# CREDENTIALING PLAN

**Product Lines Affected:**

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POLICY & PROCEDURE REFERENCES

This plan supports UCare’s policy/policies:

- QCR021 – Providers Non-Response to Requests for Credentialing Documentation
- QAG005 – Potential Deficiency in Clinical Quality of Care
- QAG015 – Complaints, Appeals, and Grievances Threshold Monitoring
- CCD021 – Delegation Management
- PRC – Site Survey Policy

This plan supports UCare’s procedure/procedures:

- CCR0015 – Organization Assessment Requirements
- CCR0019 – Complaint Review
- CCR0021 – Practitioner Credentialing
- CCR0023 – Provider on Review

Other references:

- Peer Review – Appeal Process Work Instructions
- Criteria for Credentialing File Review Grid
- Acceptable Primary Source Verifications
- State Board Ongoing Monitoring Work Instructions
- Medicare/Medicaid (OIG) Ongoing Monitoring Work Instructions
- Annual Discrimination Report Work Instructions

I. **INTRODUCTION**

The UCare Credentialing Department supports the organization by choosing competent providers using a fair, thorough application process, thereby ensuring the safety and quality of care given to members. In addition to strict adherence to organizational standards, the Credentialing Department meets all required external regulatory standards.

To provide a plan on credentialing and recredentialing of Providers consistent with Centers for Medicare & Medicaid Services (CMS) regulations, Minnesota state law, the Health Care Quality Improvement Act of 1986, and the guidelines of other applicable regulatory and accreditation agencies such as the National Committee for Quality Assurance (NCQA) and The Joint Commission Organizations (TJC).

On an annual basis the appropriate staff will review the Credentialing Plan. The Quality Improvement Advisory and Credentialing Committee (QIACC) will approve the Credentialing Plan.
The Credentialing Plan may be changed at any time upon approval by the QIACC. Any changes in regulatory or accreditation requirements shall automatically be incorporated into the Credentialing Plan as of the requirements effective date. Changes shall be effective for all new and existing Practitioners and Organizational Providers.

To prevent discrimination, UCare does not collect data nor does UCare make credentialing or recredentialing decisions based on an applicant’s race, ethnic or national identity, religion, disability, gender, age, sexual orientation, marital status, the types of procedures a practitioner performs, or the types of patients a Practitioner sees.

UCare collects information in regards to a Practitioner’s spoken languages which is used for directory purposes. However, such information is not presented or considered during the credentialing or recredentialing process.

This Credentialing Plan applies to all Practitioners and Organizational Providers defined by UCare as subject to credentialing. All Practitioners and Organizational Providers subject to credentialing must be fully credentialed prior to rendering a service to a UCare member. Continued participation by the Practitioner and Organizational Provider under this Credentialing Plan is dependent upon the Practitioner and Organizational Provider meeting, on an ongoing basis, the participation criteria set forth in this Credentialing Plan.

II. DEFINITIONS

Provider

Any Practitioner or Organizational Provider that provides health care services under contract with UCare, or a delegate where UCare retains credentialing responsibility, and is licensed or otherwise authorized to render such services. In the case of a Provider seeking initial credentialing, “Provider” may include a practitioner or organization that has not yet executed a contract with UCare or with a delegated entity where UCare holds the responsibility.

The term “Provider” is used in this UCare Credentialing Plan as a universal term that refers to all entities that provide health services under the Credentialing Plan criteria.

Practitioner

Any individual health care professional permitted by law to provide health care or services. In general, UCare credentials Practitioners who practice independently, are licensed to practice, and are accessed directly by members.

Organizational Providers

Health care facilities, such as hospitals, skilled nursing facilities, nursing homes, birthing centers, behavioral health care, freestanding surgical centers, and Ancillary Service Providers, which provide health care services. Organizational Providers do not include
facilities where contracts and payments are made to Practitioners or groups of Practitioners, 
e.g. clinics and care systems.

Ancillary Service Provider

Providers of home health services, laboratory services, radiology services, durable medical 
equipment, pharmacy services, rehabilitative services, dialysis services, hospice, infusion 
Providers, pain management centers, and similar services and supplies dispensed by order or 
prescription of the primary care physician, specialty physician or other Providers authorized 
to prescribe those services.

Credentialing Staff

The Credentialing Staff have the ability to triage credentialing applications per the Variation 
Application File Review Grid to determine if the credentialing application can be processed 
as a clean file or if it needs Medical Director(s) review. UCare’s Credentialing Staff include 
those individuals other than the Credentialing and Provider Demographic Manager, 
Credentialing Supervisor and/or Medical Director who conduct credentialing work as 
described in this Credentialing Plan.

Medical Directors

The Chief Medical Officer or an Associate Medical Director employed by UCare.

Clean Credentialing Files

Are any credentialing files that have been reviewed by Credentialing Staff and (1) do not 
vary from any credentialing criteria as outlined in this Credentialing Plan, or (2), files that 
 vary from administrative or professional criteria, however, after review of administrative and 
professional criteria by the Credentialing Staff and/or Medical Director, deemed a file with 
no current significant issues.

Credentialing

The review of qualifications and other relevant information pertaining to a Provider subject 
to credentialing who seeks to participate in UCare’s network under a contract with UCare or 
a contract with a delegate where UCare retains credentialing.

Recredentialing

Recredentialing of Providers is performed every three years or earlier for any recredentialing 
files with variations from credentialing in accordance with the processes and criteria 
described herein.

Credentialing Committee

The Credentialing Committee is responsible for reviewing credentialing and recredentialing
files with administrative and professional criteria per this Credentialing Plan and the Credentialing Committee Charter. Reviews and approves changes to the Credentialing Plan and procedures. Makes decisions for new credentialing delegation agreements, delegation issues and annual oversight audits based on information and recommendations from the Credentialing Delegation Specialist. The Credentialing Committee reports activities to the QIACC.

Pre-Application Criteria

All providers and Facilities requiring credentialing must be determined by UCare to be eligible to apply for participation status or existing participation status. Eligibility is determined by meeting the pre-application criteria that is outlined in Attachment A of this Credentialing Plan for the provider or facility types.

Administrative Criteria

Administrative Criteria are those criteria that are unrelated to the Practitioner’s professional performance, judgment and clinical competence. Administrative Criteria is outlined in Attachment A of this Credentialing Plan for individual Practitioner types and Attachment B for Organizational Provider types.

Professional Criteria

Professional Criteria are those criteria that relate to the Practitioner’s professional performance, judgment and clinical competence. In determining whether there is a variation from Professional Criteria, the Credentialing Staff and/or the Medical Director may apply specific guidelines approved by QIACC. Professional Criteria is outlined in Attachment A of this Credentialing Plan for individual Practitioner types and Attachment B for Organizational Provider types.

Quality of Care Issues

Quality of Care Issue, as understood from a regulatory context and as referred to within this Credentialing Plan, describes situations in which the quality of clinical care or service did or potentially could have adversely affected a member’s health or well being.
III. ROLES AND FUNCTIONS OF UCARE BOARD, CREDENTIALING COMMITTEE, CREDENTIALING COMMITTEE AND STAFF

A. Board of Directors (BOD)

The UCare BOD has formally delegated the responsibility and authority for acceptance, discipline, and activities that may lead to the denial or termination of Providers subject to credentialing, to UCare’s Quality Improvement Advisory and Credentialing Council (QIACC).

B. Quality Improvement Advisory and Credentialing Council (QIACC)

QIACC has the responsibility and authority for the acceptance, discipline, and the activities that may lead to final termination of Providers. The QIACC has delegated this responsibility to the Credentialing Committee which provides a monthly summary report to the QIACC.

C. Credentialing Committee

The Credentialing Committee has the responsibility for review and recommendations regarding the Credentialing Plan. The Committee reviews and makes credentialing decisions regarding files that, after Credentialing Staff and/or Medical Director review, vary from Administrative and Professional Criteria. The Credentialing Committee may approve, deny or terminate a Providers status with UCare.

The Credentialing Committee has delegated review and approval of Clean Credentialing Files to the Medical Director as described in section XI of this Credentialing Plan. In cases where the Medical Director approves a Provider with variation from Administrative or Professional Criteria in accordance with QIACC guidelines for delegated review, the Credentialing Committee shall be notified at its earliest subsequent meeting.

The Credentialing Committee shall meet monthly and voting membership shall be limited to participating Practitioners, clinic administrative staff, and UCare Medical Directors. Credentialing Staff will not have voting rights regarding any credentialing decisions, but may serve to provide information from the credentialing file and/or provide guidance on UCare credentialing policies and procedures. The majority of Credentialing Committee members shall include practicing physicians, and the committee chair must be a practicing physician. The Committee Chair may temporarily, in writing, add a practitioner, as necessary, to hear professional credentialing matters that require peer expertise not available from existing committee members. In the role of a peer review entity, the Practitioner members of the Credentialing Committee are responsible for the review of Practitioners and Organizational Providers who vary from Professional Criteria as described herein.

To affirm compliance with discrimination provision, the Credentialing Committee...
members sign a non-discrimination statement at each committee meeting.

D. **Appeals Committee**

An Appeals Committee shall be appointed on an ad hoc basis by UCare’s Medical Director, acting on behalf of UCare. Members of the Appeals Committee shall be made up of actively practicing Practitioners and may also include one consumer member of the BOD. Three people will make up the Appeals Committee. At least one of the Practitioners shall be from the same or similar specialty as the appealing Provider. Appeals Committee members shall not be appointed if they are in direct economic competition or have any other conflict of interest with the Practitioner who is the subject of the hearing. QIACC members generally should not serve on the Appeals Committee. The Appeals Committee’s purpose is to hear appeals from Practitioners after the QIACC has recommended denial or termination of a Practitioner’s status or has recommended or imposed disciplinary action, based on professional conduct or competence. Appeal Committee members will excuse themselves from any QIACC and/or BOD deliberations if they are present during their meeting.

E. **Medical Directors:** The Medical Director reviews and makes the following decisions:

a. Weekly reviews and approves files that have been deemed as Clean Credentialing Files;

b. Credentialing files that vary from Administrative Criteria;

c. Credentialing files that vary from Professional Criteria that indicate a potential professional competency or performance issue.

The Medical Director will review and act on Provider credentialing files that Credentialing Staff has identified as possible significant issues. The Medical Director(s) may decide one of the following:

a. May request further information from a Provider prior to presenting to the Credentialing Committee or the QIACC;

b. Make recommendations that the Provider’s credentialing file be reviewed by the Credentialing Committee;

c. Professional Criteria variation does not indicate a potential professional competency or performance issues pursuant to QIACC guidelines; he may approve the Practitioner and shall notify the QIACC;

d. Significant issue that warrant Provider denial or termination.

The Medical Director also provides guidance and counsel to Credentialing Staff regarding UCare’s professional standards, policies and procedures. QIACC will be notified on all files.

F. **Credentialing Staff**
Credentialing Staff shall perform administrative review functions and prepare cases for appropriate staff, workgroups or committee reviews per credentialing policies and procedures. Credentialing Staff shall review each credentialing application to determine whether the Provider meets Pre-application Criteria as defined within this Credentialing Plan. Credentialing Staff shall ensure that files have been verified and each file reviewed to identify Clean Credentialing Files and those files with variation from either Professional per the Criteria for Variation Application File Review Grid or Administrative Criteria. If any file varies from review criteria per grid, Credentialing Staff shall route the case to the Medical Director per this Credentialing Plan.

IV. Peer Review Protection and Confidentiality

All Committees described above, the BOD, and Credentialing Staff supporting credentialing actions operate as review organizations pursuant to Minn. Stat. § 145.61 et seq. and professional review bodies pursuant to the Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11101 et seq. Documents used for credentialing purposes shall be appropriately marked as peer review documents and stored separately from other documents. Access to peer review documents will be limited to authorized individuals. Peer review documents will be stored in a secure electronic or physical environment. Credentialing information will not be released except to another review organization under Minn. Stat. § 145.61 or otherwise permitted by law. Release of credentialing information to any other organization or individual that is not a review organization per Minn. Stat. § 145.61 may only occur upon approval from UCare’s General Counsel.

V. Provider Directories

Information provided in member materials, including Provider directories, which includes the online Provider directory, is consistent with the information obtained during the credentialing process. Specifically any Practitioner information regarding qualifications given to members, should match the information regarding Practitioner’s education, training, certification and designated specialty gathered during the credentialing process. Specialty refers to an area of practice, including primary care disciplines.

At the time of initial credentialing, re-credentialing, credentialing staff enters into the credentialing software database each practitioner’s verified information to include: education, training, board certification, and specialty. This information is then available to be utilized by other areas within UCare, such as directories and other materials for members.

On a daily basis the Cactus database updates the online Provider Directory (Find-a-Doc) using the current, including new, information in Cactus via an automated process by our Information Services Department. Per the Provider Relations and Contracting procedure: PRC0188 Monthly Provider Data Audit, the Provider Materials Coordinator will by the 10th day of each month randomly select five (5) active practitioner records and five (5) active group records from the
VI. **Site Surveys**

UCare or the delegate will conduct site surveys and assessment of medical/treatment record keeping for all Primary Care Clinics, OB/GYN Clinics or other high volume Providers as defined by UCare at the time of initial contracting per Provider Relations and Contracting Procedure PRC107 Site Surveys prior to UCare contracting with a clinic. UCare will also visit Provider sites that reach its members complaint threshold or as part of a corrective action as described in this Credentialing Plan.

VII. **Practitioners Subject to Credentialing:**

UCare credentials Licensed Practitioners who practice independently, are licensed to practice, and are accessed directly from members (do not require a doctor’s order to treat e.g. PTs or OTs). More specifically, UCare credentials the following Practitioner types:

- Acupuncturists (LAc)
- Bachelor of Medicine and Bachelor of Surgery (MBBS)
- Certified Nurse Midwife (CNM)
- Chiropractor (DC) (delegated to ChiroCare)
- Dentist (DDS-Medical)
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Traditional Midwife (LTM or LM)
  - Practicing exclusively in a Birthing Center
- Optometrists (OD)
- Oral & Maxillofacial Surgeons (MD)
- Physicians (MD, DO)
- Physician Assistant (PA)
- Podiatrist (DPM)
- Psychologist (LP)
  - PhD
  - PsyD
  - EdD
  - MA
  - MS
- Clinical Nurse Specialist (CNS)
- Certified Nurse Practitioner (CNP)
- Social Worker – (licensed to practice independently)
  - Wisconsin - Licensed Clinical Social Worker (LCSW)
  - Iowa – Licensed Independent Social Worker (LISW)
NOTE: Moonlight Residents, Urgent Care, Radiation Oncologists and Pain Management practitioners would require credentialing.

VII. **Organizational Providers Subject to Credentialing**

**Medical**
- Ambulatory Surgery Center (Free-Standing Only)
- Home Health Care Agency
- Hospitals
- Skilled Nursing Facilities/Nursing Home
- Birthing Centers

**Behavioral Health**
- Adult Licensed Residential Crisis (Minnesota DHS Rule 203 with Mental Health crisis services)
- Children’s Residential Facility: Mental Health (Minnesota DHS Rule 2960)
- Children’s Residential Facility: Substance Abuse (Minnesota DHS Rule 2960)
- Eating Disorders Residential Facility (Minnesota DHS Rule 36 and/or Rule 2960)
- Mental Health Partial Psych/Partial Hospitalization – Free standing only
- Mental Health Residential Treatment, IRTS, or Residential Crisis (Minnesota DHS Rule 36)
- Opioid/Methadone Treatment Program (Minnesota DHS Rule 31)
- Substance Abuse - Outpatient or Residential/Inpatient (Minnesota DHS Rule 31)

- If the hospital and the psychiatric unit have different Medicare numbers, each entity must be credentialed separately.

IX. **Practitioners Not Subject to Credentialing**

Audiologists
Genetic Counselor (CGC)
Certified Registered Nurse Anesthetist (CRNA)
Orthopedic Physician Assistant (OPAC)
Occupational Therapist (OT)
Physical Therapist (PT)
Registered Dieticians (RD)
Registered Nurse First Assistant (RNFA)
Residents
  - Unless they are working independently without supervision in a clinic setting
Speech Language Pathologists (SLP)
Hospitalist
Hospital-based practitioners including but not limited to Pathologists, Radiologists, Anesthesiologists, and Emergency Room Physicians
Licensed Alcohol and Drug Counselor (LADC)
Personal Care Assistants (PCA)
Physical Therapy Assistant (PTA)

Decisions regarding billing are separate from the credentialing process; although a Provider subject to credentialing will not be given a UCare billing number as a participating Provider until that Provider is credentialed.

Practitioners’ titles and abbreviations vary from each state and may change time to time. Check with the appropriate State licensing agencies for specific titles.

X. **Break in Service (including Leave of Absence)**

Break in Service includes, but is not limited to health, military, maternity/paternity or sabbatical leave.

1. If a credentialed Practitioner returns to the same UCare-contracted location from a verified Leave of Absence or moves to another UCare contracted location within the 36-month recredentialing cycle, the Practitioner will be reinstated to see UCare members as a credentialed provider. Credentialing Staff will re-verify the Practitioner’s state license to ensure that there are no current actions and that the Practitioner has the ability to participate in the Federal Health Care Programs. Within 60 days, the recredentialing cycle must be completed.

2. If a Practitioner returns to the same UCare-contracted location or moves to another UCare-contracted location and is outside of the 36-month recredentialing cycle, the Practitioner will be required to go through the initial credentialing process before rejoining the UCare network.

3. If a Practitioner leaves a UCare contracted location and moves to another UCare contracted location and there is a break of service more than 30 days without a verified Leave of Absence, the Practitioner will be required to go through the initial credentialing process before rejoining the UCare Network.

XI. **Application Review and Acceptance Process**

A. **Pre-Application Process**

All Providers shall submit appropriate documentation of the Pre-application Criteria. Providers who do not meet Pre-application Criteria will have their documentation returned to them by Credentialing Staff with a written explanation of why they are not eligible to apply.
Each Provider must complete an application form initially and at the time of recredentialing. Practitioners are required to apply and reapply using the Uniform Credentialing Application made available by UCare. Organizational Providers are required to apply and reapply using UCare’s Facility Credentialing Assessment Application. During the application process, the below items will be queried:

- A statement informing the Provider that the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank (NPDB-HIPDB), the relevant state licensing board, and the Medicare and Medicaid Sanctions and Reinstatement Report will be queried and reviewed as part of the application review process; and
- A statement that a report may be submitted to appropriate state licensing boards and/or the NPDB-HIPDB in the event that the application is denied.

A Provider who does not satisfy all Pre-Application Criteria shall not be eligible to apply for, or maintain, acceptance. Credentialing Staff will make a determination based on the criteria not satisfied as to an appropriate response to the Provider.

**B. Application Preparation Process**

If a Provider meets all Pre-Application Criteria, then the following steps will be taken while referring to Attachment A for individual Practitioner types and Attachment B for Organizational Provider types for Administrative and Professional criteria.

1. Credentialing Staff will collect and verify all administrative and professional credentials per National Committee for Quality Assurance (NCQA), Minnesota Department of Health (MDH) and Centers for Medicare & Medicaid Services (CMS) standards for primary source verification. Among the items included in the verification process are Provider licensure, education and training, malpractice history, work history and any other information relevant to credentialing.

2. Credentialing Staff will also flag for review:
   a. Requests for waivers of credentialing criteria, as outlined in this Credentialing Plan if a Practitioner does not meet acceptable exceptions as defined in the credentialing procedures.
   b. Requests for a specialty change where the Practitioner’s education does not match the application request.

Other information may be collected and considered at time of recredentialing as deemed appropriate by UCare to ensure a high-quality network.

**C. Practitioner Rights to Credentialing Information**

In the event that Credentialing Staff discover a discrepancy between their findings and the information submitted by the Provider, notice will be promptly made to the Credentialing Contact and/or provider. The letter must only indicate that there is a discrepancy and the
Credentialing Contact and/or Provider may request to review the information from the credentialing file within fourteen (14) days from the receipt of the letter.

- If the Credentialing Contact and/or Provider does not submit the request within the time allowed or not request to review the credentialing file, UCare will assume that the provider does not want to dispute any of the information provided.

  - If the Credentialing Contact and/or Provider respond within the time allowed, the credentialing staff will include information obtained for review of the provider’s credentialing application. If a Provider believes, upon review of the credentialing file, that any information contained therein is misleading or erroneous, the Practitioner/Provider has the right to correct erroneous information obtained during the credentialing process within 30 days by submitting in writing to the appropriate Credentialing Staff any corrections or any explanations of discrepancies by fax or email. The appropriate Credentialing Staff will annotate the credentialing software with the information received. The updated information will be scanned to the individual Practitioner’s credentialing record in the credentialing software.

Each Provider shall be entitled, upon written request, to be informed of the status of their application. In addition, to review their credentialing information per this Credentialing Plan and per the Uniform Credentialing Application and the Uniform Re-Credentialing Application (Notice of Applicants Rights), except for information such as letters of reference or recommendations that are peer privileged and/or protected from disclosure or information from the National Practitioner Data Bank (NPDB). UCare may, at its discretion, provide redacted copies or summaries of information provided by individuals if required to maintain confidentiality of protected information. Once an inquiry as has been made to UCare (via email, phone or letter), the Credentialing Staff will respond to such inquiry with 24-48 hours of receipt. The Credentialing Staff will provide applicable information and/or documentation to the practitioner and annotate the credentialing software of the request and the information provided.

Practitioners and Organizational Providers are notified of the right to correct erroneous information via this Credentialing Plan and the notification letter sent to the practitioner when erroneous/discrepancy are identified. The Credentialing Plan is located on UCare’s Provider Page. The foregoing does not require UCare to alter or delete any information contained in the file.

D. **Routing and Review Process**

Once the Provider meets the Pre-Application Criteria, Credentialing Staff will screen each file to determine whether the Provider fully meets Administrative and Professional Criteria. Providers that meet all Administrative and Professional Criteria, per the Variation Application File Review grid, are designated as Clean Credentialing Files, and are routed to the Medical
Director for review and determination of acceptance into the UCare network.
If the Provider does not fully meet Administrative and Professional Criteria per the
Variation Application File Review Grid, the file is classified as “with variation” and is
routed to the Medical Director for review as described below.

1. **Clean Credentialing Files:** UCare’s Medical Director can accept all Providers with Clean
Credentialing Files for participation in the UCare network. The weekly clean file list will
presented to the next scheduled monthly Credentialing Committee.

2. **Administrative Criteria Variation:** Applications for providers who don’t satisfy
administrative criteria are returned to the provider with instructions for submitting
administrative reconsideration. Applications for reconsideration that have been corrected
and/or completed are submitted to the Medical Director for review. The Medical Director
may delegate in writing the authority to review and approve certain types of variation from
Administrative Criteria to Credentialing Staff and such delegation shall be approved by the
Credentialing Committee. After internal coordination, the Credentialing Committee
and/or Medical Director may accept or continue the participation status of a Provider with
Administrative Criteria variation, in accordance with QIACC guidelines for delegated
review. The Credentialing Staff shall notify QIACC at its earliest subsequent meeting of
the decision for notification. The Medical Director may impose monitoring and corrective
actions per Section XIV and XV of this Credentialing Plan. If the Medical Director or the
Credentialing Committee determines that a Provider should not be accepted or continued
in the network due to administrative issues, the Credentialing Staff shall notify QIACC of
the action. Credentialing Staff shall notify the Provider in writing of denial or termination
of participation and the reasons for such within 20 days of the decision. Administrative
terminations and denials are final and are not subject to an appeal hearing unless otherwise
required by law or regulation. UCare at its discretion may reconsider the determination if
the provider submits additional information for review.

3. **Providers with Professional Variation:** Applications for providers, who don’t satisfy
Professional Criteria as outlined in the Variation Application File Review grid, are
submitted to the Medical Director for review. The Medical Director may recommend
review by the Credentialing Committee if he/she confirms there is professional criteria
variation that indicates a potential professional competency issue pursuant to QIACC
guidelines for delegated review. If the Credentialing Committee cannot make a decision,
the provider’s application will be presented at the next monthly QIACC. If the Medical
Director determines that the variation does not indicate a potential professional
competency issue, the Medical Director may approve the provider and shall notify the
QIACC at its earliest subsequent meeting of the approval. The Medical Director may
impose monitoring and corrective actions per Sections XIV and XV of this Credentialing
Plan.

4. **Credentialing Committee Review and Acceptance:** The Credentialing Committee
reviews all Providers with Professional Criteria variation that the Medical Director has
confirmed indicates a potential professional competency issue. The Credentialing
Committee receives notification of Clean Files, files that Credentialing Staff and/or
Medical Director have approved with variation from Administrative or Professional

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Criteria according to Credentialing Committee guidelines for delegated review. Any acceptance by the Credentialing Committee is conditioned by the execution of a relevant participation agreement with UCare. The Credentialing Committee may request further information from the Provider, table an application pending the outcome of an investigation of the Provider by any organization or institution, or take any other action it deems appropriate including recommending denial of the Provider. The Credentialing Committee may base its determination on facts and circumstances regarding professional conduct or competence that it deems appropriate and relevant. In cases with Professional Criteria variation, the Credentialing Committee shall determine whether the variation indicates a potential or existing professional performance issue. In the event that the Credentialing Committee denies or terminates participation in the network for failure to meet Professional Criteria, appeal provisions will apply as outlined in Section XVIII of this Credentialing Plan. Determinations made by the Credentialing Committee based on professional performance issues are not considered final until after a Practitioner has waived his or her right to a hearing, has failed to request a hearing in a timely manner or has completed the appeal process. Providers have no right to appear before the Credentialing Committee.

5. **Notification**: The Provider shall be notified within 60 calendar days from final decision of initial credentialing and all adverse recredentialing decisions. In the event of an adverse credentialing or re-credentialing decision that is subject to appeal, notice to the Provider shall meet the requirements of Section XVIII. Credentialing Appeal Process.

**XII. Expedited Credentialing**

UCare recognizes that it can be beneficial for members to make providers available before the completion of the entire credentialing process for emergency situations only (i.e. disaster, network inadequacy). A Practitioner cannot be expedited for contracting purposes. A Practitioner may only be expedited once when applying to UCare for the first time. Practitioners who had been credentialed and are in good status under a delegated credentialing arrangement do not require expedited credentialing.

The Practitioner must submit a completed application, signed and dated release, and signed and dated attestation. An application must be considered clean or it does not qualify for expedited credentialing. UCare will verify all credentialing requirements as set forth in this Credentialing Plan and related procedures. The Medical Director may approve the Practitioner prior to the next scheduled QIACC if the file is clean.

**XIII. Locum Tenens Criteria**

A Practitioner that will be a Locum Tenens less than 90 days will not be required to be credentialed. If a Practitioner will be practicing more than 90 days, the Practitioner is not considered a Locum Tenens and will require going through the initial credentialing process.
XIV. Monitoring Providers

A. Administrative Monitoring

At times, the Medical Director may decide to recommend acceptance of a Provider without all administrative documentation available where the lack of such documentation does not create a sufficient administrative issue to deny credentialing. In these cases, a Provider may be presented as notification to the Credentialing Committee with a recommendation for administrative monitoring. Credentialing Staff will record this status within the credentialing software and follow up to ensure that the necessary information is received within the specified time allowed. UCare Policy PRC021 addresses the procedure to follow for failure to respond to requests for credentialing information.

B. Routine Performance Monitoring

Providers are routinely monitored between credentialing cycles by a variety of ways.

1. Complaints, Appeals and Grievances are reviewed on a quarterly basis to determine whether Providers meet a threshold that signifies heightened concern per UCare Policy QAG015. In the event that the Provider meets this threshold the Provider will be referred to the Medical Director for Professional Criteria review as appropriate.

2. Every Quality of Care Issue is reviewed by the Medical Director. Depending on the findings of the case involving a credentialed Provider, the Medical Director shall refer the case to QIACC for appropriate credentialing action. Cases are referred based upon the level of severity of the Quality of Care Issue, or a noted pattern of quality of care concerns per UCare Policy QAG005, “Potential Deficiency in Clinical Quality of Care.”

3. UCare will conduct site visits of Practitioner sites that meet UCare’s member complaint threshold or that does not meet UCare’s office standards.

4. Information is reviewed from focus studies or other data that indicates sub-standard professional performance related to quality, member satisfaction, utilization management or any other matter related to professional performance or competence as determined by UCare.

5. Licensing board disciplinary actions orders are received for Minnesota, Iowa, North Dakota, South Dakota and Wisconsin and reviewed within 72 hours of receipt by Credentialing Staff, including the Monthly Deceased (Minnesota only) Inactive Physicians Update report.

6. The Medicare/Medicaid Exclusion Report is reviewed within 30 calendar days of a new monthly report by Credentialing Staff.
7. The Medicare Opt-Out list is reviewed by the Provider Enrollment Supervisor quarterly with notification to Credentialing Staff.

8. Other matters may arise which call into question the continued participation of a Provider to treat UCare members. Quality Management, Credentialing Staff and the Medical Directors will be alert and diligent in referring such matters to the QIACC as appropriate.

XV. Corrective Actions

A. Need for Corrective Action

If a pattern of substandard professional performance or failure to comply with Administrative or Professional Criteria is identified through UCare’s monitoring process or at the time of recredentialing, UCare may, in its own discretion, attempt to remedy the situation through any means it deems appropriate, including educational interventions and Corrective Action Plans (CAPs). CAPs shall be in writing to the Provider and outline the specific goals and outcomes required. A timeline for accomplishing the education or the corrective actions will also be specified. UCare is not required to offer a CAP prior to denying, terminating or taking any other action related to participation that is permitted under this Credentialing Plan.

B. Imposition of Corrective Action

Implementation of educational interventions and CAPs vary depending on whether non-compliance related to Administrative or Professional Criteria. Failure to comply with Administrative Criteria is reported to the Medical Director. The Medical Director in collaboration with other UCare Departments may direct educational interventions or a CAP. Failure to comply with Professional Criteria is reported to the Medical Director. The Medical Director may in his/her own discretion direct educational interventions or a CAP. The General Counsel shall review Professional Criteria corrective actions to determine whether the Provider has a right to appeal. Credentialing Staff will report both Administrative and Professional Criteria actions to the QIACC. Credentialing Staff will monitor completion of the directed action(s) and report periodically on the Provider’s status to QIACC. For Organizational Providers who do not meet UCare’s office standards, UCare will impose a CAP and will monitor the CAP until the Organizational Provider has demonstrated that it meets UCare’s office standard.

XVI. Restriction or Suspension of a Provider

Restriction is an action that UCare may take to limit the scope of practice of a Provider. Suspension is a temporary action pending resolution of a medical board or credentialing action.
A. Restriction and Suspension

UCare in its discretion may restrict the scope of practice of a Provider or suspend the Provider’s participation as a result of failure to continuously meet Administrative or Professional Criteria. If the Medical Director imposes restriction or suspension for an administrative issue, the action shall be reported to the QIACC. The Medical Director(s) shall review any cases that meet file class 3 per the Variation Application File Review Grid regarding Professional Criteria and may recommend restriction or suspension to the QIACC. The Provider shall receive written notice of the restriction or suspension.

- Administrative issues: The Provider shall have the right to submit information in response to the notice.
- Professional issues: The Provider shall receive written notice and a right to an appeal hearing prior to the imposition of the restriction or suspension unless UCare imposes a summary restriction or suspension.

B. Summary Restriction and Suspension

UCare may impose a summary restriction or suspension if the Provider’s license is restricted or suspended, or if a Medical Director determines that the health of any UCare member is in imminent danger because of actions or inaction’s of the Provider. A summary restriction or suspension should generally not exceed sixty (60) calendar days, during which time UCare shall investigate to determine if further action is warranted. The Medical Director shall inform the Provider of the summary restriction or suspension by telephone, and shall send written notice as soon as practicable.

- Administrative issues: UCare may consider information submitted by the Provider if the action is based on administrative issues.
- Professional issues: The Practitioner has a right to an appeal hearing for summary suspensions or restrictions based on professional issues. The appeal hearing may occur after the suspension or restriction period.

C. Claims Denial

Credentialing Staff shall notify Provider Relations and Contracting and Provider Enrollment & Configuration staff to deny all claims within five (5) business days after the effective date of notification of the suspension or restriction.

D. Reporting Requirements

UCare shall determine, based upon the provisions of the Health Care Quality Improvement Act of 1986 as amended, 42 U.S.C. sections 11101 et seq.; the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. sections 1201 et seq., Minnesota Statutes, section 147.111 and any other relevant federal and state statutes and regulations, whether a denial, termination or other action taken pursuant to this Credentialing Plan shall be reported to the
VII. Termination of a Provider

Providers may be terminated from the UCare network based upon the following reasons:

A. Pre-application and/or Administrative Criteria

Terminations due to Pre-Application and/or Administrative Criteria are administrative in nature and are not subject to appeal unless otherwise required per regulation or law. License surrender or revocation is grounds for immediate termination without committee action. All Practitioners terminated for Administrative Criteria will be reported to the QIACC. UCare Credentialing Staff will provide written notice of the denial, suspension, or termination within 60 days, the effective date, the reasons for such action and that the Provider may request an administrative reconsideration to the Provider.

i. Reconsideration Process

The Provider must submit a written request for reconsideration within 30 calendar days of the UCare notice.

- If the Provider does not submit the reconsideration in the time allowed, the Provider status with UCare will be administratively terminated. The Provider will not be able to reapply for participation for six (6) months from the termination date.

It is the responsibility of the Provider to reapply with UCare using the Uniform Initial Credentialing Application. In the event that the Provider reapplies, the time period in which the Provider was inactive, will result in a lapse of covered services.

- If the Provider requests reconsideration in the time allowed, UCare will notify the Provider with further instructions regarding how the reconsideration process will work.

  - The Provider will have the opportunity to submit a written statement and any relevant written evidence to the Credentialing Committee and/or QIACC, whichever made the decision under reconsideration.
  - The Credentialing Committee and/or QIACC shall consider the Provider’s statement and evidence presented in making a final decision on the action and may uphold, rescind or modify its previous decision.

ii. Written Decision
Within 20 business days after the Credentialing Committee and/or QIACC makes a decision on the action, UCare shall notify the Provider with a written statement of its reconsideration decision and the reason(s) for its decision.

iii. No Further Reconsideration

After the administrative reconsideration decision, a Provider will have no further right to appeal the reconsideration or to appear before the QIACC and/or Peer Review Committee. If the Credentialing/Peer Review Committee or the QIACC uphold the reconsideration decision, the Provider will not be able to reapply for participation for twelve (12) months from the termination date.

A. Professional Criteria

Termination for failure to meet Professional Criteria is subject to appeal. The Medical Director may refer to the QIACC termination for failure to meet Professional Criteria. The QIACC may also, independent of a Medical Director referral; recommend termination for failure to meet Professional Criteria. The QIACC can consider any information regarding professional conduct or competence that is members they deem relevant and appropriate. Terminations determined by the QIACC based on Professional Criteria are not considered final until after a Practitioner has waived the right to a hearing, has failed to request a hearing in a timely manner, or has completed the appeal process. Effective date of any professional termination action is the date of notice of the Provider of the final action.

B. Provider Contract Compliance

UCare Policy PRC06: Provider Contract Termination governs the procedures to follow to effect contract termination. Credentialing Staff shall coordinate with Provider Relations and Contracting any actions that may require contract termination.

In any termination, Credentialing Staff shall notify Provider Relations and Contracting and Provider Enrollment staff to deny all claims one day after the effective date of notification of the suspension or restriction.

XVIII. Credentialing Appeal Process

A. Right and Request to Appeal

Appeals are offered to practitioners after the QIACC recommends denial or termination of participation status or other disciplinary action based on Professional Criteria. The QIACC will also offer an appeal in any case where the action is reportable to the National Practitioner Data Bank-Healthcare Integrity and Protection Databank (NPDB-HIPDB).

If the Practitioner is offered the opportunity to appeal, UCare shall follow this Credentialing Plan as set forth below. Hearings are not offered to Organizational Providers. If a delegate of
UCare has made the adverse decision, the Practitioner generally shall have access to the delegate’s appeal process, although UCare will retain the authority to make a final decision. Appeals regarding Provider contracts are governed by UCare Policy PRC06 – Administrative Provider Contract Termination.

1. The Practitioner shall be given written notice of proposed action and notice of the right to appeal via certified letter. The notice must inform the Practitioner that an adverse action has been proposed against the Practitioner and the reasons for the proposed action. The Practitioner is informed of his/her right to review the credentialing file, with the exception of information which is protected under peer review. The Practitioner shall be given 30 calendar days from receipt of such notice to exercise this right. The notice must also inform the Practitioner of his or her right to request a hearing on the proposed action, of the 30 calendar day time limit for requesting such a hearing, and of his or her rights in the hearing (including, as described below, the right to counsel, to a copy of the record of the proceedings, to call and cross-examine witnesses, to present relevant evidence, to submit a written statement following the hearing, and to receive written notice from the Appeals Committee stating the basis of its recommendation and from the BOD or appointed committee of the BOD stating the basis of its decision).

2. Upon timely receipt of a Practitioner’s written request, UCare shall notify the Practitioner that an appeal hearing will be scheduled and UCare will provide further information when a hearing date is set. Any hearing will occur prior to an effective date of denial or termination. A restriction or suspension may be extended beyond 60 days to complete the hearing process. If the Practitioner fails to request a hearing in writing within 30 calendar days of receipt of the notice, the Practitioner waives any appeal right under this Credentialing Plan.

3. The hearing date will be not less than 30 calendar days from the date the Practitioner receives the hearing notice, unless a shorter period is mutually agreed to by the parties. Requests for a postponement or extension must be received within 10 business days prior to the scheduled hearing date to be considered. The Medical Director on a showing of good cause may grant postponements and extensions.

4. Failure of the Practitioner to attend the appeal hearing either in person or via telephone conference call will result in forfeiture of appeal rights, unless the Practitioner is able to demonstrate reasonable circumstances that prevented such attendance.

B. Pre-Hearing Matters

1. When a hearing is scheduled, UCare Credentialing Staff will provide written notice to the Practitioner stating the time, place, and date of the hearing, the composition of the
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Appeals Committee and list of the witnesses (if any) expected to be called by UCare at the hearing. UCare will provide any documents expected to be presented at the appeal to support its decision. The letter should contain copies of the information that is unprotected under peer review statutes upon which UCare based its decision. UCare’s General Counsel must approve any release of records.

2. The Practitioner must provide UCare with the name of his or her representing counsel, if any, any witnesses expected to testify and any documents to be presented at the appeal hearing at least 15 business days prior to the hearing.

3. UCare’s QIACC or its chairperson, acting on behalf of UCare will select the Appeals Committee members. The Appeals Committee and the Practitioner will be provided information regarding UCare’s credentialing determination prior to the hearing. This information shall include, but not be limited to, the reason for UCare’s determination including any supporting documentation, any additional documents to support UCare’s determination, and any documents to be used by the Practitioner to contest UCare’s decision. This information shall be provided as soon as possible but no later than 5 business days prior to the hearing.

4. Documents not disclosed consistent with this Section shall only be presented with good cause for failure to disclose previously and with the consent of both parties in the appeal. The Appeals Committee may, in its sole discretion, postpone further action and final decision if necessary to review new information presented.

C. The Hearing

1. The Practitioner and UCare may be represented by counsel. UCare shall arrange for a record to be made of the hearing. It will be an audiotape, videotape, or court reporter record, at UCare’s discretion. Copies of this record shall be made available to the Practitioner upon payment of a reasonable charge associated with preparation of the copy. A Chairperson will be selected prior to the hearing.

2. Prior to the presentation of evidence or testimony by either party, the Chairperson of the Appeals Committee shall announce the purpose of the hearing and the procedure that will be followed for the presentation of evidence, including any time limits or other rules or constraints on the proceedings.

3. UCare may present any relevant oral testimony to the Appeals Committee for consideration. The Practitioner or the Practitioner’s counsel shall have the opportunity to cross-examine any witness testifying on behalf of UCare. If the Practitioner requesting the hearing does not testify on his or her own behalf, the Practitioner may be questioned by UCare and/or by the Appeals Committee. After the completion of UCare’s submission of evidence, the Practitioner shall present any relevant evidence to
rebut or explain the situation or events described by UCare as constituting the basis for the determination.

4. UCare shall have the opportunity to cross-examine any witness testifying on behalf of the Practitioner. Throughout the course of the hearing, the Appeals Committee may examine or question any witness giving oral testimony for UCare or the Practitioner. UCare may present any additional witnesses or submit additional documents to rebut the Practitioner’s evidence. The Practitioner shall have the opportunity to cross-examine any additional witnesses testifying on behalf of UCare.

5. Upon the completion of UCare’s and the Practitioner’s submission of testimony and evidence, first UCare and then the Practitioner shall have the opportunity to make a brief closing statement. Following the hearing, UCare and the Practitioner shall have the opportunity to submit written statements to the Appeals Committee. If the Practitioner and his/her attorney waive written briefs, the Appeals Committee members may meet briefly after the hearing and make a recommendation. If the practitioner and his/her attorney choose to submit written briefs, a date will be set for the submission of the documentation which will be faxed to the Appeals Committee members. A telephone conference will take place to make a decision. After the decision is made, the Credentialing Manager, with assistance from UCare’s General Counsel, creates a summary of Findings of Facts, Conclusions, and Recommendations. The summary will be forwarded to all Appeals Committee members for their signature. The Appeals Committee shall establish a reasonable time frame for the submission of such statements.

D. Evidentiary Standards

The oral testimony and documentary evidence provided by UCare and the Practitioner shall be reasonably related to the specific issues or matters involved in the recommended action. The Appeals Committee has the right to refuse to consider testimony or evidence that it does not deem useful in making a decision. The rules of evidence applicable in a court of law do not apply. If a party objects to the presentation of any testimony or evidence, the grounds shall be stated for the objection and the Appeals Committee has the sole discretion to determine whether this evidence will be considered. The Appeals Committee has the ability to determine the relative weight to be given to various items of testimony or evidence submitted.

E. Appeals Committee’s Decision

The Appeals Committee shall make its determination based on the information and evidence produced at the hearing, including the oral testimony of witnesses, summary oral and written statements, and all documentary evidence submitted to UCare and at the hearing. UCare shall have the initial burden of going forward to present evidence in support of its determination. Thereafter, the Practitioner shall have the burden of demonstrating by clear and convincing
evidence that UCare’s determination lacks any factual basis or is arbitrary and capricious.

After the hearing and the receipt of any written statements, the Appeals Committee shall convene and privately discuss the evidence presented at the hearing and the determination of the QIACC. The Appeals Committee may uphold, reject, or modify the action. The Appeals Committee’s decision shall be by the affirmative vote of the majority of the members of the Appeals Committee. The Practitioner shall be notified in writing of the Appeals Committee’s recommendation to the BOD. Such notice shall include a statement of the basis for its recommendation, and may be incorporated into the final notice of action by the BOD or committee appointed by the BOD.

F. Board of Directors Action

The recommendation goes to the Board of Directors (BOD), who in its own discretion may appoint the Executive Committee or Sub Committee of the BOD to review and make a determination regarding whether the Appeals Committee as to whether it acted arbitrarily and capriciously. The BOD may approve, reject, or modify the Appeals Committee’s recommendation. The Practitioner shall have no right to appear before the BOD or appointed committee of the BOD.

When the BOD has ratified the action, the Credentialing Manager will send a certified letter with return receipt to the Practitioner and legal counsel, if used, enclosing a copy of the Findings of Facts, Conclusions, and Recommendations. If the Practitioner is to be terminated, the letter will include notification of the termination date.

G. Notice and Effective Date of Action

If the BOD or appointed committee of the BOD affirms a recommendation to deny or terminate the Practitioner’s participation status, the decision shall be the date of notification of the final decision, unless otherwise directed by the BOD. Notification or “notice” means depositing the correspondence in the United States mail, using certified mail with return receipt addressed to the other party at the office address given in the application, or personal delivery of written notice to the other party. UCare shall provide the Practitioner with written notice of the decision within 5 business days of the decision. Such notice shall include a statement of the basis for the BOD’s decision.

Any final action following an appeal shall be reported by UCare in accordance with Section XIX of this Credentialing Plan below.

XIX. Reporting Requirements

UCare shall determine, based upon the provisions of the Health Care Quality Improvement Act of 1986, 42 U.S.C. § 401 et seq., Minn. Stat. § 147.111, and any other relevant federal and state statutes and regulations, whether and when any adverse decision shall be reported to the NPDB-HIPDB, the relevant state licensing board, or any other appropriate agency. UCare shall be entitled to make its determination in its sole discretion, in accordance with such policies and procedures as
the QIACC shall adopt provided, however, that the determination shall be made in good faith. UCare shall notify the affected Provider, in writing, in the event such a report is made.

XXI. Delegated Credentialing

UCare may delegate certain credentialing and recredentialing functions to specific participating organizations (“Delegate”). The credentialing activities of Delegate shall comply with UCare credentialing policies unless otherwise specified in the delegation agreement. UCare shall retain full and final authority for all delegated credentialing activities and retains the ultimate right to accept or reject Providers into the UCare network. UCare policy regarding delegation is described in UCare Policy CCD021 and the Delegation Process. The policies/processes will describe in more detail the delegation process that consists of the following:

A. Pre-Delegation Assessment

The Credentialing Staff will conduct this assessment against UCare’s Credentialing policies and procedures, the National Committee for Quality Assurance (NCQA), and Center for Medicare and Medicaid Services (CMS Standards). Credentialing files are examined to assess the potential delegate business practices and ability to comply with UCare standards. Assessment recommendations are presented to the Quality Management Director. Pre-assessment audit summary is brought to the Credentialing Committee and QIACC as a notification, and they may take any action it deems appropriate. The potential delegate must have a passing score of 100% to be considered for delegation with UCare.

If after review of the pre-delegation assessment it is determined that the delegate does not meet UCare and/or NCQA standards, the delegate will be notified via letter. The delegate may not apply for delegation for a period of 24 months from the date of the letter.

B. Written Delegation Agreement

After approval of delegated credentialing, Credentialing Staff and UCare’s legal council will draft an agreement between UCare and the entity, using the standard credentialing delegation agreement that contains all NCQA required elements. Expectations of UCare and the delegate are explicitly described in a mutually agreed upon written delegation agreement. The agreement specifies the scope of delegation (including any sub delegates), reports required, and procedures required in credentialing Providers and other details of the relationship between the parties. The delegation agreement shall meet any federal or state regulatory requirements. After signature by both parties, the Credentialing Staff will provide an original to the delegated entity, a copy to UCare’s Compliance and, if necessary, a copy to the PRC Contract Manager. In addition, the UCare original shall be routed internally to UCare’s Legal Department (Paralegal). The original will be placed on the Legal Contracts Site. The Legal Department will also keep the hard copy.

C. Ongoing Monitoring/Oversight

The Credentialing Staff will monitor the delegate for compliance with reporting responsibilities by
review of profiles and other reports submitted by the delegate, the credentialing database for
timeliness of credentialing actions and state board actions. The delegate shall provide regular
reports regarding credentialing actions that include the information as specified in the Delegation
Agreement. At a minimum, the delegate must report on their progress in conducting
credentialing activities and on activities carried out to improve performance at least twice a year.
All suspensions or restrictions shall be reported to UCare within 7 business days. All terminations
and suspensions shall be reported to UCare within 24 hours. UCare may conduct an independent
investigation into the credentials and/or professional conduct of any applicant or participating Provider. The delegate shall be required to permit UCare timely and reasonable access to all credentialing documents and related files.

Overview of the credentialing activities will be reviewed in July and January by the QIACC. If the Credentialing Staff experience difficulties with a delegate, such as lack of timely credentialing, the Credentialing Manager with review with the Quality Management Director. The Quality Management Director will work with the delegate to informally resolve the issue. If the Quality Management Director cannot resolve an issue with a delegate, the matter will be brought to Compliance with recommendations to establish a Corrective Action Plan (CAP). If it becomes necessary to establish a CAP, the delegated entity is responsible for writing the CAP and forwarding a copy to UCare within 30 business days or other time frame established by Senior Management Staff and/or the Compliance Department. The CAP may only be communicated via written communication.

D. **Annual Audit**

An annual audit of the delegate will be conducted or certain elements may be waived provided
that proof of acceptable NCQA accreditation is provided to UCare. However; UCare will still
request that the Delegate submit their policies and procedures. UCare has the right to audit the
delegate’s credentialing status at any other time subject to the provisions of the delegation agreement. If deficiencies are found during the audit, UCare may request and approve a Corrective Action Plan from the delegate. More frequent audits may be scheduled based upon performance of the delegate. Overview of the credentialing audits will be reviewed in July and January by the QIACC. In addition, will also be presented to the Compliance Oversight Sub-Committee.

If at any time during the contract period, the delegate is no longer NCQA accredited, the delegate
will not be eligible for delegation oversight relief. A pre-delegation assessment will not need to be conducted, but an annual file audit and semiannual reporting, among other requirements in NCQA CR1- CR9., will need to be performed within 12 months of the expiration of the NCQA accreditation. Semi-annual reporting may continue on the reporting schedule established prior to the delegate losing accreditation status or UCare may make a business decision to require additional reporting.

Each party’s credentialing information shall not be released by the other to any third party
without the other’s written consent or as permitted by law.

E. **Shared Delegation**
Several local health plans have agreed to participate in a credentialing collaborative. The collaborative members will share responsibility for the site visits to delegates that hold contracts with multiple health plans. A single representative that is from a fully accredited NCQA health plan will conduct the file review portion of the audit and share the information with the other collaborative members. UCare will review the delegate’s Policies and Procedures and any other applicable documents. UCare makes the final decision on its audit outcome. Health plans that share the same delegates are audited using the credentialing collaborative audit tool which covers regulatory and accreditation requirements (e.g. NCQA, MDH and CMS).

F. Revocation or Termination of Delegation

All Delegation Agreements between UCare and entities to which UCare has delegated credentialing will contain appropriate provisions describing the remedies available to UCare, including termination, in the event that the delegate does not properly perform the delegated functions. More specifically, in the event that a delegate fails to meet any of the requirements in the signed Contract Amendment, Credentialing Delegation Agreement, CAP, and/or demonstrates a lack of commitment to improve the deficiencies noted in the CAP, UCare, at its discretion, may revoke/rescind a credentialing delegation at any time. Unless otherwise permitted by the contract. UCare will provide appropriate written notice to the delegate of such revocation or termination. The delegate may also terminate the delegation agreement upon appropriate written notice to UCare as permitted under the agreement. If delegation is revoked or terminated, UCare shall resume responsibility of all credentialing functions.

G. Current List of Delegated Entities

Currently UCare delegates to the following entities for initial and recredentialing. Those marked with asterisks’ (**) are NCQA accredited; therefore portions of the audit will be waived.

<table>
<thead>
<tr>
<th>Health System</th>
<th>Effective Date</th>
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<tr>
<td>Altru (North Region Health Alliance)</td>
<td>January 2009</td>
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<tr>
<td>Avera</td>
<td>November 2009</td>
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<tr>
<td>Children’s</td>
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<td>DentaQuest</td>
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<td>Essentia</td>
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<td>Franciscan Skemp Healthcare</td>
<td>January 2008</td>
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<td>HealthPartners**</td>
<td>January 2007</td>
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<td>Landmark/ChiroCare</td>
<td>December 2006</td>
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<td>Luther Midelfort/Red Cedar</td>
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<td>MeritCare (Sanford North)</td>
<td>January 2007</td>
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<td>MMSI</td>
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<td>Park Nicollet</td>
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<td>Sanford Health System** (South)</td>
<td>January 2007</td>
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<tr>
<td>St. Mary’s/Duluth Clinics (Essentia)</td>
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<tr>
<td>University of Wisconsin</td>
<td>June 2009</td>
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<tr>
<td>Gundersen Health Plan, Inc.</td>
<td>January 2014</td>
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QIACC APPROVAL: May 27, 2014

DIRECTOR APPROVAL: ________________________

CEO APPROVAL: ______________________

DATE 05/28/14

Key Words: Credentialing, QIACC, Medical Director, Credentialing Committee
Attachment A

PRACTITIONER CRITERIA FOR ACCEPTANCE

Physicians
(Includes: Medical Doctors (MD), Doctor of Osteopathy (DO))

Physicians who are applying to be a UCare participating or existing participating physician must meet UCare’s Pre-Application, Administrative, and Professional criteria. For new applicants or existing participating physicians who do not meet any of UCare’s criteria, the physician will not be accepted into the network or will have their existing status terminated with UCare.

A. Pre-Application Criteria
1. The need for the practitioner’s specialty or the Provider type in UCare’s Network;
2. Physician’s stated practice scope is covered under UCare’s benefits;
3. Execution of or UCare’s intent to execute an individual, group or facility contract with UCare;
4. Appropriate verified license, registration, certification or other required qualification to practice in the state(s) where the physician is applying to provide care or services;

   Minnesota: Per MN Statue 147A.01, subd 23 A Physician who is a “Supervising Physician” in the state of Minnesota shall not supervise more than 5 full-time equivalent physician assistants (PA) simultaneously. With the approval of the board, or in a disaster or emergency situation the Supervising Physician may supervise more than five (5) full-time equivalent physician assistants simultaneously.

   Iowa: Per Chapter 148C.3, # 2 The rule shall provide that not more than 5 PA shall be supervised by a physician at one time.

5. The physician holds current board certification or has completed the appropriate training as defined by the licensing or registration agency of the physician’s profession applicable to the physician’s stated scope of practice or as otherwise defined by UCare;

   Physician who graduated in or after 1985, completion of a residency program or current board certification recognized by the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AMA), the Royal College of Physicians and Surgeons of Canada or The College of Family Physicians of Canada in requested field of practice.

   The physician must have training in the specialty that will be practiced at the location listed on the credentialing application.

   Physicians trained in Canada who do not maintain certification by the American Board of Family Practice (ABFP) the following are required
   i. Successful completion of at least two year Canadian residency
   ii. Current certification by the Canadian Board of Family Practice (CBFP)
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6. The physician is not excluded from participation in, or sanctioned by, Medicare, Medicaid, or other state or federal health care programs;

7. The physician does not employ or contract with any person or entity that has been excluded from federal, state or local government program(s) and for UCare’s Medicare products has not opted out of the Medicare program;

8. An unaltered signed release granting UCare permission to review the records of and to contact any licensing entity, medical society, medical school, hospital, clinic, insurance company, or other entity, institution, or organization that does or may have records concerning the Provider.

9. An unaltered release relieving from liability any person, entity, institution, or organization that provides information as part of the application process;

10. An attestation or proof of professional liability insurance that meets the minimum level established by UCare;

11. A signed attestation of the physician that the application is complete and correct, including those portions of the application that contain information about limitations that would affect a physician’s performance, history of loss of medical license and felony convictions and history of limitations of privileges or disciplinary actions.

12. Disclosure questions that are signed and dated and appropriately marked “yes”, “no” or “N/A”.

A negative answer to any disclosure question requires an explanation by the Practitioner. Non-disclosure of professional concerns occurs if: the Practitioner provides a negative answer to or fails to adequately explain any disclosure question where subsequent information gathered by UCare contradicts that answer.

13. The physician has not previously been denied based on Administrative Criteria for participation by UCare within the preceding six (6) months for not responding to the reconsideration notification per XVII, A (i) or from the committee’s decision within the preceding twelve (12) months per XVII (iii) other than for failure to respond to UCare in a timely manner accordance with a request for credentialing documents.

B. Administrative Criteria

1. Successful completion of any site review or medical record keeping review required by UCare

2. Adequate provision of 24-hour coverage for all urgent and emergency conditions, as determined by UCare;

3. If the physician practices in a medical group or clinic, the physician is in good standing at such group or clinic;

4. The physician is appropriately practicing in accordance with his or her clinical privileges and/or the outpatient scope of practice approved or as determined by UCare;

5. If the practitioner’s practice requires clinical privileges to admit patients to a hospital, the physician maintains active admitting privileges in good standing at a UCare contracted hospital or provides evidence acceptable to UCare that the physician has made satisfactory arrangements for another UCare participating physician to admit UCare members needing hospitalization;

6. Current and valid Drug Enforcement Administration (DEA) registration or prescriptive authority, if applicable, in every state in which the physician provides
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care to UCare’s members as specified in Practitioner’s qualifications for participation, or evidence acceptable to UCare that the physician has made satisfactory arrangements for another UCare participating physician to prescribe to UCare members;

7. The physician has not misrepresented, misstated, or omitted a relevant or material fact on the physician’s application, disclosure statements, or any other documents provided as part of the credentialing process;

8. The physician has not engaged in any conduct resulting in a gross misdemeanor or felony conviction, charge, or indictment;

9. The physician has demonstrated a willingness (or in the case of recredentialing, and ability) to practice in a managed care environment and to cooperate with UCare with respect to administrative procedures, quality assurance such as site visits and medical record reviews, utilization management, and other matters as determined by UCare;

10. The physician has not previously been denied based on Professional Criteria for participation by UCare within the preceding twenty-four (24) months, other than for failure to respond to UCare in a timely manner in accordance with a request for recredentialing documents;

11. The physician did not previously resign or was terminated by UCare within the preceding twenty-four (24) months per UCare’s discretion, other than for (1) relocation purposes, (2) suspension or loss of licensure based solely upon reasons unrelated to the physician’s professional performance, or (3) failure to respond to UCare in a timely manner in accordance with a request for recredentialing documents;

12. Requests for a specialty change where the physician’s education does NOT match the application request;

13. Any physician who fails to continuously satisfy pre-application criteria.

C. Professional Criteria

1. The physician has not engaged in conduct that violates state or federal law or ethical standards of professional conduct governing the practice of the physician’s profession;

2. The physician has not been the subject of professional disciplinary action by a licensing board, managed care plan, insurer, clinic, hospital, medical review board, peer review organization, or other health care organization, administrative body, or government agency, including, but not limited to, the imposition of disciplinary or administrative sanctions for inappropriate, inadequate, or tardy completion of medical records;

3. The physician is not the subject of any reports of an “adverse action” against the physician, as defined in the Health Care Quality Improvement Act and its implementing regulations;

4. The physician has not engaged in any conduct involving dishonesty, fraud, deceit, or misrepresentation including a pattern of false, intentionally duplicative, or abusive claims submission;

5. The physician does not have a history of professional liability lawsuits or other incidents, which may indicate a potential competency or quality of care problem;
6. The physician has not been involuntarily terminated from professional employment or a hospital medical staff resigned from professional employment or a hospital medical staff after knowledge of an investigation in the physician’s conduct, or in lieu or in anticipation of disciplinary action;

7. The physician does not use or advocate the use of unproved modalities of treatment or therapy regarded in the local medical community as medical inappropriate;

8. The physician has no history of denial or cancellation or failure to renew professional liability insurance;

9. The physician has no known ongoing mental or physical condition likely to adversely affect the ability of the physician to perform the essential functions of the physician’s profession with or without reasonable accommodations;

10. The physician has no known ongoing medical or physical condition that could constitute a direct threat to the health and safety of others;

11. The physician has not used illegal drugs or improperly used any controlled substance during the past three (3) year, and

12. The physician’s participation with UCare demonstrates a satisfactory quality assurance, member satisfaction, utilization management, and performance, when it relates to professional competence or conduct as determined by UCare (applicable to participating physician only).

**Doctor of Podiatric Medicine (DPM)**

Doctor of Podiatric Medicine (DPM) who is applying to be a UCare participating or existing participating DPM must meet UCare’s Pre-Application, Professional, and Administrative criteria. For new applicants or existing participating DPM’s who do not meet any of UCare’s criteria, the DPM will not be accepted into the network or will have their existing status terminated with UCare.

**A. Pre-Application Criteria**

1. The need for the practitioner’s specialty or the Provider type in UCare’s Network;
2. DPM’s stated practice scope is covered under UCare’s benefits;
3. Execution of or UCare’s intent to execute an individual, group or facility contract with UCare;
4. Appropriate verified license, registration, certification or other required qualification to practice in the state(s) where the physician is applying to provide care or services;
5. The DPM holds current board certification or has completed the appropriate training as defined by the licensing or registration agency of the physician’s profession applicable to the physician’s stated scope of practice or as otherwise defined by UCare:

   - DPMs who graduated in or after 1985, completion of a residency approved by the American Board of Podiatric Surgery (ABPS), Medical Education of the American Podiatric Medical Association and American Board of Podiatric Orthopedics and Primary Podiatric Medicine in requested field of practice.
6. The DPM is not excluded from participation in, or sanctioned by, Medicare, Medicaid, or other state or federal health care programs;
7. The DPM does not employ or contract with any person or entity that has been excluded from federal, state or local government program(s) and for UCare’s Medicare products has not opted out of the Medicare program;
8. An unaltered signed release granting UCare permission to review the records of an to contact any licensing entity, medical society, medical school, hospital, clinic, insurance company, or other entity, institution, or organization that does or may have records concerning the DPM;
9. An unaltered release relieving from liability any person, entity, institution, or organization that provides information as part of the application process;
10. An attestation or proof or professional liability insurance that meets the minimum level established by UCare
11. A signed attestation of the DPM that the application is completed and correct, including those portions of the application that contain information about limitations that would affect the DPM’s performance, history of loss of medical license and felony convictions and history of limitations of privileges or disciplinary actions
12. Disclosure questions that are signed and dated and appropriately marked “yes”, “no”, or “N/A”;
   A negative answer to any disclosure question requires an explanation by the DPM, non-disclosure of professional concern occurs if; the DPM provides a negative answer to or fails to adequately explain any disclosure question where subsequent information gathered by UCare contradicts that answer
13. The physician has not previously been denied based on Administrative Criteria for participation by UCare within the preceding six (6) months for not responding to the reconsideration notification per XVII, A (i) or from the committee’s decision within the preceding twelve (12) months per XVII (iii) other than for failure to respond to UCare in a timely manner accordance with a request for credentialing documents.

B. Administrative Criteria
   1. Successful completion of any site review or medical record keeping review required by UCare;
   2. Adequate provision of 24-hour coverage for all urgent and emergency conditions, as determined by UCare;
   3. If the DPM practices in a medical group or clinic, the physician is in good standing at such group or clinic;
   4. The DPM is appropriately practicing in accordance with his or her clinical privileges and/or the outpatient scope of practice approved or as determined by UCare;
   5. If the DPM practice requires clinical privileges to admit patients to a hospital, the DPM maintains active admitting privileges in good standing at a UCare contracted hospital or provides evidence acceptable to UCare that the DPM has made satisfactory arrangements for another UCare participating physician to admit members needing hospitalization;
   6. Current and valid Drug Enforcement Administration (DEA) registration or prescriptive authority, if applicable, in every state in which the DPM provides care to UCare’s members as specified in Practitioner’s qualifications for participation, or evidence acceptable to UCare that the DPM has made satisfactory arrangements for another UCare participating physician to prescribe to UCare members;
   7. The DPM has not misrepresented, misstated, or omitted a relevant or material fact on the DPM’s application, disclosure statements, or any other documents provided as
part of the credentialing process;
8. The DPM has not engaged in any conduct resulting in a gross misdemeanor or felony conviction, charge, or indictment;
9. The DPM as demonstrated a willingness (or in the case of recredentialing, an ability) to practice in a managed care environment and to cooperate with UCare with respect to administrative procedures, quality assurance such as sit visits and medical record reviews, utilization management, and other matters as determined by UCare;
10. The DPM has not previously been denied based on Professional Criteria for participation by UCare with the preceding twenty-four (24) months, other than for failure to respond to UCare in a timely manner in accordance with a request credentialing documents;
11. The DPM did not previously resign or was terminated by UCare with the preceding twenty-four (24) months per UCare’s discretion, other than for (1) relocation purposes, (2) suspension or loss of licensure based solely upon reasons unrelated to the DPM’s professional performance, or (3) failure to respond to UCare in a timely manner in accordance with a request for recredentialing documents;
12. Requests for a specialty change where the DPM’s education does NOT match the application request;
13. Any DPM who fails to continuously satisfy pre-application criteria.

C. Professional Criteria
1. The DPM has not engaged in conduct that violates state or federal law or ethical standards of professional conduct governing the practice of the DPM’s profession;
2. The DPM has not been the subject of professional disciplinary action by a licensing board, managed care plan, insurer, clinic, hospital, medical review board, peer review organization, or other health care organization, administrative body, or government agency, including, but not limited to, the imposition of disciplinary or administrative sanctions for inappropriate, inadequate, or tardy completion of medical records;
3. The DPM is not the subject of any reports of an “adverse action” against the DPM, as defined in the Health Care Quality Improvement Act and its implementing regulations;
4. The DPM has not engaged in any conduct involving dishonesty, fraud, deceit, or misrepresentation including a pattern of false, intentionally duplicative, or abusive claims submissions;
5. The DPM does not have a history of professional liability lawsuits or other incidents, which may indicate a potential competency or quality of care problems;
6. The DPM has not been involuntarily terminated from professional employment or a hospital medical staff after knowledge of an investigation into the DPM’s conduct, or in lieu of or in anticipation of disciplinary action;
7. The DPM does not use or advocate the use of unproven modalities of treatment or therapy regarded in the local medical community as medically inappropriate;
8. The DPM has no history of denial or cancellation of failure to renew professional liability insurance;
9. The DPM has no known ongoing mental or physical condition likely to adversely affect the ability of the DPM to perform the essential functions of the DPM’s profession with or without reasonable accommodation;
10. The DPM has no know ongoing medical or physical condition that could constitute a direct threat to the health and safety of others;
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11. The DPM has not used illegal drugs or improperly used any controlled substance during the past three (3) years;
12. The DPM’s participation with UCare demonstrates a satisfactory quality assurance, member satisfaction, utilization management, and performance, when it relates to professional competence or conduct as determined by UCare (applicable to participating DPMs only).

Physician Assistant (PA)

Physician Assistant’s (PAs) who are applying to be a UCare participating or existing participating PA must meet UCare’s Pre-Application, Administrative and Professional criteria. For new applicants or existing participating PAs who do not meet any of UCare’s criteria, the PA will not be accepted into the network or will have their existing status terminated with UCare

A. Pre-Application Criteria

1. The need for the practitioner’s specialty or the Provider type in UCare’s network;
2. Physician’s stated practice scope is covered under UCare’s benefits;
3. Execution of or UCare’s intent to execute an individual, group or facility contract with UCare;
4. Appropriate verified license, registration, certification or other required qualification to practice in the state(s) where the PA is applying to provide care or services;
   - **Minnesota:** Must have the Notice of Intent to Practice on file with the Board per state statute 147A. The PA should have a Delegation Agreement between themselves and the supervision physician at every primary practice location. Refer to the Physicians section of this Credentialing Plan, Attachment A for Physician requirements under Pre-Application Criteria, # 4.
   - **Iowa:** Requires a licensed PA to be supervised by physician per 148C. Refer to the Physicians section of this Credentialing Plan, Attachment A for Physician requirements under Pre-Application Criteria, # 4.
   - **North Dakota:** The physician shall file with the board a copy of the contract establishing that relationship. That contract must be approved by the board of medical examiners and the physician who supervises the PA must practice in ND per ND Administrative Code 50-03-01-03.
   - **South Dakota** SD Physician Assistant may only practice under the supervision of a licensed SD Physician. The PA and the licensed SD physician must enter into a PA practice agreement that must be submitted to the Board office and be approved before the PA may begin to practice per SDCL 36-4A-1.1.
   - **Wisconsin:** A PA may not prescribe or dispense any drug independently. A PA may only prescribe or dispense a drug pursuant to written guidelines for supervised prescriptive practice. The guidelines shall be kept on file at the practice site and made available to the board upon request per Administrative Code (Med) 8.08
5. PAs must have and maintain certification by the National Commission on Certification of Physicians Assistants (NCCPA)
6. The PA is not excluded from participation in, or sanctioned by, Medicare, Medicaid, or other state or federal health care programs;
7. The PA does not employ or contract with any person or entity that has been excluded from federal, state or local government program(s) and for UCare’s Medicare products has not opted out of the Medicare program;

8. An unaltered signed release granting UCare permission to review the records of an to contact any licensing entity, medical society, medical school, hospital, clinic, insurance company, or other entity, institution, or organization that does or may have records concerning the PA;

9. An unaltered release relieving from liability any person, entity, institution, organization that provides information as part of the application process;

10. An attestation or proof of professional liability insurance that meets the minimum level established by UCare;

11. A signed attestation of the PA that the application is complete and correct, including those portions of the application that contain information about limitations that would affect the PAs performance, history of loss of medical license and felony convictions and history of limitations of privileges or disciplinary actions

12. Disclosure questions that are signed and dated and appropriately marked “yes”, “no”, or “N/A”.

   A negative answer to any disclosure question requires an explanation by the PA. Non-disclosure of professional concerns occurs if; the PA provides a negative answer to or fails to adequately explain any disclosure question where subsequent information gathered by UCare contradicts that answer.

13. The physician has not previously been denied based on Administrative Criteria for participation by UCare within the preceding six (6) months for not responding to the reconsideration notification per XVII, A (i) or from the committee’s decision within the preceding twelve (12) months per XVII (iii) other than for failure to respond to UCare in a timely manner accordance with a request for credentialing documents.

B. Administrative Criteria

1. Successful completion of any site review or medical record keeping review required by UCare;

2. Adequate provision of 24-hour coverage for all urgent and emergency conditions, as determined by UCare;

3. If the PA practices in a medical group or clinic, the PA is in good standing at such group or clinic;

4. The PA is appropriately practicing in accordance with his or her clinical privileges and/or the outpatient scope of practice approved or as determined by UCare;

5. PA’s must have a sponsoring/collaborative physician for admits of UCare members needing hospitalization. The sponsoring/collaborative physician must be an active UCare participating practitioner.

6. Current and valid Drug Enforcement Administration (DEA) registration or prescriptive authority, if applicable, in every state in which the PA provides care to UCare’s members as specified in practitioner’s qualifications for participation, or evidence acceptable to UCare that the PA has made satisfactory arrangements for another UCare participating physician to prescribe to UCare members;

7. The PA has not misrepresented, misstated, or omitted relevant or material fact on the PA’s application, disclosure statements, or any other documents provided as part of the credentialing process;

8. The PA has not engaged in any conduct resulting in a gross misdemeanor or
felony conviction, charge, or indictment;

9. The PA has demonstrated a willingness (or in the case of recredentialing, an ability) to practice in a managed care environment and to cooperate with UCare with respect to administrative procedures, quality assurance such as site visits and medical record reviews, utilization management, and other matters as determine by UCare;

10. The PA has not previously been denied based on Professional Criteria for participation by UCare within the preceding twenty-four (24) months, other than for failure to respond to UCare in a timely manner accordance with a request for credentialing documents;

11. The PA did no previously resign or was terminated by UCare within the preceding twenty-four (24) months per UCare’s discretion, other than for (1) relocation purposes, (2) suspension or loss of licensure based solely upon reasons unrelated to the practitioner’s professional performance, or (3) failure to respond to UCare in a timely manner in accordance with request for recredentialing documents.

12. Requests for a specialty change where the PA’s education does NOT match the application request;

13. Any PA who fails to continuously satisfy pre-application criteria.

C. Professional Criteria

1. The PA has not engaged in conduct that violates state or federal law or ethical standards of professional conduct governing the practice of the PA’s profession;

2. The PA has not been the subject of professional disciplinary action by a licensing board, managed care plan, insurer, clinic, hospital, medical review board, peer review organization, or other health care organization, administrative body, or government agency, including, but not limited to, the imposition of disciplinary or administrative sanctions for inappropriate, inadequate, or tardy completion of medical records;

3. The PA is not the subject of any reports of an “adverse action” against the DPM, as defined in the Health Care Quality Improvement Act and its implementing regulations;

4. The PA has not engaged in any conduct involving dishonesty, fraud, deceit, or misrepresentation including a pattern of false, intentionally duplicative, or abusive claims submissions;

5. The PA does not have a history of professional liability lawsuits or other incidents, which may indicate a potential competency or quality of care problems;

6. The PA not been involuntarily terminated from professional employment or a hospital medical staff after knowledge of an investigation into the DPM’s conduct, or in lieu of or in anticipation of disciplinary action;

7. The PA does not use or advocate the use of unproven modalities of treatment or therapy regarded in the local medical community as medically inappropriate;

8. The PA has no history of denial or cancellation of failure to renew professional liability insurance;

9. The PA has no known ongoing mental or physical condition likely to adversely affect the ability of the DPM to perform the essential functions of the DPM’s profession with or without reasonable accommodation;

10. The PA has no know ongoing medical or physical condition that could constitute a direct threat to the health and safety of others;

11. The PA has not used illegal drugs or improperly used any controlled substance during the past three (3) years;
12. The PA’s participation with UCare demonstrates a satisfactory quality assurance, member satisfaction, utilization management, and performance, when it relates to professional competence or conduct as determined by UCare (applicable to participating PAs only)

**Advanced Practice Registered Nurses (APRN)**
(Includes: Certified Nurse Midwives (CNM), Certified Nurse Practitioners (NP), Clinical Nurse Specialists (CNS))

Advanced Practice Registered Nurses (APRNs) who are applying to be a UCare participating or existing participating APRN must meet UCare’s Pre-Application, Professional, and Administrative criteria. For new applicants or existing participating APRN’s who do not meet any of UCare’s criteria, the APRN will not be accepted into the network or will have their existing status terminated with UCare

**A. Pre-Application Criteria**

1. The need for the APRN’s specialty or the APRN type in UCare’s network;
2. APRN’s stated practice scope is covered under UCare’s benefits;
3. Execution of or UCare’s intent to execute an individual, group or facility contract with UCare;
4. Appropriate verified license, registration, certification or other required qualification to practice in the state(s) where the APRN is applying to provide care or services;

- **Minnesota:** MN APRNs are required to have a Collaborative Management Plan. In addition, if the APRN is prescribing the APRN must have a written Prescribing Agreement per MN Statue 148.235, subd 4.
  i. The physician named on the Collaborative Management Plan or the Prescribing Agreement must be an active participating with UCare Physician.

- **Iowa** APRN’s in IA are not required to have a prescriptive agreement per Iowa Administrative Code 655-7.2

- **North Dakota:** APRN’s with prescriptive authority are not required to have a written collaborative agreement with a physician. ND repealed this November 2011. Per Administrative Rules and Regulations Title 54.

- **South Dakota:** SD APRNs must have a collaborative agreement on file with the SD Board of Nursing if prescribing. The collaborative physician must have a SD license (the SD Board of Nursing verifies this). In addition, if writing prescriptions for schedules 2, 3 and 4 the APRN must have a SD DEA. Per SD (SDCL) State Statue 36-9A-12 #2.

- **Wisconsin** May issue only those prescription orders appropriate to the advanced practice nurse prescriber’s area of competence, as established by his or her education, training or experience per Administrative Code (N) 8.06. Nothing in the Administrative Code describes if the APRN needs a collaborative management plan or prescriptive plan.

5. APRN’s must have and maintain certification by a national nurse certification organization acceptable to the state nursing board in the state the APRN is practicing as follows:
   - American Academy of Nurse Practitioners
6. The APRN is not excluded from participation in, or sanctioned by, Medicare, Medicaid, or other state or federal health care programs;
7. The APRN does not employ or contract with any person or entity that has been excluded from federal, state or local government program(s) and for UCare’s Medicare products has not opted out of the Medicare program;
8. An unaltered signed release granting UCare permission to review the records of and to contact any licensing entity, medical society, medical school, hospital, clinic, insurance company, or other entity, institution, or organization that does or may have records concerning the APRN;
9. An unaltered release relieving from liability any person, entity, institution or organization that provides information as part of the application process;
10. An attestation or proof of professional liability insurance that meets the minimum level established by UCare;
11. A signed attestation of the APRN that the application is complete and correct, including those portions of the application that contain information about limitations that would affect the APRNs performance, history of loss of medical license and felony convictions and history of limitations of privileges or disciplinary actions;
12. Disclosure questions that are signed and dated and appropriately marked “yes”, “no”, or “N/A”.
A negative answer to any disclosure question requires an explanation by the APRN. Non-disclosure of professional concerns occurs if: the APRN provides a negative answer to or fails to adequately explain any disclosure question where subsequent information gathered by UCare contradicts that answer.
13. The physician has not previously been denied based on Administrative Criteria for participation by UCare within the preceding six (6) months for not responding to the reconsideration notification per XVII, A (i) or from the committee’s decision within the preceding twelve (12) months per XVII (iii) other than for failure to respond to UCare in a timely manner accordance with a request for credentialing documents.

B. Administrative Criteria

1. Successful completion of any site review or medical record keeping review required by UCare;
2. Adequate provision of 24-hour coverage for all urgent and emergency conditions, as determined by UCare;
3. If the APRN practices in a medical group or clinic, the APRN is in good standing at such group or clinic;
4. The APRN is appropriately practicing in accordance with his or her clinical privileges and/or the outpatient scope of practice approved or as determined y UCare;
5. The APRN must have a sponsoring/collaborative physician for admits of UCare members needing hospitalization. The sponsoring/collaborative physician must be an active UCare participating practitioner;
6. Current and valid Drug Enforcement Administration (DEA) registration or prescriptive authority, if applicable, in every state in which the APRN provides care to UCare’s members as specified in practitioner’s qualifications for participation, or evidence acceptable to UCare that the APRN has made satisfactory arrangements for another UCare participating physician to prescribe to UCare members;

7. The APRN has not misrepresented, misstated, or omitted a relevant or material fact on the APRN’s application, disclosure statements, or any other documents provided as part of the credentialing process;

8. The APRN has not engaged in any conduct resulting in a gross misdemeanor or felony conviction, charge, or indictment;

9. The APRN has demonstrated a willingness (or in the case of recredentialing, an ability) to practice in a managed care environment and to cooperate with UCare with respect to administrative procedures, quality assurance such as site visits and medical record reviews, utilization management, and other matters as determined by UCare;

10. The APRN has not previously been denied based on Professional Criteria for participation by UCare within the preceding twenty-four (24) months, other than for failure to respond to UCare in a timely manner accordance with a request for credentialing documents;

11. The APRN did not previously resign or was terminated by UCare within the preceding twenty-four (24) months per UCare’s discretion, other than for (1) relocation purposes, (2) suspension or loss of licensure based solely upon reasons unrelated to the APRN’s professional performance, or (3) failure to respond to UCare in a timely manner in accordance with a request for recredentialing documents;

12. Requests for a specialty change where the APRN’s education does NOT match the application request;

13. Any APRN who fails to continuously satisfy pre-application criteria.

C. Professional Criteria

1. The APRN has not engaged in conduct that violates state or federal law or ethical standards of professional conduct governing the practice of the DPM’s profession;

2. The APRN has not been the subject of professional disciplinary action by a licensing board, managed care plan, insurer, clinic, hospital, medical review board, peer review organization, or other health care organization, administrative body, or government agency, including, but not limited to, the imposition of disciplinary or administrative sanctions for inappropriate, inadequate, or tardy completion of medical records;

3. The APRN is not the subject of any reports of an “adverse action” against the DPM, as defined in the Health Care Quality Improvement Act and its implementing regulations;

4. The APRN has not engaged in any conduct involving dishonesty, fraud, deceit, or misrepresentation including a pattern of false, intentionally duplicative, or abusive claims submissions;

5. The APRN does not have a history of professional liability lawsuits or other incidents, which may indicate a potential competency or quality of care problems;

6. The APRN has not been involuntarily terminated from professional employment or a hospital medical staff after knowledge of an investigation into the DPM’s conduct, or in lieu of or in anticipation of disciplinary action;

7. The APRN does not use or advocate the use of unproven modalities of treatment or therapy regarded in the local medical community as medically inappropriate;
8. The APRN The DPM has no history of denial or cancellation of failure to renew professional liability insurance;
9. The APRN has no known ongoing mental or physical condition likely to adversely affect the ability of the DPM to perform the essential functions of the DPM’s profession with or without reasonable accommodation;
10. The APRN has no know ongoing medical or physical condition that could constitute a direct threat to the health and safety of others;
11. The APRN has not used illegal drugs or improperly used any controlled substance during the past three (3) years;
12. The APRN participation with UCare demonstrates a satisfactory quality assurance, member satisfaction, utilization management, and performance, when it relates to professional competence or conduct as determined by UCare (applicable to participating APRNs only).

**Licensed Traditional Midwives (LTM)**

Licensed Traditional Midwives (LTMs) who are applying to be a UCare participating or existing participating LTM must meet UCare’s Pre-Application, Administrative and Professional criteria. For new applicants or existing participating physicians who do not meet any of UCare’s criteria, the LTM will not be accepted into the network or will have their existing status terminated with UCare.

**A. Pre-Application Criteria**

1. The need for the LTM specialty or the LTM type in UCare’s Network;
2. The LMT stated practice scope is covered under UCare’s benefits;
3. Execution of or UCare’s intent to execute an individual, group or facility contract with UCare;
4. Appropriate verified license, registration, certification or other required qualification to practice in the state(s) where the LMT is applying to provide care or services;
5. LTM’s must have and maintain certification by the North American Registry of Midwives (NARM);
6. The LTM is not excluded from participation in, or sanctioned by, Medicare, Medicaid, or other state or federal health care programs;
7. The LTM does not employ or contract with any person or entity that has been excluded from federal, state or local government program(s) and for UCare’s Medicare products has not opted out of the Medicare program;
8. An unaltered signed release granting UCare permission to review the records or an to contact any licensing entity, medical society, medical school, hospital, clinic, insurance company, or other entity, institution, or organization that does or may have records concerning the LTM;
9. An unaltered release relieving from liability any person, entity, institution, or organization that provides information as part of the application process;
10. An attestation or proof of professional liability insurance that meets the minimum level established by UCare;
11. A signed attestation of the LTM that the application is complete and correct, including those portions of the application that contain information about limitations that would affect the LTM’s performance, history of loss of medical license and felony convictions and history of limitations of privileges or disciplinary actions.
12. Disclosure questions that are signed and date and appropriately marked “yes”, “no”, or “N/A”.

A negative answer to any disclosure question requires an explanation by the DDS or DMD. Non-disclosure of professional concerns occurs if; the DDS or DMD provides a negative answer to or fails to adequately explain any disclosure question where subsequent information gathered by UCare contradicts that answer.

13. The physician has not previously been denied based on Administrative Criteria for participation by UCare within the preceding six (6) months for not responding to the reconsideration notification per XVII, A (i) or from the committee’s decision within the preceding twelve (12) months per XVII (iii) other than for failure to respond to UCare in a timely manner accordance with a request for credentialing documents.

B. Administrative Criteria
1. Successful completion of any site review or medical record keeping review required by UCare;
2. Adequate provision of 24-hour coverage for all urgent and emergency conditions, as determined by UCare;
3. If the LTM practices in a medical group or clinic, the DMD is in good standing at such group or clinic;
4. The LTM is appropriately practicing in accordance with his or her clinical privileges and/or the outpatient scope of practice approved or as determined by UCare;
5. If the LTM practice requires clinical privileges to admit patients to a hospital, the LTM maintains active admitting privileges in good standing at a UCare contracted hospital or provides evidence acceptable to UCare that the LTM has made satisfactory arrangements for another participating LTM (physician) to admit UCare members needing hospitalization;
6. Current and valid Drug Enforcement Administration (DEA) registration or prescriptive authority, if applicable, in every state in which the LTM provides care to UCare’s members as specified in practitioner’s qualifications for participation, or evidence acceptable to UCare that the LTM has made satisfactory arrangements for another UCare participating physician to prescribe to UCare members;
7. The LTM has not misrepresented, misstated, or omitted a relevant or material fact on the LTM application, disclosure statements, or any other documents provided as part of the credentialing process;
8. The LTM has not engaged in any conduct resulting in a gross misdemeanor or felony conviction, charge, or indictment;
9. The LTM has demonstrated a willingness (or in the case of recredentialing, an ability) to practice in a managed care environment and to cooperate with UCare with respect to administrative procedures, quality assurance such as site visits and medical record reviews, utilization management, and other matters as determined by UCare;
10. The LTM has not previously been denied based on Professional Criteria for participation by UCare within the preceding twenty-four (24) months, other than failure to respond to UCare in a timely manner accordance with a request for credentialing documents;
11. The LTM did not previously resign or was terminated by UCare within the preceding twenty-four (24) months per UCare’s discretion, other than for (1) relocation purposes, (2) suspension or loss of licensure based solely upon reasons unrelated to
the DDS or DMD professional performance, or (3) failure to respond to UCare in a
timely manner in accordance with a request for recredentialing documents;
12. Requests for a specialty change where the LTM’s education does NOT match the
application request;
13. Any LTM who fails to continuously satisfy pre-application criteria.

C. Professional Criteria
1. The LTM has not engaged in conduct that violates state or federal law or ethical
   standards of professional conduct governing the practice of the LTM’s profession;
2. The LTM has not been the subject of professional disciplinary action by a licensing
   board, managed care plan, insurer, clinic, hospital, medical review board, peer review
   organization, or other health care organization, administrative body, or government
   agency, including, but not limited to, the imposition of disciplinary or administrative
   sanctions for inappropriate, inadequate, or tardy completion of medical records;
3. The LTM is not the subject of any reports of an “adverse action” against the LTM, as
   defined in the Health Care Quality Improvement Act and its implementing
   regulations;
4. The LTM has not engaged in any conduct involving dishonesty, fraud, deceit, or
   misrepresentation including a pattern of false, intentionally duplicative, or abusive
   claims submissions;
5. The LTM does not have a history of professional liability lawsuits or other incidents,
   which may indicate a potential competency or quality of care problems;
6. The LTM has not been involuntarily terminated from professional employment or a
   hospital medical staff after knowledge of an investigation into the LTM’s conduct, or
   in lieu of or in anticipation of disciplinary action;
7. The LTM does not use or advocate the use of unproven modalities of treatment or
   therapy regarded in the local medical community as medically inappropriate;
8. The LTM has no history of denial or cancellation of failure to renew professional
   liability insurance;
9. The LTM has no known ongoing mental or physical condition likely to adversely
   affect the ability of the LTM’s to perform the essential functions of the LTM’s
   profession with or without reasonable accommodation;
10. The LTM has no known ongoing medical or physical condition that could constitute a
    direct threat to the health and safety of others;
11. The LTM has not used illegal drugs or improperly used any controlled substance
    during the past three (3) years;
12. The LTM participation with UCare demonstrates a satisfactory quality assurance,
    member satisfaction, utilization management, and performance, when it relates to
    professional competence or conduct as determined by UCare (applicable to
    participating LTM’s only).

Doctor of Dental Surgery or Doctor of Dental Medicine

Doctor Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) who are applying to be a
UCare participating or existing participating physician must meet UCare’s Pre-Application,
Administrative and Professional criteria. For new applicants or existing participating physicians
who do not meet any of UCare’s criteria, the physician will not be accepted into the network or
will have their existing status terminated with UCare.
A. Pre-Application Criteria:
1. The need for the DDS or DMD specialty or the DDS or DMD type in UCare’s Network;
2. DDS or DMD stated practice scope is covered under UCare’s benefits;
3. Execution of or UCare’s intent to execute an individual, group or facility contract with UCare;
4. Appropriate verified license, registration, certification or other required qualification to practice in the state(s) where the physician is applying to provide care or services;
5. The DDS or DMD holds current board certification or has completed the appropriate training as defined by the licensing or registration agency of the physician’s; profession applicable to the physician’s stated scope of practice or as otherwise defined by UCare
6. The DDS or DMD is not excluded from participation in, or sanctioned by, Medicare, Medicaid, or other state or federal health care programs;
7. The DD or DMD does not employ or contract with any person or entity that has been excluded from federal, state or local government program(s) and for UCare’s Medicare products has not opted out of the Medicare program;
8. An unaltered signed release granting UCare permission to review the records or an to contact any licensing entity, medical society, medical school, hospital, clinic, insurance company, or other entity, institution, or organization that does or may have records concerning the DDS or DMD;
9. An unaltered release relieving from liability any person, entity, institution, or organization that provides information as part of the application process;
10. An attestation or proof of professional liability insurance that meets the minimum level established by UCare;
11. A signed attestation of the DDs or DMD that the application is complete and correct, including those portions of the application that contain information about limitations that would affect the DDS or DMDs performance, history of loss of medical license and felony convictions and history of limitations of privileges or disciplinary actions
12. Disclosure questions that are signed and date and appropriately marked “yes”, “no”, or “N/A”.
   A negative answer to any disclosure question requires an explanation by the DDS or DMD. Non-disclosure of professional concerns occurs if; the DDS or DMD provides a negative answer to or fails to adequately explain any disclosure question where subsequent information gathered by UCare contradicts that answer.
13. The physician has not previously been denied based on Administrative Criteria for participation by UCare within the preceding six (6) months for not responding to the reconsideration notification per XVII, A (i) or from the committee’s decision within the preceding twelve (12) months per XVII (iii) other than for failure to respond to UCare in a timely manner accordance with a request for credentialing documents.

B. Administrative Criteria
1. Successful completion of any site review or medical record keeping review required by UCare;
2. Adequate provision of 24-hour coverage for all urgent and emergency conditions, as determined by UCare;
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3. If the DDS or DMD practices in a medical group or clinic, the DMD is in good standing at such group or clinic;

4. The DDS or DMD is appropriately practicing in accordance with his or her clinical privileges and/or the outpatient scope of practice approved or as determined by UCare;

5. If the DDS or DMD practice requires clinical privileges to admit patients to a hospital, the DDS or DMD maintains active admitting privileges in good standing at a UCare contracted hospital or provides evidence acceptable to UCare that the DDS or DMD has made satisfactory arrangements for another participating DDS or DMD (physician) to admit UCare members needing hospitalization;

6. Current and valid Drug Enforcement Administration (DEA) registration or prescriptive authority, if applicable, in every state in which the DDS or DMD provides care to UCare’s members as specified in practitioner’s qualifications for participation, or evidence acceptable to UCare that the DDS or DMD has made satisfactory arrangements for another UCare participating physician to prescribe to UCare members;

7. The DDS or DMD has not misrepresented, misstated, or omitted a relevant or material fact on the APRN’s application, disclosure statements, or any other documents provided as part of the credentialing process;

8. The DDS or DMD has not engaged in any conduct resulting in a gross misdemeanor or felony conviction, charge, or indictment;

9. The DDS or DMD has demonstrated a willingness (or in the case of recredentialing, an ability) to practice in a managed care environment and to cooperate with UCare with respect to administrative procedures, quality assurance such as site visits and medical record reviews, utilization management, and other matters as determined by UCare;

10. The DDS or DMD has not previously been denied based on Professional Criteria for participation by UCare within the preceding twenty-four (24) months, other than for failure to respond to UCare in a timely manner accordance with a request for credentialing documents;

11. The DDS or DMD did not previously resign or was terminated by UCare within the preceding twenty-four (24) months per UCare’s discretion, other than for (1) relocation purposes, (2) suspension or loss of licensure based solely upon reasons unrelated to the DDS or DMD professional performance, or (3) failure to respond to UCare in a timely manner in accordance with a request for recredentialing documents;

12. Requests for a specialty change where the APRN’s education does NOT match the application request;

13. Any APRN who fails to continuously satisfy pre-application criteria.

C. Professional Criteria

1. The DDS or DMD has not engaged in conduct that violates state or federal law or ethical standards of professional conduct governing the practice of the DDS’ or DMD’s profession;

2. The DDS or DMD has not been the subject of professional disciplinary action by a licensing board, managed care plan, insurer, clinic, hospital, medical review board, peer review organization, or other health care organization, administrative body, or government agency, including, but not limited to, the imposition of disciplinary or
3. The DDS or DMD is not the subject of any reports of an “adverse action” against the DPM, as defined in the Health Care Quality Improvement Act and its implementing regulations;
4. The DDS or DMD has not engaged in any conduct involving dishonesty, fraud, deceit, or misrepresentation including a pattern of false, intentionally duplicative, or abusive claims submissions;
5. The DDS or DMD does not have a history of professional liability lawsuits or other incidents, which may indicate a potential competency or quality of care problems;
6. The DDS or DMD has not been involuntarily terminated from professional employment or a hospital medical staff after knowledge of an investigation into the DDS’ or DMD’s conduct, or in lieu of or in anticipation of disciplinary action;
7. The DDS or DMD does not use or advocate the use of unproven modalities of treatment or therapy regarded in the local medical community as medically inappropriate;
8. The DDS or DMD has no history of denial or cancellation of failure to renew professional liability insurance;
9. The DDS or DMD has no known ongoing mental or physical condition likely to adversely affect the ability of the DDS’ or DMD’s to perform the essential functions of the DPM’s profession with or without reasonable accommodation;
10. The DDS or DMD has no know ongoing medical or physical condition that could constitute a direct threat to the health and safety of others;
11. The DDS or DMD has not used illegal drugs or improperly used any controlled substance during the past three (3) years;
12. The DDS or DMD participation with UCare demonstrates a satisfactory quality assurance, member satisfaction, utilization management, and performance, when it relates to professional competence or conduct as determined by UCare (applicable to participating DDS or DMD only).

**Acupuncturists**

Acupuncturists (LAc) who are applying to be a UCare participating or existing participating LAc must meet UCare’s Pre-Application, Administrative and Professional criteria. For new applicants or existing participating LAc who do not meet any of UCare’s criteria, the LAc will not be accepted into the network or will have their existing status terminated with UCare.

**A. Pre-Application Criteria**

1. The need for the LAc’s specialty or the LAc type in UCare’s network;
2. LAc stated practice scope is covered under UCare’s benefits;
3. Execution of or UCare’s intent to execute an individual, group or facility contract with UCare;
4. Appropriate verified license, registration, certification or other required qualification to practice in the state(s) where the LAc is applying to provide care or services
   a. LAc must have completed the appropriate training in Oriental Medicine, maintain National Certification Commission on Acupuncture and Oriental Medicine (NCCAOM) Certification or training that is deemed equivalent by
the state licensing board, and hold a current state license to practice acupuncture (grandfathered by the licensing board)

5. The LAc is not excluded from participation in, or sanctioned by, Medicare, Medicaid, or other state or federal health care programs;

6. The LAc does not employ or contract with any person or entity that has been excluded from federal, state or local government program(s) and for UCare’s Medicare products has not opted out of the Medicare program;

7. An unaltered signed release granting UCare permission to review the records of and to contact any licensing entity, medical society, medical school, hospital, clinic, insurance company, or other entity, institution, or organization that does or may have records concerning the LAc;

8. An unaltered release relieving from liability any person, entity, institution, or organization the provides information as part of the application process;

9. An attestation or proof of professional liability insurance that meets the minimum level established by UCare;

10. A signed attestation of the LAc that the application is complete and correct, including those portions of the application that contain information about limitations that would affect the LAc’s performance, history of loss of medical license and felony convictions and history of limitations of privileges or disciplinary actions

11. Disclosure questions that are signed and dated and appropriately marked “yes”, “no”, or “N/A”.

A negative answer to any disclosure question requires an explanation by the LAc. Non-disclosure of professional concerns occurs if; the LAc provides a negative answer to or fails to adequately explain any disclosure question where subsequent information gathered by UCare contradicts that answer.

12. The physician has not previously been denied based on Administrative Criteria for participation by UCare within the preceding six (6) months for not responding to the reconsideration notification per XVII, A (i) or from the committee’s decision within the preceding twelve (12) months per XVII (iii) other than for failure to respond to UCare in a timely manner accordance with a request for credentialing documents.

B. Administrative Criteria

1. Successful completion of any site review or medical record keeping review required by UCare;

2. Adequate provision of 24-hour coverage for all urgent and emergency conditions, as determined by UCare;

3. If the LAc practices in a medical group or clinic, the LAc is in good standing at such group or clinic;

4. The LAc is appropriately practicing in accordance with his or her clinical privileges and/or the outpatient scope of practice approved or as determined by UCare;

5. The LAc has not misrepresented, misstated, or omitted a relevant or material fact on the LAc’s application, disclosure statements, or any other documents provided as part of the credentialing process;

6. The LAc has not engaged in any conduct resulting in a gross misdemeanor or felony conviction, charge, or indictment;

7. The LAc has demonstrated a willingness (or in the case of recredentialing, an ability)
to practice in a managed care environment and to cooperate with UCare with respect to administrative procedures, quality assurance such as site visits and medical record reviews, utilization management, and other matters as determined by UCare;

8. The LAc has not previously been denied based on Professional Criteria for participation by UCare within the preceding twenty-four (24) months, other than for failure to respond to UCare in a timely manner accordance with a request for credentialing documents;

9. The LAc did not previously resign or was terminated by UCare within the preceding twenty-four (24) months per UCare’s discretion, other than for (1) relocation purposes, (2) suspension or loss of licensure based solely upon reasons unrelated to the LAc’s professional performance, or (3) failure to respond to UCare in a timely manner in accordance with a request for recredentialing documents;

10. Requests for a specialty change where the LAc’s education does NOT match the application request;

11. Any LAc who fails to continuously satisfy pre-application criteria.

C. Professional Criteria

1. The LAc has not engaged in conduct that violates state or federal law or ethical standards of professional conduct governing the practice of the LAc’s profession;

2. The LAc has not been subject of professional disciplinary action by a licensing board, managed care plan, insurer, clinic, hospital, medical review board, peer review organization, or other health care organization, administrative body, or government agency, including, but not limited to, the imposition of disciplinary or administrative sanctions for inappropriate, inadequate, or tardy completion of medical records;

3. The LAc is not the subject of any reports of an “adverse action” against the LAc, as defined in the Health Care Quality Improvement Act and its implementing regulations;

4. The LAc has not engaged in any conduct involving dishonesty, fraud, deceit, or misrepresentation including a pattern of false, intentionally duplicative, or abusive claims submissions;

5. The LAc does not have a history of professional liability lawsuits or other incidents, which may indicate a potential competency or quality of care problems;

6. The LAC has not been involuntarily terminated from professional employment or a hospital medical staff after knowledge of an investigation into the LAc’s conduct, or in lieu of or in anticipation of disciplinary action;

7. The LAc does not use or advocate the use of unproven modalities of treatment or therapy regarded in the local medical community as medically inappropriate;

8. The LAc has no history of denial or cancellation of failure to renew professional liability insurance;

9. The LAc has no known ongoing mental or physical condition likely to adversely affect the ability of the LAc to perform the essential functions of the LAc’s profession with or without reasonable accommodation;

10. The LAc has no know ongoing medical or physical condition that could constitute a
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direct threat to the health and safety of others;
11. The LAc has not used illegal drugs or improperly used any controlled substance during the past three (3) years;
12. The LAc’s participation with UCare demonstrates a satisfactory quality assurance, member satisfaction, utilization management, and performance, when it relates to professional competence or conduct as determined by UCare (applicable to participating LAc’s only).

Optometrists (OD)

Optometrists who are applying to be a UCare participating or existing participating Optometrist must meet UCare’s Pre-Application, Administrative and Professional criteria. For new applicants or existing participating Optometrists who do not meet any of UCare’s criteria, the Optometrist will not be accepted into the network or will have their existing status terminated with UCare

A. Pre-Application Criteria:
1. The need for the OD’s specialty or the OD type in UCare’s Network;
2. OD’s stated practice scope is covered under UCare’s benefits;
3. Execution of or UCare’s intent to execute an individual, group or facility contract with UCare;
4. Appropriate verified license, registration, certification or other required qualification to practice in the state(s) where the OD is applying to provide care or services
5. The OD is not excluded from participation in, or sanctioned by, Medicare, Medicaid, or other state or federal health care programs;
6. The OD does not employ or contract with any person or entity that has been excluded from federal, state or local government program(s) and for UCare’s Medicare products has not opted out of the Medicare program;
7. An unaltered signed release granting UCare permission to review the records of and to contact any licensing entity, medical society, medical school, hospital, clinic, insurance company, or other entity, institution, or organization that does or may have records concerning the OD;
8. An unaltered release relieving from liability any person, entity, institution, or organization that provides information as part of the application process;
9. An attestation or proof of professional liability insurance that meets the minimum level established by UCare;
10. A signed attestation of the OD that the application is complete and correct, including those portions of the application that contain information about limitations that would affect the OD’s performance, history of loss of medical license and felony convictions and history of limitations of privileges or disciplinary actions
11. Disclosure questions that are signed and dated and appropriately marked “yes”, “no”, or “N/A”.

A negative answer to any disclosure question requires an explanation by the provider. Non-disclosure of professional concerns occurs if: the OD provides a negative answer to or fails to adequately explain any disclosure question where subsequent information gathered by UCare contradicts the answer.
12. The physician has not previously been denied based on Administrative Criteria for participation by UCare within the preceding six (6) months for not responding to
B. Administrative Criteria

1. Successful completion of any site review or medical record keeping review required by UCare;
2. Adequate provision of 24-hour coverage for all urgent and emergency conditions, as determined by UCare;
3. If the OD practices in a medical group or clinic, the OD is in good standing at such group or clinic;
4. The OD is appropriately practicing in accordance with his or her clinical privileges and/or the outpatient scope of practice approved or as determined by UCare;
5. Current and valid Drug Enforcement Administration (DEA) registration or prescriptive authority, if applicable, in every state in which the OD provides care to UCare’s members as specified in practitioner’s qualifications for participation, or evidence acceptable to UCare that the OD has made satisfactory arrangements for another UCare participating physician to prescribe to UCare members;
6. The OD has not misrepresented, misstated, or omitted a relevant or material fact on the OD’s application, disclosure statements, or any other documents provided as part of the credentialing process;
7. The OD has not engaged in any conduct resulting in a gross misdemeanor or felony conviction, charge, or indictment;
8. The OD has demonstrated a willingness (or in the case of recredentialing, an ability) to practice in a managed care environment and to cooperate with UCare with respect to administrative procedures, quality assurance such as site visits and medical record reviews, utilization management, and other matters as determined by UCare;
9. The OD has not previously been denied based on professional Criteria for participation by UCare within the preceding twenty-four (24) months, other than for failure to respond to UCare in a timely manner accordance with a request for credentialing documents;
10. The OD did not previously resign or was terminated by UCare within the preceding twenty-four (24) months per UCare’s discretion, other than for (1) relocation purposes, (2) suspension or loss of licensure based solely upon reasons unrelated to the OD’s professional performance, or (3) failure to respond to UCare in a timely manner in accordance with a request for recredentialing documents;
11. Requests for a specialty change where the OD’s education does NOT match the application request;
12. Any OD who fails to continuously satisfy pre-application criteria.

C. Professional Criteria

1. The OD has not engaged in conduct that violates state or federal law or ethical standards of professional conduct governing the practice of the OD’s profession;
2. The OD has not been the subject of professional disciplinary action by a licensing board, managed care plan, insurer, clinic, hospital, medical review board, peer review organization, or other health care organization, administrative body, or government agency, including, but not limited to, the imposition of disciplinary or administrative
sanctions for inappropriate, inadequate, or tardy completion of medical records;
3. The OD is not the subject of any reports of an “adverse action” against the OD, as defined in the Health Care Quality Improvement Act and its implementing regulations;
4. The OD has not engaged in any conduct involving dishonesty, fraud, deceit, or misrepresentation including a pattern of false, intentionally duplicative, or abusive claims submissions;
5. The OD does not have a history of professional liability lawsuits or other incidents, which may indicate a potential competency or quality of care problems;
6. The OD has not been involuntarily terminated from professional employment or a hospital medical staff after knowledge of an investigation into the OD’s conduct, or in lieu of or in anticipation of disciplinary action;
7. The OD does not use or advocate the use of unproven modalities of treatment or therapy regarded in the local medical community as medically inappropriate;
8. The OD has no history of denial or cancellation of failure to renew professional liability insurance;
9. The OD has no known ongoing mental or physical condition likely to adversely affect the ability of the OD to perform the essential functions of the OD’s profession with or without reasonable accommodation;
10. The OD has no known ongoing medical or physical condition that could constitute a direct threat to the health and safety of others;
11. The OD has not used illegal drugs or improperly used any controlled substance during the past three (3) years;
12. The OD’s participation with UCare demonstrates a satisfactory quality assurance, member satisfaction, utilization management, and performance, when it relates to professional competence or conduct as determined by UCare (applicable to participating ODs only).

**Mental Health Practitioners**

*(Includes: Psychologists, Social Workers, Marriage and Family Therapy)*

Mental Health Practitioners (MHP) who are applying to be a UCare participating or existing participating MHP must meet UCare’s Pre-Application, Administrative and Professional criteria. For new applicants or existing participating MHPs who do not meet any of UCare’s criteria, the MHP will not be accepted into the network or will have their existing status terminated with UCare.

**A. Pre-Application Criteria**

1. The need for the MHP’s specialty or the MHP type in UCare’s Network;
2. MHP’s stated practice scope is covered under UCare’s benefits;
3. Execution of or UCare’s intent to execute an individual, group or facility contract with UCare;
4. Appropriate verified license, registration, certification or other required qualification to practice in the state(s) where the MHP is applying to provide care or services;
5. The MHP is not excluded from participation in, or sanctioned by, Medicare, Medicaid, or other state or federal health care programs;
6. The MHP does not employ or contract with any person or entity that has been excluded from federal, state or local government program(s) and for UCare’s
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Medicare products has not opted out of the Medicare program;

7. An unaltered signed release granting UCare permission to review the records of and to contact any licensing entity, medical society, medical school, hospital, clinic, insurance company, or other entity, institution, or organization that does or may have records concerning the MHP;

8. An unaltered release relieving from liability any person, entity, institution, or organization that provides information as part of the application process;

9. An attestation or proof of professional liability insurance that meets the minimum level established by UCare;

10. A signed and dated attestation of the MHP that the application is complete and correct, including those portions of the application that contain information about limitations that would affect the MHP’s performance, history of loss of medical license and felony convictions and history of limitations of privileges or disciplinary actions

11. Disclosure questions that are signed and dated and appropriately marked “yes”, “no”, or “N/A”.

A negative answer to any disclosure question requires an explanation by the MHP. Non-disclosure of professional concerns occurs if; the MHP provides a negative answer to or fails to adequately explain any disclosure question where subsequent information gathered by UCare contradicts that answer.

12. The physician has not previously been denied based on Administrative Criteria for participation by UCare within the preceding six (6) months for not responding to the reconsideration notification per XVII, A (i) or from the committee’s decision within the preceding twelve (12) months per XVII (iii) other than for failure to respond to UCare in a timely manner accordance with a request for credentialing documents.

B. Administrative Criteria

1. Successful completion of any site review or medical record keeping review required by UCare;

2. Adequate provision of 24-hour coverage for all urgent and emergency conditions, as determined by UCare;

3. If the MHP practices in a medical group or clinic, the MHP is in good standing at such group or clinic;

4. The MHP is appropriately practicing in accordance with his or her clinical privileges and/or the outpatient scope of practice approved or as determined by UCare;

5. The MHP has not misrepresented, misstated, or omitted a relevant or material fact on the MHP’s application, disclosure statements, or any other documents provided as part of the credentialing process;

6. The MHP has not engaged in any conduct resulting in a gross misdemeanor or felony conviction, charge, or indictment;

7. The MHP has demonstrated a willingness (or in the case of recredentialing, an ability) to practice in a managed care environment and to cooperate with UCare with respect to administrative procedures, quality assurance such as site visits and medical record reviews, utilization management, and other matters as determined by UCare;

8. The MHP has not previously been denied based on Professional Criteria for participation by UCare within the preceding twenty-four (24) months, other than for failure to respond to UCare in a timely manner accordance with a request for credentialing documents;
PROPRIETARY AND CONFIDENTIAL

9. The MHP did not previously resign or was terminated by UCare within the preceding twenty-four (24) months per UCare’s discretion, other than for (1) relocation purposes, (2) suspension or loss of licensure based solely upon reasons unrelated to the MHP’s professional performance, or (3) failure to respond to UCare in a timely manner in accordance with a request for credentialing documents;
10. Requests for a specialty change where the MHP’s education does NOT match the application request;
11. Any MHP who fails to continuously satisfy pre-application criteria.

C. Professional Criteria
1. the MHP has not engaged in conduct that violates state or federal law or ethical standards of professional conduct governing the practice of the MHP’s profession;
2. the MHP has not been the subject of professional disciplinary action by a licensing board, managed care plan, insurer, clinic, hospital, medical review board, peer review organization, or other health care organization, administrative body, or government agency, including, but not limited to, the imposition of disciplinary or administrative sanctions for inappropriate, inadequate, or tardy completion of medical records;
3. The MHP is not the subject of any reports of an “adverse action” against the MHP, as defined in the Health Care Quality Improvement Act and its implementing regulations;
4. The MHP has not engaged in any conduct involving dishonesty, fraud, deceit, or misrepresentation including a pattern of false, intentionally duplicative, or abusive claims submissions;
5. The MHP does not have a history of professional liability lawsuits or other incidents, which may indicate a potential competency or quality of care problems;
6. The MHP has not been involuntarily terminated from professional employment or a hospital medical staff after knowledge of an investigation into the MHP’s conduct, or in lieu of or in anticipation of disciplinary action;
7. The MHP does not use or advocate the use of unproven modalities of treatment or therapy regarded in the local medical community as medically inappropriate;
8. The MHP has no history of denial or cancellation of failure to renew professional liability insurance;
9. The MHP has no known ongoing mental or physical condition likely to adversely affect the ability of the MHP to perform the essential functions of the MHP’s profession with or without reasonable accommodation;
10. The MHP has no know ongoing medical or physical condition that could constitute a direct threat to the health and safety of others;
11. The MHP has not used illegal drugs or improperly used any controlled substance during the past three (3) years;
12. The MHP’s participation with UCare demonstrates a satisfactory quality assurance, member satisfaction, utilization management, and performance, when it relates to professional competence or conduct as determined by UCare (applicable to participating MHPs only).
Chiropractor (DC)

Chiropractors (DC) who are applying to be a UCare participating or existing participating DC must meet UCare’s Pre-Application, Administrative and Professional criteria. For new applicants or existing participating DC who do not meet any of UCare’s criteria, the DC will not be accepted into the network or will have their existing status terminated with UCare.

A. Pre-Application Criteria
1. The need for the DC’s specialty type in UCare’s network;
2. DC stated practice scope is covered under UCare’s benefits;
3. Execution of or UCare’s intent to execute an individual, group or facility contract with UCare;
4. Appropriate verified license, registration, certification or other required qualification to practice in the state(s) where the DC is applying to provide care or services
   a. DC must be a graduate of a college of chiropractic which is accredited by the Council on Chiropractic Education, or another agency appropriately approved by the U.S Department of Education.
5. The DC is not excluded from participation in, or sanctioned by, Medicare, Medicaid, or other state or federal health care programs;
6. The DC does not employ or contract with any person or entity that has been excluded from federal, state or local government program(s) and for UCare’s Medicare products has not opted out of the Medicare program;
7. An unaltered signed release granting UCare permission to review the records of and to contact any licensing entity, medical society, medical school, hospital, clinic, insurance company, or other entity, institution, or organization that does or may have records concerning the DC;
8. An unaltered release relieving from liability any person, entity, institution, or organization the provides information as part of the application process;
9. An attestation or proof of professional liability insurance that meets the minimum level established by UCare;
10. A signed attestation of the DC that the application is complete and correct, including those portions of the application that contain information about limitations that would affect the DC’s performance, history of loss of medical license and felony convictions and history of limitations of privileges or disciplinary actions
11. Disclosure questions that are signed and dated and appropriately marked “yes”, “no”, or “N/A”.
   A negative answer to any disclosure question requires an explanation by the DC. Non-disclosure of professional concerns occurs if; the DC provides a negative answer to or fails to adequately explain any disclosure question where subsequent information gathered by UCare contradicts that answer.
12. The DC has not previously been denied based on Administrative Criteria for participation by UCare within the preceding six (6) months for not responding to the reconsideration notification per XVII, A (i) or from the committee’s decision within the preceding twelve (12) months per XVII (iii) other than for failure to respond to UCare in a timely manner accordance with a request for credentialing documents.

B. Administrative Criteria
1. Successful completion of any site review or medical record keeping review required
2. Adequate provision of 24-hour coverage for all urgent and emergency conditions, as determined by UCare;
3. If the DC practices in a medical group or clinic, the DC is in good standing at such group or clinic;
4. The DC is appropriately practicing in accordance with his or her clinical privileges and/or the outpatient scope of practice approved or as determined by UCare;
5. The DC has not misrepresented, misstated, or omitted a relevant or material fact on the DC application, disclosure statements, or any other documents provided as part of the credentialing process;
6. The DC has not engaged in any conduct resulting in a gross misdemeanor or felony conviction, charge, or indictment;
7. The DC has demonstrated a willingness (or in the case of recredentialing, an ability) to practice in a managed care environment and to cooperate with UCare with respect to administrative procedures, quality assurance such as site visits and medical record reviews, utilization management, and other matters as determined by UCare;
8. The DC has not previously been denied based on Professional Criteria for participation by UCare within the preceding twenty-four (24) months, other than for failure to respond to UCare in a timely manner accordance with a request for credentialing documents;
9. The DC did not previously resign or was terminated by UCare within the preceding twenty-four (24) months per UCare’s discretion, other than for (1) relocation purposes, (2) suspension or loss of licensure based solely upon reasons unrelated to the LAc’s professional performance, or (3) failure to respond to UCare in a timely manner in accordance with a request for recredentialing documents;
10. Requests for a specialty change where the DC’s education does NOT match the application request;
11. Any DC who fails to continuously satisfy pre-application criteria.

C. Professional Criteria

1. The DC has not engaged in conduct that violates state or federal law or ethical standards of professional conduct governing the practice of the LAc’s profession;
2. The DC has not been the subject of professional disciplinary action by a licensing board, managed care plan, insurer, clinic, hospital, medical review board, peer review organization, or other health care organization, administrative body, or government agency, including, but not limited to, the imposition of disciplinary or administrative sanctions for inappropriate, inadequate, or tardy completion of medical records;
3. The DC is not the subject of any reports of an “adverse action” against the DC, as defined in the Health Care Quality Improvement Act and its implementing regulations;
4. The DC has not engaged in any conduct involving dishonesty, fraud, deceit, or misrepresentation including a pattern of false, intentionally duplicative, or abusive claims submissions;
5. The DC does not have a history of professional liability lawsuits or other incidents, which may indicate a potential competency or quality of care problems;
6. The DC has not been involuntarily terminated from professional employment or a hospital medical staff after knowledge of an investigation into the DC’s conduct, or in lieu of or in anticipation of disciplinary action;
7. The DC does not use or advocate the use of unproven modalities of treatment or therapy regarded in the local medical community as medically inappropriate;
8. The DC has no history of denial or cancellation of failure to renew professional liability insurance;
9. The DC has no known ongoing mental or physical condition likely to adversely affect the ability of the DC to perform the essential functions of the DC’s profession with or without reasonable accommodation;
10. The DC has no known ongoing medical or physical condition that could constitute a direct threat to the health and safety of others;
11. The DC has not used illegal drugs or improperly used any controlled substance during the past three (3) years;
12. The DC’s participation with UCare demonstrates a satisfactory quality assurance, member satisfaction, utilization management, and performance, when it relates to professional competence or conduct as determined by UCare (applicable to participating DC’s only).
FACILITIES CRITERIA FOR ACCEPTANCE

Facilities who are applying to be a UCare participating or existing participating facility must meet UCare’s Pre-Application, Administrative and Professional criteria. For new applicants or existing participating facilities who do not meet any of UCare’s criteria, the facility will not be accepted into the network or will have their existing status terminated with UCare.

A. Pre-application Criteria
   All facilities providers must be determined by UCare to be eligible to apply for participation status. Eligibility is determined by:
   1. The need for the facility’s specialty or type in UCare’s Network;
   2. Execution of or UCare’s intent to execute a network agreement with UCare;
   3. A copy of all applicable accreditation/certificates/CMS or state review;
      If the facility is not accredited, and the CMS or state review is greater than three (3) years, UCare will conduct its own health plan site review.
   4. A copy of the facility’s liability insurance (for both general and professional) certificate showing levels that meet UCare requirements;
   5. The facility is not excluded from participation in, or sanctioned by, Medicare, Medicaid or other state or federal health care programs;
   6. A copy of the facility’s licensure; and
   7. The facility does not employ or contract with any person or entity that has been excluded from federal, state or local government program(s).

B. Administrative Criteria
   Administrative criteria for facilities providers subject to credentialing include:
   1. The facility has demonstrated a willingness to practice in a managed care environment and to cooperate with UCare with respect to administrative procedures, quality assurance such as site visits and medical record reviews, utilization management, and other matters as determined by UCare;
   2. The facility has a current, valid accreditation or certification acceptable to UCare, or in lieu of an acceptable accreditation or certification, the facility has successfully completed a health plan site review performed by UCare;
   3. The facility has not previously been denied for participation by UCare within the preceding twenty-four (24) months, other than for failure to respond to UCare in accordance with a request for assessment or re-assessment documents; and
   4. The facility did not previously resign or was terminated by UCare within the preceding twenty-four (24) months per UCare’s discretion, other than for (1) relocation purposes, (2) suspension or loss of licensure based solely upon reasons
unrelated to the facility’s professional performance, or (3) failure to respond to UCare in a timely manner in accordance with a reassessment request for documents.

C. Professional Criteria

Professional Criteria are those criteria that relate to the facility’s professional performance, judgment and clinical competence. Professional Criteria are as follows:

1. The facility has not engaged in conduct that violate state or federal law or ethical standards of conduct governing the facility’s operations;
2. The facility has not been the subject of professional disciplinary action by a licensing board, managed care plan, insurer, clinic, hospital, medical review board, peer review organization, or other health care organization, administrative body, or governing agency, including, but not limited to, the imposition of disciplinary or administrative sanctions for inappropriate, inadequate, or tardy completion of medical records;
3. The facility has not been previously excluded from or sanctioned by the Medicaid or Medicare programs;
4. The facility has not engaged in any conduct involving dishonesty, fraud, deceit, or misrepresentation including a pattern of false, intentionally duplicative, or abusive claims submissions;
5. The facility does not have a history of liability lawsuits or other incidents, which may indicate a potential competency or quality of care problems;
6. The facility does not use or advocate the use of unproven modalities of treatment or therapy regarded in the local medical community as medically inappropriate;
7. The facility has no history of denial or cancellation or failure to renew liability insurance; and
8. The facility’s participation with UCare demonstrates a satisfactory quality assurance, member satisfaction, utilization management, and performance, when it relates to professional competence or conduct as determined by UCare (applicable to participating Providers only).
9. The Organizational Provider maintains all records required by law and community standards and meets UCare’s standards for office quality and cleanliness.