their practice location, an attestation form and documentation of their collaborative relationships with physicians and/or with a hospital.

- If the NP is opting to maintain a collaborative agreement, EmblemHealth accepts a written copy. In accordance with the Provider Agreement, the physician must be participating with EmblemHealth.
- If the NP is opting to not maintain a collaborative agreement, a completed copy of the New York State Education Department (NYSED) Collaborative Relationships Attestation Form is accepted to demonstrate option of practicing with collaborative relationships as defined by the NYSED.

If not prescribing or admitting, an explanation is needed to confirm coverage arrangements.

NPs as Attending Physicians

Services provided by an NP that are medical in nature must be reasonable and necessary, be included in the plan of care, and would be performed by a physician in the absence of the NP. If the services performed by an NP can be performed by a registered nurse in the absence of a physician, they are not considered attending physician services and are not separately billable.

Services Otherwise Excluded from Coverage

NP services may not be covered if they are otherwise excluded from coverage even though an NP may be authorized by state law to perform them. For example, Medicare law excludes from coverage routine foot care and services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury, or to improve the functioning of a malformed body part. Therefore, these services are precluded from coverage even though they may be within an NP's scope of practice under state law.

Physician Assistant Services

The professional services of a Physician Assistant (PA) may be covered in-network if he or she is contracted, meets qualification for PAs, and is legally authorized to provide services in the state where the services are performed. Payments are allowed for assistant-at-surgery services and services provided in all areas and settings permitted under applicable state licensure laws.

Note: No separate payment is made to the PA when a facility or other provider charges or is paid any amount for such professional services. A facility or other provider includes a hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, ambulatory surgical center, community mental health center, rural health center, or federally qualified health center.

PA Qualification Requirements for Network Participation

A PA must be licensed by the state to practice as a PA and meet one of the following two qualifications:

- Graduated from a PA educational program accredited by the Accreditation Review Commission on Education for the Physician Assistant (or its predecessor agencies, the Commission on Accreditation of Allied Health Education Programs [CAAHEP] and the Committee on Allied Health Education and Accreditation [CAHEA])
- Passed the national certification examination administered by the National Commission on Certification of Physician Assistants (NCCPA)

Credentialing Application for PAs

Refer to the Join Our Network section of emblemhealth.com for the Credentialing Application for Physician Assistants.

Covered Services

Services are covered if they meet all four of the following criteria:

- Considered physician's services if provided by a Doctor of Medicine or Osteopathy (MD/DO)
- Performed by a person who meets all PA qualifications and is legally authorized to perform the services in the state in which they are performed
- Performed under the general supervision of an MD/DO

PA Covered Services

PAs may provide services billed under all levels of CPT evaluation and management codes, and diagnostic tests, if provided under the general supervision of a physician. Examples of services PAs may provide include services traditionally reserved for physicians, such as examinations (including the initial preventive physical examination), minor surgery, setting casts for simple fractures, interpreting x-rays, and other activities involving an independent evaluation or treatment of the patient's condition.

Services Otherwise Excluded from Coverage

PA services may not be covered if they are otherwise excluded from coverage even though a PA may be authorized by state law to perform them.

Physician Supervision

The PA's physician supervisor (or a physician designated by the supervising physician or employer as provided under state law or regulations) is primarily responsible for the overall direction and management of the PA's professional activities, and for assuring the services provided are medically appropriate for the patient. The physician supervisor (or physician designee) need not be physically present when a service is provided by the PA to a patient and may be contacted by telephone, if necessary, unless state law or regulations require otherwise.

Organizational Provider Credentialing

The minimum qualification requirements for participating in EmblemHealth networks include, but are not limited to:

- Current accreditation or an acceptable site visit
- Meets applicable licensing requirements
- Current Medicare and Medicaid certification status
- Malpractice insurance coverage
- Acceptable history with regards to malpractice

The following organizational providers require credentialing:

- Adult Day Health Care
- AIDS Adult Day Care
- Ambulatory Surgery Facilities
- Assisted Living Residence (ALR)
- Clinical Laboratories
- Comprehensive Outpatient Rehabilitation Centers (CORCs)
- Dialysis (End-Stage Renal Facilities)
- Durable Medical Equipment Vendors (DMEs)
- Enhanced Assisted Living Residence (EALR)
- Federally Qualified Health Centers (FQHCs)
- Freestanding Imaging Centers
- Freestanding Outpatient Alcohol/Drug Abuse Centers
- Freestanding Outpatient Mental Health Centers
- Home Health Agencies and Home Infusion Agencies
- Hospices
- Hospitals
- Meals (Home and Congregate)
- Office-Based Surgery Practices (OBSPs)
- Outpatient Diabetes Self-Management Training
- Outpatient Physical Therapy and Speech Language Pathology
- Personal Care Services (PCS)
- Personal Emergency Response Services (PERS)
- Portable X-Ray Suppliers
- Psychiatric Hospitals
- Rural Health Clinics (RHCs)
- Skilled Nursing Facilities
- Social and Environmental Supports
- Social Day Care
- Special Needs Assisted Living Residence (SNALR)
- Substance Abuse Residential Rehabilitation
- Transportation Services
- Urgent Care Centers

Site Visits

Site visits are completed for non-accredited entities, as applicable. Although the Centers for Medicare & Medicaid Services (CMS) or state review or certification does not serve as accreditation of an institution, a CMS or state review can be accepted in lieu of the required site visit. The actual report from the institution must be retrieved to verify the review was performed and the report meets acceptable standards; however, a letter from CMS confirming the facility was reviewed and indicating it passed inspection is acceptable in lieu of the survey report.

Organizational Provider Recredentialing

EmblemHealth has a process for the periodic recredentialing of organizational providers previously approved by the CRC. All organizations are recredentialed every three years.

All organizations participating in EmblemHealth networks are required to obtain initial approval from the CRC and are also

subject to the recredentialing process.

Recredentialing Review Criteria

The review criteria for recredentialing is the same as the credentialing criteria.