UCARE POLICY MANUAL

Product Lines Affected:

<table>
<thead>
<tr>
<th>FEDERAL PROGRAMS</th>
<th>SPECIAL NEEDS PLANS FOR DUAL ELIGIBLES</th>
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</thead>
<tbody>
<tr>
<td>X  UFS Value</td>
<td>X  MSHO</td>
</tr>
<tr>
<td>X  UFS Essentials Rx, Value Plus, Classic, Prime, Standard</td>
<td>X  UCare Connect + Medicare (SNBC)</td>
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<tr>
<td>X  EssentialCare Secure, Grand</td>
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<tr>
<th>STATE PROGRAMS</th>
<th>INDIVIDUAL COMMERCIAL PLANS (EXCHANGE)</th>
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<tbody>
<tr>
<td>X  PMAP</td>
<td>X  UCare Choices</td>
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<tr>
<td>X  MSC+</td>
<td>X  Fairview UCare Choices</td>
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<tr>
<td>X  UCare Connect (SNBC)</td>
<td>X  OTHER</td>
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<td>X  MnCare</td>
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UCARE CREDENTIALING PLAN

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This Credentialing Plan applies to all providers defined by UCare subject to credentialing. All providers subject to credentialing must be fully credentialed prior to rendering any services to UCare members. Continued participation by the provider under this Credentialing Plan is dependent upon the provider or facility meeting the participation criteria set for in Credentialing Procedure QCR0030- Criteria for Acceptance.
I. Introduction

The UCare Credentialing Department provides a plan on (re)credentialing of providers consistent with the National Committee for Quality Assurance (NCQA), Centers for Medicare & Medicaid Services (CMS) regulations, Minnesota state law, and the Health Care Quality Improvement Act of 1986, and supports the organization by monitoring the competency of providers using a fair, thorough application process, thereby promoting the safety and quality of care given to members.

On an annual basis the appropriate staff will review the Credentialing Plan and the Credentialing Committee will approve the Credentialing Plan.

The Credentialing Plan may be changed at any time upon approval by the Credentialing Committee. Any changes in regulatory or accreditation requirements shall automatically be incorporated into the Credentialing Plan as of the regulators and/or accreditation effective date. Changes shall be effective for all new and existing providers.

Decisions regarding billing are separate from the credentialing process, although providers subject to credentialing will not be given an UCare billing number for participation until the provider is fully credentialed.

II. Definitions

Practitioner or Provider (Provider): Any health care professional that provides health care under contract with UCare and is a licensed individual health care professional permitted by law to independently provider health care services and direct treatment to patients.

Organizational Provider (Facility): A specific location or group of locations at which providers provide services to UCare enrollees, as outlined in Section III below.

Credentialing Staff: UCare’s Credentialing Staff are those individuals who conduct the credentialing functions in accordance with this Credentialing Plan. Credentialing Staff develop and implement the credentialing policies and procedures.

Medical Directors: The Associate Medical Director chairs the Credentialing Committee, works collaboratively with the Credentialing Staff to ensure implementation of the Credentialing Plan and serves as a clinical resource.

Clean Credentialing Files: Credentialing files that have been evaluated per the Credentialing Plan and (1) do not vary from any credentialing criteria as outlined in QCR0030 – Criteria for Acceptance, or (2) has variations from criteria within QCR0030 – Criteria for Acceptance that have been deemed by the Medical Director as having no current significant issues.
Standards/ Regulations

**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.

**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 describe herein.

**Credentialing Committee:** The Credentialing Committee is responsible for reviewing (re)credentialing files under administrative and professional criteria, requests for new certification boards that are not recognized by the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), and the Credentialing Committee Charter per this Credentialing Plan. The Credentialing Committee reviews and approves changes to the Credentialing Plan, new credentialing delegation agreements, delegation issues and annual oversight audits based on information and recommendation from the Credentialing Department. The Credentialing Committee reports its activities to the QIC.

**Criteria:** Eligibility is determined by meeting pre-application, administrative and professional criteria as outlined in procedures QCR0030 Criteria for Acceptance.

**Pre-Application:** Pre-Application Criteria are those criteria all providers requiring credentialing must meet to be eligible to apply for participation status or existing participation status.

**Administrative:** Administrative Criteria are those criteria that do not directly relate to providers’ professional performance, judgment and clinical competence.

**Professional:** Professional Criteria are those criteria that relate to providers’ professional performance, judgment and clinical competence. In determining whether there is a variation from Professional Criteria, the Credentialing Staff and/or Medical Director apply specific guidelines approved the by the Credentialing Committee.

**Quality of Care Issues:** Quality of Care issues, as understood from a regulatory context and 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 per Quality of Care procedure QAG 005 Potential Deficiency in Clinical Quality of Care and procedure QAG0022 Management of Potential Deficiencies in Clinical Quality of Care.

**III. Provider and Facilities Subject to Credentialing**

Providers’ titles and abbreviations vary from each state. Check with the appropriate state licensing agencies for specific titles.

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NCQA CR1, Element A, Factor 1
Standards/ Regulations

- Advanced Practice Registered Nurses (APRN, CNS and CNM)
- Acupuncturists (LAc)
- Chiropractor (DC) (delegated to ChiroCare)
- Dentist (DDS/DMD- Medical Benefit) (delegated to Delta Dental for Dental Benefit)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Clinical Counselor (LPC) in MN only and must be able to practice without supervision.
- Licensed Professional Counselor-Mental Health (LPC-MH) (SD only)
- Licensed Traditional Midwife (LTM or LM) practicing exclusively in a Birthing Center.
- Optometrists (OD)
- Physicians (MD, DO, MBBS, MBCh) including Oral & Maxillofacial Surgeons, moonlighting residents, urgent care, Radiation Oncologists, Pain Management and Telemedicine.
- Podiatrist (DPM)
- Psychologist (LP)
- Social Worker
  - IA: Licensed Independent Social Worker (LISW)
  - MN & ND: Licensed Independent Clinical Social Worker (LICSW)
  - SD: Certified Social Worker-Private or Independent Practice (CSW-PIP)
  - WI: Certified Independent Clinical Social Worker (CICSW)
- Locum Tenens (If practicing more than 90 days)

Medical Facilities

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

Behavioral Health Facilities

- Inpatient
- Outpatient
- Ambulatory setting

IV. Roles and Functions of UCare Board, Credentialing Committee, Medical Director/Designated Physician and Staff

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
Quality Improvement Council (QIC): QIC has the responsibility and authority for the acceptance, discipline and the activities that may lead to final termination of providers. The QIC has delegated this responsibility to the Credentialing Committee which provides a monthly summary report to the QIC.

Credentialing Committee: The Credentialing Committee has the responsibility for review, recommendations and approval regarding the Credentialing Plan. The Committee reviews and makes credentialing decisions regarding files that vary from Administrative and Professional Criteria that requires review under the Credentialing Plan. The Credentialing Committee may approve, deny or terminate a provider’s status with UCare.

The Credentialing Committee has delegated review and approval of Clean Credentialing Files to the Medical Director 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 QIC guidelines for delegated review, the Credentialing Committee shall be notified at its earliest subsequent meeting.

At times it is necessary for the Credentialing Staff to research specialty certification boards that are not recognized by the American Board of Medical Specialties (ABMS) and the American Osteopathic Association (AMA) or other boards recognized by NCQA to determine if UCare should incorporate the specialty certification boards as part of the primary source verification process at the time of (re)credentialing. The Credentialing Staff will research and prepare the information to be presented at the Credentialing Committee. The Credentialing Committee will then make a decision to accept or deny the specialty certification board.

The Credentialing Committee shall meet monthly and voting membership shall be limited to participating practitioners and UCare Medical Directors. Credentialing Staff will not have voting rights regarding any (re)credentialing decisions, but may serve to provide information from the credentialing file and/or provide guidance on UCare’s credentialing policies and procedures. 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 providers and facilities who vary from Professional Criteria as describe herein.

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
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<tr>
<th>Standards/Regulations</th>
<th>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 provider who is the subject of the hearing. Credentialing Committee members generally should not serve on the Appeals Committee. The Appeals Committee’s purpose is to hear appeals from providers after the Credentialing Committee has recommended denial or termination of a provider’s status or has recommended or imposed disciplinary action, based on professional conduct or competence. Appeals Committee members will excuse themselves from any Credentialing Committee and/or BOD deliberations if they are present during their meeting.</th>
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<tr>
<td>NCQA CR1, Element A, Factor 10</td>
<td><strong>Medical Directors/Designated Physician’s Direct Responsibility in the Credentialing Program:</strong> The Medical Director reviews and makes the following decisions:</td>
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<td>And</td>
<td>a. Weekly reviews and, if appropriate, approves files that have been deemed as clean (re)credentialing files;</td>
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<tr>
<td>NCQA CR2, Element A, Factor 3</td>
<td>b. Reviews (re)credentialing files that vary from Administrative Criteria;</td>
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<td>c. Reviews (re)credentialing files that vary from Professional Criteria and indicated a potential professional competency or performance issue.</td>
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<td>The Medical Director will review and act on provider (re)credentialing files that Credentialing Staff has identified as possible significant issues. The Medical Director(s) may decide one of the following:</td>
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<td>a. Approve as a clean file with no significant issues;</td>
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<td>b. Request further information from a provider prior to presenting to the Credentialing Committee;</td>
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<td>c. Make recommendations that the provider’s (re)credentialing file be reviewed by the Credentialing Committee;</td>
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<td>d. Approve the provider on the basis that the Professional Criteria variation does not indicate a potential professional competency or performance issues pursuant to the Variation Application File Review grid;</td>
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<td>e. Significant issue that warrants Restriction or Suspension of a provider.</td>
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<td>The Medical Director also provides guidance and counsel to Credentialing Staff regarding UCare’s professional standards, policies and procedures. The Credentialing Committee will be notified on all files.</td>
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<tr>
<td>Credentialing Staff:</td>
<td>Credentialing Staff shall perform administrative review</td>
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functions and prepare cases for Medical Director, legal, workgroups, or committee reviews per credentialing policies and procedures. Credentialing Staff shall review each (re)credentialing application to determine whether the provider meets Pre-Application Criteria as defined in QCR0030 – Criteria for Acceptance. Credentialing Staff shall ensure that files have been verified and each file has been reviewed to identify clean credentialing files and those files with variation(s) from either Administrative and/or Professional Criteria per the Variation Application File Review grid. If any file varies from review criteria, Credentialing Staff shall route the case to the Medical Director per this Credentialing Plan.

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<tr>
<th>Standards/Regulations</th>
<th>V. Routing and Review</th>
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<tr>
<td>NCQA CR1, Element A, Factor 4</td>
<td>Once the provider has been determined to meet all Pre-Application, Administrative and Professional Criteria per the Variation Application File Review grid, the credentialing record is designated as clean and clean credentialing files and are routed to the Medical Director for review and determination of acceptance into the UCare network. For any providers who do not meet Pre-Application, Administrative or Professional Criteria, per the Variation Application File Review grid, the credentialing file is classified as “with variation” and is routed to the Medical Director for review as described below:</td>
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<td><strong>1. Clean Credentialing Files:</strong> UCare’s Medical Director can accept all providers with Clean Credentialing Files for participation in the UCare network. The weekly clean-file lists will be presented to the next scheduled monthly Credentialing Committee on the Clean File and Delegated Report.</td>
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<td><strong>2. Administrative Criteria Variation:</strong> Applications for providers who don’t satisfy administrative criteria are returned to the provider with instructions for submitting the file for 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 the 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 variations, in accordance with QIC guidelines for delegated review. The Credentialing Staff shall notify QIC at is earliest subsequent meeting of the decision for notification. The Medical Director may impose monitoring and corrective actions per Section XIV and XVI 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 will notify QIC of the action. Credentialing Staff shall</td>
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<tr>
<td>Standards/Regulations</td>
<td>notify the provider in writing of the denial or termination of participation and the reasons for such within 20 calendar 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.</td>
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<td>3. <strong>Professional Criteria Variation:</strong> Applications for providers, who do not 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 s/he confirms there is a professional criteria variation that indicates a potential professional competency issue pursuant to QIC guidelines for delegated review. If the Credentialing Committee cannot make a decision, the provider’s application will be presented at the next monthly QIC. 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 QIC at its earliest subsequent meeting of the approval. The Medical Director may impose monitoring and corrective actions per Sections XIV and XVI of this Credentialing Plan.</td>
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<td>4. <strong>Credentialing Committee Review and Acceptance:</strong> The Credentialing Committee reviews all providers with a Professional Criteria variation that the Medical Director has confirmed indicates a potential professional competency issue. The Credentialing Committee receives notification of Clean Files and files that Credentialing Staff and/or the Medical Director have approved with variations from Administrative or Professional Criteria according to Credentialing Committee guidelines for delegated review. Any acceptance by the Credentialing Committee is conditioned upon 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 a 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 provider has waived his or her right to a hearing, has failed to request a</td>
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<td>Standards/ Regulations</td>
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<td>Hearing in a timely manner or has completed the appeal process. Facilities have no right to appear before the Credentialing Committee.</td>
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<td><strong>VI. Managing Credentialing Files to Meet Established Criteria</strong></td>
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<td>Credentialing files that have been evaluated per the Credentialing Plan 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, are deemed a file with no current and/or significant issues.</td>
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<td>In either case, the Credentialing Staff will mark the credentialing file as a clean file and on a weekly basis send the approval list to the Medical Director for approval. Once a month the clean files will be reported to the Credentialing Committee.</td>
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<td><strong>VII. Delegation</strong></td>
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<td>UCare may delegate a part or all of the (re)credentialing functions to specific participating organizations or newly contracted delegated entities (“Delegate”) for provider credentialed types and facilities. This may include primary source verification and ongoing monitoring. The credentialing activities of the Delegate shall comply with UCare credentialing policies, NCQA and state and federal regulations unless otherwise specified in the delegation agreement. UCare shall retain full and final authority for all delegated credentialing activities and shall retain the ultimate right to accept or reject providers into the UCare network. The delegation evaluation findings and recommendations (includes pre-assessment and annual audits) shall be presented to the Compliance Delegation Sub-Committee and the Credentialing Committee for review and determination. The Committees may decide to:</td>
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<td>• Approve new and existing delegation</td>
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<td>• Approve continued delegation with restrictions or conditions</td>
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<td>• Terminate delegation</td>
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<td>UCare’s policy regarding delegation is described in UCare Procedures CCD021 Delegation Management and QCR0029 Oversight of Credentialing Delegates.</td>
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<td><strong>Revocation or Termination of Delegation:</strong> 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. UCare will provide the appropriate written</td>
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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.

Current List of Credentialing Delegated Entities: Currently UCare delegates to the following entities for initial and recredentialing. Those marked with asterisks (*) are NCQA accredited or certified; therefore portions of the audit will be waived.

<table>
<thead>
<tr>
<th>Health System</th>
<th>Effective Date</th>
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<tbody>
<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 Health System</td>
<td>June 2009</td>
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<tr>
<td>Delta Dental</td>
<td>January 2015</td>
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<td>Essentia</td>
<td>January 2008</td>
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<tr>
<td>Fairview Health System*</td>
<td>March 1999</td>
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<td>HealthPartners*</td>
<td>January 2007</td>
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<tr>
<td>Landmark/ChiroCare</td>
<td>December 2006</td>
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<tr>
<td>Luther Mideffort/Red Cedar</td>
<td>January 2008</td>
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<tr>
<td>MMSI</td>
<td>April 2005</td>
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<tr>
<td>Sanford Health System*</td>
<td>January 2007</td>
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<tr>
<td>St. Mary’s/Duluth Clinics (Essentia)</td>
<td>January 2007</td>
</tr>
<tr>
<td>University of Wisconsin</td>
<td>June 2009</td>
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VIII. Discrimination

To prevent discrimination, UCare does not collect data or make (re)credentialing decisions based on an applicant’s race, ethnic or national identity, religion, disability, gender, age, sexual orientation, marital status, or patient type (e.g. Medicaid in which the practitioner specializes).

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

IX. Provider 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 indicate that there is a discrepancy and request that the provider (re)submit the information needed to complete the credentialing file within fourteen (14) days from the receipt of the letter.

**Does Not Respond:** If the response is not submitted in the time allowed or not requested, UCare will assume that the provider does not want to dispute any of the information provided and the provider will be administratively terminated as an
<table>
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<tr>
<th>Standards/Regulations</th>
<th>UCare participating provider. The provider may not re-apply for participation for six (6) months from the termination date.</th>
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<tr>
<td>NCQA CR1, Element B, Factor 2</td>
<td><strong>Responds:</strong> If the response is received in 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 provider has the right to correct erroneous information obtained during the credentialing process within 30 calendar days of receipt by submitting in writing to the appropriate Credentialing Staff any corrections or any explanations of discrepancies in writing (via email or fax). The appropriate Credentialing Staff will annotate the credentialing record with the information received. The updated information will be scanned to the individual provider’s credentialing record in the credentialing software.</td>
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<tr>
<td>NCQA CR1, Element B, Factor 3</td>
<td>Each provider shall be entitled, upon written request, to be informed of the status of their application. In addition, each provider shall be entitled to review his or her 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 a written request has been made to UCare in writing (via email or fax), the Credentialing Staff will respond to such inquiry within 24-48 hours of receipt. The Credentialing Staff will provide applicable information and/or documentation to the provider and annotate the credentialing software of the request and the information provided. Providers are notified of the right to correct erroneous information via this Credentialing Plan and the notification letter sent to the provider when erroneous information/discrepancies are identified. The Credentialing Plan is located on the UCare Provider Page. The foregoing does not require UCare to alter or delete any information contained in the file.</td>
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<tr>
<td>NCQA CR1, Element A, Factor 9</td>
<td><strong>X. Notification</strong> The provider shall be notified within 60 calendar days from final decision for initial credentialing and 20 calendar days for any adverse recredentialing decisions. In the event of an adverse (re)credentialing decision that is subject to appeal, notice to the provider shall meet the requirements of Section XVIII.</td>
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| NCQA CR1, Element A, Factor 11 | **XI. Peer Review Protection and Confidentiality** All committees described above, the BOD, and Credentialing Staff supporting credentialing actions operate as a review organizations pursuant to Minn. Stat. §
Standards/ Regulations

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 as 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.

Prior to serving on the Credentialing Committee, each committee member must sign a confidentiality agreement and thereafter on an annual basis.

NCQA CR1, Element A, Factor 12

XII. 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 provider information regarding qualifications given to members should match the information regarding a provider’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 (re)credentialing: Credentialing Staff enters into the credentialing software each provider’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 credentialing software is updated by UCare’s Information Services Department to ensure updates occur to the online provider directory (Find-a-Doc) using the most current information.

On a monthly basis the Provider Materials Coordinator will randomly select five (5) active provider records and five (5) active groups records from the credentialing software and validate the display information on Find-a-Doc per PRC0188 Provider Directory Updates.

XIII. Monitoring

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 with the specified time allowed. UCare Policy QCR021 Provider’s Non-response to Requests for Credentialing Documentation addresses the procedure to follow for failure to respond to requests for credentialing information.

**Routine Performance Monitoring:** Credentialed providers are routinely monitored in-between credentialing cycles by the following:

- UCare or the delegate will conduct site surveys and assessments of medical/treatment records 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 PRC0107 Site Surveys prior to UCare contracting with a clinic. In addition, UCare will also visit provider sites that reach its member-complaint threshold or as part of a corrective action as described in this Credentialing Plan as well as procedure PRC0180 Provider Network Analysis.

- The Medicare Opt-Out list is reviewed by the Provider Enrollment and Configuration Department quarterly with notification to the Credentialing Department.

- The Medicare/Medicaid Exclusion Report (Streamline) is reviewed within 30 calendar days by the Provider Enrollment and Configuration Department with notification to the Credentialing Department.

- Licensing board disciplinary actions orders are received from Minnesota, Iowa, North Dakota, South Dakota and Wisconsin. Orders are reviewed within 30 calendars days of notification or least every six (6) months where notifications are not received.

- Complaints, Appeals and Grievances are reviewed on a quarterly basis to determine if 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.

- 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 the Credentialing Committee 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.

- 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.

- 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 Credentialing Committee as appropriate.

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<td>NCQA CR6, Element A, Factor 1</td>
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### XIV. 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 not subject to appeal unless otherwise required per regulation law. License surrender or revocation and Medicare/Medicaid exclusions are grounds for immediate termination without committee action. All providers terminated for Administrative Criteria will be reported to the Credentialing Committee. UCare’s Credentialing Staff will provide written notice of the denial, suspension, or termination to the provider within 20 calendar days. The notification will include the effective date of the action, the reason(s) for such action and provide information regarding the provider’s right to request an administrative reconsideration. The provider is responsible for providing a detailed explanation, in writing (via email or fax), to the Credentialing Specialist Senior.

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

C. **Provider Contract Compliance:** UCare Policy PRC006 Administrative 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.
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<td>In any termination, Credentialing Staff shall notify Provider Relations and Contracting and Provider Enrollment staff to deny all claims one business day after the effective date of notification of the suspension or restriction.</td>
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**Reconsideration Request for Pre-Application or Administrative Criteria Terminations:**

- The provider must submit a written request for reconsideration within 30 calendar days of the UCare notice for Pre-Application or Administrative Criteria terminations.

- If the provider does not submit the reconsideration request in the time allowed, the provider’s 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 Credentialing Application. In the event that the provider reapplications, 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 applicable Credentialing Staff that requested the information.

- Credentialing Staff and/or the Medical Directors 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, or request that the provider’s information be reviewed at the next scheduled Credentialing Committee.

**Written Reconsideration Request Decision:** Within 20 business days after 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.

**Reconsideration Request Denial:** After the administrative reconsideration decision, a provider will have no additional right to appeal the reconsideration or to appear before the Credentialing Committee and/or Peer Review Committee. If the Credentialing/Peer Review Committee upholds the reconsideration decision, the
### XV. Corrective Actions

**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, termination or taking any other action related to participation that is permitted under this Credentialing Plan.

**Imposition of Corrective Action:** Implementation of educational interventions and CAPs vary depending on whether non-compliance is 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 education interventions or a CAP. The General Counsel shall review Professional Criteria corrective actions to determine whether the provider has the right to appeal. Credentialing Staff will report both Administrative and Professional Criteria actions to the Credentialing Committee. Credentialing Staff will monitor completion of direction action(s) and report periodically on the provider’s status to the Credentialing Committee. For facilities who do not meet UCare’s office standards, UCare will impose a CAP and will monitor the CAP until the facility 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.

**Restriction and Suspension:** UCare in its discretion may restrict the scope of practice of a provider or suspend 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 Credentialing Committee. The Medical Director 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 Credentialing Committee.
### Standards/Regulations

- **Administrative issues:** The provider shall receive written notice and 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.

**Summary Restriction or 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 inactions 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.
- **Professional issues:** The provider has a right to an appeal a hearing for summary restrictions or suspensions. The appeal hearing may occur after the suspension or restriction period.

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

### XVII. Credentialing Appeal Process

**Right and Request to Appeal:** Appeals are offered to providers after the Credentialing Committee recommends denial or termination of participation status or other disciplinary action based on Professional Criteria. The Credentialing Committee will also offer an appeal in any case where the action is reportable to the NPDB.

If the provider is offered the opportunity to appeal, UCare shall follow this Credentialing Plan as set forth below. Hearings are not offered to facilities. If a delegate of UCare has made the adverse decision, the provider 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 **PRC006 Administrative Provider Contract Termination.**

1. The provider shall be given written notice of proposed action and notice of the right to appeal via certified letter. The notice must inform the provider that an adverse action has been proposed against them and the reasons for the proposed action. The provider is informed of his/her right
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<p>| NCQA CR6, Element A, Factor 3 (Bullet 2) | to review the credentialing file, with the exception of information which is protected under peer review. The provider shall be given 30 calendar days from receipt of such notice to exercise this right. The notice must also inform the provider 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 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. |
| NCQA CR6, Element A, Factor 3 (Bullet 3) | 2. Upon timely receipt of a provider’s written request, UCare shall notify the provider 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 provider fails to request a hearing in writing within 30 calendar days of receipt of the notice, the provider waives any appeal rights under this Credentialing Plan.  |
|  | 3. The hearing date will be not be less than 30 calendar days from the date the provider receives the hearing notice, unless a shorter period is mutually agreed to by both 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 the postponements and extensions.  |
|  | 4. Failure of the provider to attend the appeal hearing either in person or via telephone conference call will result in forfeiture of appeal rights, unless the provider is able to demonstrate reasonable circumstances that prevented such attendance.  |
|  | <strong>Pre-Hearing Matters</strong>  |
|  | 1. When a hearing is scheduled, UCare’s Credentialing Staff will provide written notice to the provider stating the time, place and date of the hearing, the composition of the 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 statues upon which UCare based its decision. UCare’s General Counsel must approve any release of records. |</p>
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<td>NCQA CR6, Element A, Factor 3 (Bullet 4)</td>
<td>2. The provider 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.</td>
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<td>NCQA CR6, Element A, Factor 3 (Bullet 5)</td>
<td>3. UCare’s Credentialing Committee or its chairperson, acting on behalf of UCare will select the Appeals Committee members. The Appeals Committee and the provider will be provided information regarding UCare’s credentialing determination prior to the hearing. This information shall include, but not 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 provider 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.</td>
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<td>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.</td>
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**The Hearing**

1. The provider 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 provider 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 provider or the provider’s counsel shall have the opportunity to cross-examine any witness testifying on behalf of UCare. If the provider requesting the hearing does not testify on his or her own behalf, the provider may be questioned by UCare and/or by the Appeals Committee. After the completion of UCare’s submission of evidence, the
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provider 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 provider. Throughout the course of the hearing, the Appeals Committee may examine or question any witness giving oral testimony for UCare or the provider. UCare may present any additional witnesses or submit additional documents to rebut the provider’s evidence. The provider shall have the opportunity to cross-examine any additional witnesses testifying on behalf of UCare.

5. Upon the completion of UCare’s and the provider’s submission of testimony and evidence, first UCare and then the provider shall have the opportunity to make a brief closing statement. Following the hearing, UCare and the provider shall have the opportunity to submit written statements to the Appeals Committee. If the provider and his/her attorney waive written briefs, the Appeals Committee members may meet briefly after the hearing and make a recommendation. If the provider 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.

**Evidentiary Standards:** The oral testimony and documentary evidence provided by UCare and the provider 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.

**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 provider 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 Credentialing Committee. 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 provider 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.

**Board of Directors Action:** The recommendation goes to the Board of Directors (BOD), who in its own discretion may appoint the Executive Committee or Subcommittee of the BOD to review and make a determination whether the Appeals Committee acted arbitrarily and capriciously. The BOD may approve, reject, or modify the Appeals Committee’s recommendation. The provider 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 provider and legal counsel, if used, enclosing a copy of the Findings of Facts, Conclusions, and Recommendations. If the provider is to be terminated, the letter will include notification of the termination date.

**Notice and Effective Date of Action:** If the BOD or appointed committee of the BOD affirms a recommendation to deny or terminate the provider’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 provider 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 the reporting requirements defined in this Credentialing Plan.

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

Break in Service includes, but is not limited to health, military, maternity/paternity or sabbatical leave.
| Standards/Regulations | 1. If a credentialed provider 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 provider will be reinstated to see UCare members. Credentialing Staff must re-verify state license to ensure that there are not current actions that the provider has the ability to participate in the Federal Health Care Programs. Within 60 days, the recredentialing cycle must be completed.  
2. If a provider returns to the same UCare contracted location or moves to another UCare contracted locations and is outside of the 36-month recredentialing cycle, the provider will be required to go through the initial credentialing process before rejoining the UCare network.  
3. If a provider leaves an 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 provider will be required to go through the initial credentialing process before rejoining the UCare network.  

XIX. 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 provider may not be expedited for contracting purposes. A provider may only be expedited once when applying to UCare for the first time. Providers who had been credentialed and are in good status under a delegated credentialing arrangement do not require expedited credentialing. The provider 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 provider prior to the next scheduled Credentialing Committee if the file is clean.  

XX. 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; Minn Stat, section 147.00; the Health Insurance Portability and Accountability Act of 1996 and any other relevant federal and state statutes and regulations, whether a denial, termination or or other action taken pursuant to this Credentialing Plan shall be reported to the NPDB, 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 Credentialing Committee shall adopt provided, however, that the determination shall be made in good faith. UCare
will make all required reports described above. UCare shall notify the affected provider, in writing, in the event such report is made.

### XXI. References

This policy supports UCare policies:
- QCR021 – Providers Non-Response to Requests for Credentialing Documentation
- QAG005 – Potential Deficiency in Clinical Quality of Care
- QAG015 – CAG Department and Provider Reporting
- CIA021 – Delegation Management

This policy supports UCare procedures:
- QCR0015 – Organization Assessment Requirements
- QCR0019 – Complaint Review
- QCR0021 – Practitioner Credentialing
- QCR0023 – Provider on Review
- QCR0029 – Oversight of Credentialing Delegates
- QCR0030 - Criteria for Acceptance
- QAG022 – Management of Potential Deficiencies in Clinical Quality of Care
- PRC006 – Administrative Provider Contract Termination
- PRC0107 – Site Surveys
- PRC0180 – Provider Network Analysis
- PRC0188 – Provider Directory Updates
- CCD021 – Delegation Management

**OTHER REFERENCES**
- National Committee for Quality Assurance (NCQA)
- Centers for Medicare & Medicaid Services (CMS)
- Minnesota Department of Health (MDH)
- CRW101 – Acceptable Application and Verification Criteria
- CRW102 – Annual Non Discrimination Report
- CRW113 – Issue File Review (Variation Application File Review Grid)
- CRW116 – State Board Ongoing Monitoring
- CRW119 – Streamline Monthly Query

**APPROVALS**

**DIRECTOR/VICE PRESIDENT:** Greg Hanley  
**Date:** 3/13/2018

**COMMITTEE (as appropriate):** Credentialing Committee  
**Date:** 3/13/2018

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**Key Words:** Credentialing, QIC, Medical Director, and Credentialing Committee