UCARE

CREDENTIALING POLICY
# TABLE OF CONTENTS

I. PURPOSE 5  
II. DEFINITIONS 5-6  
III. SCOPE 6-7  

IV. ROLES AND FUNCTIONS OF UCARE BOARD, COMMITTEES AND STAFF 7  
A. Board of Directors (BOD)………………………………………………………………... 7  
B. Quality Improvement Advisory and Credentialing Committee (QIACC)……………… 7-8  
C. Appeals Committee……………………………………………………………………... 8  
D. Medical Directors……………………………………………………………………….. 8-9  
E. Credentialing Staff………………………………………………………………………. 9  

V. PEER REVIEW PROTECTION 9  

VI. CRITERIA FOR PROVIDER PARTICIPATION 9  
A. Pre-application Criteria for Practitioners………………………………………………… 9-10  
B. Pre-application Criteria for Organizational Providers…………………………………… 10-11  
C. Administrative Criteria for Practitioners……………………………………………… 11-12  
D. Administrative Criteria for Organizational Providers…………………………………… 12  
E. Professional Criteria for Practitioners………………………………………………… 12-13  
F. Professional Criteria for Organizational Providers……………………………………… 14  
G. Locum Tenens Criteria………………………………………………………………… 14  
H. Break in Service………………………………………………………………………… 14-15  

VII. APPLICATION REVIEW AND ACCEPTANCE PROCESS 15  
A. Pre-application Process………………………………………………………………... 15-16  
B. Application Preparation Process………………………………………………………… 16  
C. Routing and Review Process…………………………………………………………... 16-18  

VIII. MONITORING PROVIDERS 18  
A. Administrative Monitoring……………………………………………………………… 18  
B. Routine Performance Monitoring……………………………………………………... 18-19  

IX. CORRECTIVE ACTIONS 19  
A. Need for Corrective Action……………………………………………………………… 19  
B. Imposition of Corrective Action………………………………………………………… 19  

X. RESTRICTION OR SUSPENSION OF A PROVIDER 20  
A. Restriction and Suspension……………………………………………………………… 20  
B. Summary Restriction and Suspension………………………………………………….. 20  
C. Claims Denial……………………………………………………………………………… 20  
D. Reporting Requirements………………………………………………………………… 20-21  

XI. TERMINATION OF A PROVIDER 21  
A. Pre-application and/or Administrative Criteria………………………………………… 21  
B. Professional Criteria……………………………………………………………………… 21  
C. Provider Contract Compliance………………………………………………………….. 21
XII. CREDENTIALING APPEAL PROCESS

A. Right and Request to Appeal
B. Pre-Hearing Matters
C. The Hearing
D. Evidentiary Standards
E. Appeals Committee’s Decision
F. Board of Directors Action
G. Notice and Effective Date of Action
H. Notification of Members

XIII. REPORTING REQUIREMENTS

XIV. DELEGATED CREDENTIALING

A. Pre-Delegation Assessment
B. Written Delegation Agreement
C. Ongoing Monitoring/Oversight
D. Annual Audit
POLICY TITLE: Credentialing

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DEPARTMENT: Provider Enrollment and Configuration

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POLICY & PROCEDURE REFERENCES

This policy supports UCare policy/policies:
- PEC021 - 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

This policy supports UCare procedures:
- CCR-0001 - Practitioner Professional Qualifications
- CCR-0002 - Primary Source Verification for Board Certification or Highest Level of Education
- CCR-0004 - Primary Verification of State License
- CCR-0005 - Primary Verification of Clinical Privileges
- CCR-0006 - Primary Verification of DEA Registration
- CCR-0008: Nondisclosure of Professional Information
- CCR-0009 - State Board Disciplinary Action Review and Licensure Monitoring
- CCR-0011 - Delegation of Credentialing Functions
- CCR-0012 - Medicare/Medicaid Sanction Review
- CCR-0013 - Appeals of Credentialing Decisions
- CCR-0015 - Initial Organization Assessment Requirements
- CCR-0016 - Credentialing Review and Approval
- CCR-0019 - Incorporating Complaints of QOC Data into the Credentialing Process
- CCR-0020 - Providers Subject to Credentialing
- CCR-0021 - Practitioner Initial Credentialing
- CCR-0022 - Practitioner Recredentialing
- CCR-0023 - Provider on Review
- CCR-0026 - Organizational Re-assessment Requirements
I. PURPOSE

To provide policy on credentialing and recredentialing of Providers consistent with the 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).

II. DEFINITIONS

Allied Health Practitioner
Specially trained and licensed independent health workers other than physicians, physician assistants, dentists, optometrists, chiropractors, podiatrists, and mental health professionals. Allied Health Practitioners include nurses, physical, occupational and speech therapists and other health workers who have limitations on their scope of practice or do not usually engage in independent practice.

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.

“Clean” Credentialing Files
Credentialing files on Providers that have been reviewed by Credentialing Staff and certified by the Medical Director as complete, without variation from professional or administrative credentialing criteria.

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.

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

Organizational Provider
Health care facilities, such as hospitals, skilled nursing facilities, nursing homes, 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.

Practitioner
Any individual health care professional permitted by law to provide health care or services.
Provider
Any Practitioner or Organizational Provider that provides health care services under contract with UCare and is licensed or otherwise authorized to render such services. The term “Provider” is used within UCare as a universal term that refers to all entities that provide health 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.

Quality of Care Issue
Quality of Care Issue, as understood from a regulatory context and as referred to within this policy, 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.

Recredentialing
The periodic review of qualifications of credentialed Providers.

III. SCOPE
This policy applies to all Providers defined by UCare as subject to credentialing. Entities who have been delegated credentialing on behalf of UCare must act consistently with this policy unless otherwise negotiated and documented within the applicable contract and/or delegation agreement. All Providers subject to credentialing must be fully credentialed prior to rendering a service to a UCare member. Continued participation by these Providers under this policy is dependent upon the Provider meeting, on an ongoing basis, the participation criteria set forth in this policy. Recredentialing of Providers is performed every three years in accordance with the processes and criteria described herein.

Practitioners subject to credentialing include all physicians, physician assistants, dentists, chiropractors, doctors of osteopathy, doctors of podiatric medicine, optometrists, psychiatrists, psychologists, licensed independent clinical social workers, licensed independent marriage and family therapists certified nurse midwives, nurse practitioners and, in general, any other Practitioner who is permitted by law to practice independently within the scope of the individual’s license or certification. Credentialing by UCare of individual Practitioners is not required for those Practitioners under contract with a hospital and who practice exclusively within the inpatient hospital setting. Examples include pathologists, anesthesiologists, hospitalists and emergency room physicians. Credentialing of individual Practitioners is also not required when Practitioners practice solely within freestanding facilities such as surgicenters since these Practitioners do not have an independent relationship with UCare. Residents are not subject to credentialing unless they are working independently without supervision in a clinic setting. In addition, all of the Organizational Providers as defined above are subject to the credentialing procedures set forth in this policy for such providers.

UCare does not make credentialing decisions based on an applicant’s race, ethnic or national identity, gender, age, sexual orientation, the types of procedures a practitioner performs, or the types of patients a practitioner sees.
IV. ROLES AND FUNCTIONS OF UCARE BOARD, COMMITTEES 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 Committee (QIACC). The BOD, or a committee appointed by the BOD, may review cases where the QIACC recommends denial or termination for professional reasons, and may accept, reject or modify the QIACC’s recommendation. The BOD, or a committee appointed by the BOD, shall review determinations by the Appeals Committee, and makes final decisions in cases where the Provider exercises their right to appeal under this policy. The BOD receives regular reports regarding credentialing activities and retains the authority to take any action it deems appropriate consistent with this policy. Additionally, the BOD has delegated to the QIACC responsibility for review and recommendations regarding credentialing policy. The Chair of the BOD appoints QIACC members and designates the chair of the QIACC.

B. Quality Improvement Advisory and Credentialing Committee (QIACC). QIACC has the responsibility and authority for the acceptance, discipline, and the activities that may lead to final termination of Providers, subject to review and any final action by the BOD. The QIACC is also responsible for review and recommendations regarding credentialing policy. The QIACC has delegated review and approval of “Clean” Credentialing Files to the Medical Director. The Medical Director also reviews files where Credentialing Staff have identified a variation from Professional Criteria, and forwards such files to QIACC for review if the Medical Director confirms the variation from Professional Criteria indicates a potential professional competency or performance issue pursuant to QIACC guidelines. The Medical Director also has been delegated review of files with deviation from administrative criteria. Providers with Administrative and Professional Criteria deviation may be approved by the Medical Director without further review by the QIACC if the approval is consistent with QIACC guidelines for delegated review by the Medical Director. In cases where the Medical Director approves a Provider with variation from Professional or Administrative Criteria, the QIACC shall be notified at its earliest subsequent meeting. The QIACC shall meet monthly with the exception of August and November. QIACC voting membership shall be limited to participating Practitioners and clinic administrative staff. 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 QIACC members shall include practicing physicians, and the QIACC chair must be a practicing physician. The QIACC 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 QIACC are responsible for the review of Practitioners and Organizational Providers who vary from Professional Criteria as described herein.
C. Appeals Committee. An Appeals Committee shall be appointed on an ad hoc basis by UCare’s QIACC or its chairperson, 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 recommended or imposed disciplinary action, based on professional conduct or competence. Appeal Committee members will excuse themselves from any QIACC and/or BOD deliberations.

D. Medical Directors. The Medical Director reviews and accepts Providers who have “Clean” Credentialing Files. The Medical Director also reviews files where Credentialing Staff have identified a variation from Professional Criteria, and forwards such files to QIACC which are confirmed to have Professional Criteria variation that indicates a potential professional competency or performance issue pursuant to QIACC guidelines. If the Medical Director determines such variation does not indicate a potential professional competency or performance issues pursuant QIACC guidelines, he may approve the Practitioner and shall notify the QIACC. The Medical Director may request further information from a Provider prior to presenting a case to the QIACC. The Medical Director also provides guidance and counsel to Credentialing Staff, the Provider Network Management (PNM) Director and others regarding UCare’s professional standards, policies and procedures. In addition, the Medical Director has been delegated review of files with variation from UCare Administrative Criteria. The Medical Director shall coordinate the necessary action with the Provider Network Management Director and/or Senior Management regarding individual cases that deviate from Administrative Criteria. In those cases where the Medical Director determines, after such coordination, that it is in UCare’s best interest to deny participation due to failure to meet Administrative Criteria, the QIACC will be notified of this determination. In those cases where, after a coordinated review, the Provider is deemed acceptable to UCare despite variation from Administrative Criteria, the Provider will be presented to the QIACC for approval.

E. Staff. Credentialing Staff shall perform administrative review functions and prepare cases for appropriate staff or committee review 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 policy. 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 or Administrative Criteria. If any file varies from review criteria, Credentialing Staff shall route the case to the Medical Director per this policy.
V. PEER REVIEW PROTECTION

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 and locked in secured, file cabinets when not in use. 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. Each Provider shall have the right, upon written request, to review his or her credentialing file, except for information that is privileged or protected from such disclosure, and to submit corrective statements with respect to the initial application. UCare will place the corrective statement in the Provider’s credentialing file, but this does not require UCare to alter or delete any information contained in the file.

VI. CRITERIA FOR PROVIDER PARTICIPATION

Participation and continued participation in UCare’s network as a credentialed Provider requires meeting the following Pre-application, Administrative and Professional Criteria.

A. Pre-application Criteria for Practitioners. All Practitioners requiring credentialing must be determined by UCare to be eligible to apply for participation status. Eligibility is determined by meeting the following criteria:

1. The need for the Practitioner’s specialty or the Provider type in UCare’s network;

2. Whether Practitioner’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 Practitioner is applying to provide care or services;

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

6. The Practitioner is not excluded from participation in, or sanctioned by, Medicare, Medicaid or other state or federal health care programs;
7. The Practitioner 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. A complete, signed application as specified in Section VII of this policy, including an unaltered release relieving from liability any person, entity, institution, or organization that provides information as part of the application process; and

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

B. Pre-application Criteria for Organizational Providers. All Organizational Providers must be determined by UCare to be eligible to apply for participation status. Eligibility is determined by:

1. A signed attestation that attests that the application is complete and correct;

2. The need for the Organizational Provider’s specialty or type in UCare’s Network;

3. Execution of or UCare’s intent to execute a network agreement with UCare;

4. A consent or release form which allows UCare to verify application information as well as monitor the organization’s compliance with orders by a state licensing agency or other healthcare organization;

5. A copy of all applicable accreditation/certificates/CMS or state review;

6. A copy of the Organizational Provider’s liability insurance certificate showing levels that meet UCare requirements;

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

8. A copy of the Organizational Provider’s licensure; and

9. The Organizational Provider does not employ or contract with any person or entity that has been excluded from federal, state or local government program(s).

C. Administrative Criteria for Practitioners. Administrative Criteria for Practitioners include:

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 Practitioner practices in a medical group or clinic, the Practitioner is in good standing at such group or clinic;

4. The Practitioner 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 Provider maintains active privileges in good standing at a UCare contracted hospital or provides evidence acceptable to UCare that the Practitioner has made satisfactory arrangements for another UCare participating Practitioner to admit UCare members needing hospitalization;

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

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

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

9. The Practitioner 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 Practitioner 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 a timely manner in accordance with a request for credentialing documents; and

11. The Practitioner 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 practitioner’s professional performance, or (3) failure to respond to UCare in a timely manner in accordance with a request for credentialing documents.
D. Administrative Criteria for Organizational Providers. Administrative Criteria for Organizational Providers subject to credentialing include:

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

2. The Organizational Provider 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;

3. The Organizational Provider has a current, valid accreditation or certification acceptable to UCare, or in lieu of an acceptable accreditation or certification, the Provider has successfully completed a site review performed by UCare;

4. The Organizational Provider 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 documents; and

5. The Organizational Provider 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 provider’s professional performance, or (3) failure to respond to UCare in a timely manner in accordance with a reassessment request for documents.

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

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

2. The Practitioner 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 Practitioner is not the subject of any reports of an “adverse action” against the Practitioner, as defined in the Health Care Quality Improvement Act and its implementing regulations;
4. The Practitioner 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 Practitioner does not have a history of professional liability lawsuits or other incidents, which indicates a potential competency or quality of care problem;

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

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

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

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

11. The Practitioner has not used illegal drugs or improperly used any controlled substance during the past three (3) years; and

12. The Practitioner’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).

F. Professional Criteria for Organizational Providers. Professional Criteria are those criteria that relate to the Organizational Provider’s professional performance, judgment and clinical competence. Professional Criteria are as follows:

1. The Organizational Provider has not engaged in conduct that violate state or federal law or ethical standards of conduct governing the Organizational Provider’s operations;

2. The Organizational Provider 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 Organizational Provider has not been previously excluded from or sanctioned by the Medicaid or Medicare programs;

4. The Organizational Provider 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 Organizational Provider does not have a history of liability lawsuits or other incidents, which indicates a potential competency or quality of care problems;

6. The Organizational Provider 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 Organizational Provider has no history of denial or cancellation or failure to renew liability insurance; and

8. The Organizational Provider’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).

G. **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 Locum Tenens more than 90 days, the practitioner is not considered a Locum Tenens and will require going through the initial credentialing process.

H. **Break in Service (including Leave of Absence).** Break in Service includes, but is not limited to health, military, maternity/paternity or sabbatical leave. If a credentialed Practitioner returns to the same UCare contracted location from a verified Leave of Absence within the 36-month recredentialing cycle, the Practitioner will be reinstated to see UCare members as a credentialed provider. If a Practitioner leaves a UCare contracted location and moves to another UCare contracted location from a verified Leave of Absence within the 36-month recredentialing cycle, the Practitioner will be reinstated to see UCare members as a credentialed provider. 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.
VII. 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 Organizational Provider Assessment Application. However, other forms approved by UCare may be used which include at a minimum the following:

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;

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

2. 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;

3. 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; and

4. A signed attestation of the Provider that the application is complete and correct.

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. This may include follow up by Provider Network Management staff, inquiries as to information lacking, or return of the application due to failure to meet Pre-Application Criteria. If Credentialing Staff determines after any follow-up efforts that the Provider does not meet Pre-Application Criteria, the application shall be returned and the Provider shall be notified in writing by Credentialing Staff of the specific reason why eligibility to participate in UCare’s network has not been met.

B. Application Preparation Process. If a Provider meets all Pre-Application Criteria, then the following steps will be taken.

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 verification.

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

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 Provider of the discrepancy. Each Provider shall be entitled, upon written request, to review their credentialing file except for information such as letters of reference or recommendations that are peer privileged and/or protected from disclosure. UCare may, at its discretion, provide redacted copies or summaries of information provided by individuals if required to maintain confidentiality of protected information. If a Provider believes, upon review of the credentialing file, that any information contained therein is misleading or erroneous, the Provider may submit a corrective statement, which UCare shall place in the file. The foregoing does not require UCare to alter or delete any information contained in the file.

C. 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. Credentialing Staff shall annotate completion of their review in the credentialing file. Providers that meet all Administrative and Professional Criteria 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, 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.

2. Administrative Criteria Variation. Providers that vary from Administrative Criteria are submitted to the Medical Director for review. The Medical Director may delegate in writing to Credentialing Staff the authority to review and approve certain types of variation from Administrative Criteria, and such delegation shall be approved by the QIACC. After internal coordination with the Provider Network Management Director and/or Senior Management, the 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 Medical Director shall notify QIACC at its earliest subsequent meeting of the approval. However, if the Medical Director determines the QIACC should review the Provider, the Provider will be presented to the QIACC for approval. The Medical Director may also direct monitoring and corrective actions per Section VIII and IX of this policy. If the Medical Director, after internal coordination with the Provider Network Management Director and/or Senior Management, determines that a Provider should not be accepted or continued in the network due to administrative issues, the Medical
Director 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.
Administrative terminations and denials are final and are not subject to an appeal
hearing unless otherwise required by law or regulation. However, UCare at its
discretion may reconsider the determination if the Provider submits additional
information for review.

3. Providers with Professional Variation. Providers that vary from Professional Criteria
are submitted to the Medical Director for review. The Medical Director shall forward
Providers for QIACC review 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 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 also direct monitoring and corrective
actions per Sections VIII and IX of this policy.

4. QIACC Review and Acceptance. The QIACC reviews all Providers with
Professional Criteria variation that the Medical Director has confirmed indicates a
potential professional competency issue. The QIACC also is notified of Providers
where the Medical Director has approved a Provider with variation from
Administrative or Professional Criteria according to QIACC guidelines for delegated
review by the Medical Director. The QIACC has complete discretion in reviewing
these Providers and in recommending denial, acceptance with conditions, or
termination of these Providers. Any acceptance by the QIACC is conditioned by the
execution of a relevant participation agreement with UCare. The QIACC 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
QIACC may base its determination on any facts and circumstances it deems
appropriate and relevant. In cases with Professional Criteria variation, the QIACC
shall determine whether the variation indicates a potential or existing professional
performance issue. In the event that the QIACC denies or terminates participation in
the network for failure to meet Professional Criteria, appeal provisions will apply as
outlined in Section XII of this policy. Determinations made by the QIACC 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
QIACC.

5. Board of Directors Review. The UCare Board of Directors (BOD) shall receive
reports of the number of Providers with variation from criteria, which have been
approved by the Medical Director or the QIACC. The BOD may request additional
information on such Providers, and may take any further action it deems appropriate.
The BOD, or a committee appointed by the BOD, shall make the final determination
on cases where the QIACC makes a denial or termination decision that is appealed.
The BOD, or committee appointed by the BOD, has the discretion to take any action
in reviewing an appeal, and any determination by the BOD, or committee appointed by the BOD, shall be considered final. Providers have no right to appear before the BOD committee appointed by the BOD.

6. **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 XII.

**VIII. 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 QIACC with a recommendation for administrative monitoring. Credentialing Staff will record this status within the credentialing file and follow up to ensure that the necessary information is received within a timely period of time. UCare Policy PNM021 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 bi-annual 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. 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.

4. Medical and Nursing Board Disciplinary Actions are reviewed within 72 hours of receipt by Credentialing Staff, including the Monthly Deceased Inactive Physicians Update report.

5. The Medicare/Medicaid Sanction-Reinstatement Report is reviewed within 30 calendar days of a new monthly report by Credentialing Staff.
6. The Medicare Opt-Out list is reviewed by the Provider Network Management Department quarterly with notification to Credentialing Staff.

7. 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.

IX. 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 policy.

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.

X. 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, in consultation with the Provider Network Management Director and/or Senior Management, imposes restriction or suspension for an administrative issue, the action shall be reported to the QIACC. The Medical Director(s) shall review any case regarding Professional Criteria and may recommend restriction or suspension to the QIACC. The Provider shall receive written notice of the restriction or suspension. For administrative issues, the
Provider shall have the right to submit information in response to the notice. For 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. 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. UCare may consider information submitted by the Provider if the action is based on administrative issues.

C. **Claims Denial.** Credentialing Staff shall notify Provider Network Management and Claims staff to deny all claims within five (5) business days after the effective date of notification of the suspension or restriction. Credentialing Staff shall also ensure that Provider Network Management and Claims Staff are notified within five (5) business days of the removal of a suspension or restriction in order to assure prompt claim payment.

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 policy 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 may be adopted, provided 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.

**XI. 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 other administrative terminations are processed through the Medical Director. The Medical Director will coordinate administrative terminations with Provider Network Management and/or Senior Management. All Practitioners terminated for Administrative Criteria will be
reported to the QIACC and the BOD. UCare Credentialing Staff in coordination with Provider Network Management Staff will provide written notice of termination within 60 days, the effective date, and the reasons for such action to the Provider.

B. 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 they deem relevant and appropriate. The QIACC coordinates with the Medical Director notification to the Provider of their appeal rights. The Medical Director shall notify Senior Management of the QIACC recommendation. The BOD, or a committee appointed by the BOD, shall make final determinations on professional terminations that have been appealed or that it chooses to review. 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.

C. Provider Contract Compliance. UCare Policy PNM06 governs the procedures to follow to effect contract termination. Credentialing Staff shall coordinate with Provider Network Management any actions that may require contract termination.

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

XII. CREDENTIALING APPEAL PROCESS

A. Right and Request to Appeal. If the Practitioner is offered the opportunity to appeal, UCare shall follow the procedures set forth below or an alternative procedure approved by the QIACC. 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.

1. The Practitioner shall be given written notice of the right to appeal. 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 shall be given thirty (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 thirty (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

21
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 sixty (60) days to complete the hearing process. If the Practitioner fails to request a hearing in writing within thirty (30) calendar days of receipt of the notice, the Practitioner waives any appeal right under this policy.

3. The hearing date will be not less than thirty (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 ten (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 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.

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 fifteen (15) business days prior to the hearing.

3. 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 five (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. 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 BOD, or an appointed committee of the BOD, shall review the recommendation of the Appeals Committee as to whether it acted arbitrarily and capriciously. The BOD will 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.

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 five (5) business days of the decision. Such notice shall include a statement of the basis for the BOD’s decision.

H. Notification of Members. In the event of termination of participation status, UCare shall notify the members who regularly obtained health services from or who are
assigned to the Practitioner and assist the members in obtaining another Practitioner of care.

XIII. 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.

XIV. 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 procedure CCR0011. These policies/procedures describe in more detail the delegation process that consists of the following:

A. Pre-Delegation Assessment. Credentialing Staff conducts this assessment. Credentialing policies, practices, system interface and credentialing files are examined to assess the potential delegate business practices and ability to comply with UCare standards. Assessment recommendations are presented to the PEC Director. Pre-assessment audit summary is brought to QIACC as a notification, and the QIACC may take any action it deems appropriate.

B. Written Delegation Agreement. Expectations of UCare and the delegate are explicitly described in a mutually agreed upon written delegation agreement. The agreement specifies the scope of delegation, reports required, 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.

C. Ongoing Monitoring/Oversight. The delegate shall provide regular reports regarding credentialing actions that include the information as specified in the Delegation Agreement. All suspensions or restrictions shall be reported to UCare within seven (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.
D. **Annual Audit.** An annual audit of the delegate will be conducted or certain elements may be waived provided that proof of acceptable accreditation is provided to UCare. However; UCare will still request that 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.

UCare and the Delegate shall treat all credentialing data as confidential, peer review information. 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.

APPROVED

__________________________
CHIEF EXECUTIVE OFFICER

__________________________
DATE

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*Key Words:* Credentialing, QIACC, Medical Director