



UnitedHealthcare Credentialing Plan. 2019-2021

This Credentialing and Recredentialing Plan may be distributed to Physicians, other health care professionals and Facilities upon request. Additionally, a Credentialing Entity may distribute this Plan to entities that have applied for delegation of the credentialing responsibility.

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Section 1.0

Introduction.

Section 1.1 – Purpose.

The purpose of this Credentialing and Recredentialing Plan (“Credentialing Plan”) is to explain the policy of United HealthCare Services, Inc. and its affiliates (UnitedHealthcare) for Credentialing and Recredentialing. All Licensed Independent (LIPs) Practitioners and Facilities that the Credentialing Entity names as part of its Network including Leased Networks as required by Credentialing Authority are subject to the Credentialing Plan. Licensed Independent Practitioners and Facilities that provide health care services to Covered Persons under their out-of-network benefits or on an emergency basis are not subject to this Credentialing Plan.

Credentialing is a peer-review process designed to review certain information pertinent to the Credentialing Entity’s decision whether to contract with Licensed Independent Practitioner or Facility, either initially or on an ongoing basis, as determined by Credentialing Entity. The process described in the Credentialing Plan will be initiated only after the Credentialing Entity makes a preliminary determination that it wishes to pursue contracting or re-contracting with the Applicant.

The Credentialing Entity does not make Credentialing and Recredentialing decisions based on a Licensed Independent Practitioner’s race, ethnic/national identity, gender, age, sexual orientation or the types of procedures or patients in which the Licensed Independent Practitioner or Facility specializes. Credentialing Entity also does not discriminate in terms of participation, reimbursement, or indemnification, against any Licensed Independent Practitioner who is acting within the scope of the applicable license or certification under State law, solely on the basis of the license or certification. This does not preclude the Credentialing Entity from including in its Network Licensed Independent Practitioners who meet certain demographic or specialty needs such as, but not limited to, cultural needs of its Covered Persons.

No portion of this Credentialing Plan grants rights to Covered Persons, Licensed Independent Practitioners or Facilities, nor is it intended to establish a standard of care or to be used as evidence relevant to establishing a standard of care.

Section 1.1– Credentialing Policy.

The Credentialing Entity’s credentialing policy consists of this Credentialing Plan and any Credentialing Authority’s standards (shown in Attachment E, as may be amended from time to time). To the extent this Credentialing Plan includes less stringent Credentialing standards than any applicable Credentialing Authority’s standards, UnitedHealthcare will adopt the revised or clarified standard unless otherwise amended in this Credentialing Plan.

Section 1.3—Authority of Credentialing Entity and Changes to Credentialing Plan.

To the extent permitted by any Credentialing Authority’s standards and this Credentialing Plan, Credentialing Entity has the sole right to determine which Licensed Independent Practitioners and Facilities it will accept and maintain within its Network, and the terms on which it will allow participation.

Quality Oversight Committee has the authority to approve this Credentialing Plan. Credentialing Entity has the right to change this Credentialing Plan to meet regulatory requirements or other organizational or business need with Credentialing Entity’s Quality Oversight Committee approval. This Credentialing Plan does not limit Credentialing Entity’s or UnitedHealthcare’s rights under the pertinent Participation Agreements that govern their relationships with Licensed Independent Practitioners and Facilities.

Section 2.0

Definitions.

For the purposes of this Credentialing Plan, the terms listed below have the meanings described below and are capitalized throughout this Plan. The National Credentialing Committee has the discretion to further interpret, expand and clarify these definitions.

- “Appeal” has the meaning given to it by any governing Credentialing Authorities or the pertinent Participation Agreement.
- “Applicant” means a Licensed Independent Practitioner or a Facility that has submitted an Application to Credentialing Entity for Credentialing or Recredentialing.
- “Application” means the document provided by Credentialing Entity (or its designee) to a LIP or a Facility which, when completed, will contain information for National Credentialing Committee to review as part of its determination whether Applicant meets the Credentialing Criteria.
- “Application Date” means the date on which the Credentialing Entity receives the signed, dated and complete Application for Network participation from a LIP or a Facility.
- “Benefit Plan” means a health benefits plan that: (1) is underwritten, issued and/or administered by Credentialing Entity, and (2) contains the terms and conditions of a Covered Person’s health benefits coverage.
- “Board of Directors” means the Credentialing Entity’s Board of Directors.
- “CMS” means the Centers for Medicare and Medicaid Services.
- “Covered Person” means a person who is covered by a Benefit Plan (i.e., members, subscribers, insureds, participants, enrollees, customers or other Covered Persons).
- “Credentialing Authorities” means the National Committee for Quality Assurance (“NCQA”), other accrediting body as applicable to UnitedHealthcare, the Center for Medicare and Medicaid Services (“CMS”), as applicable, and other applicable state and federal regulatory authorities; to the extent such authorities dictate Credentialing requirements.
- “Credential”, “Credentialing”, or “Recredentialing” means the process of assessing and validating the applicable criteria and qualifications of Licensed Independent Practitioners and Facilities to become or continue as Participating LIPs and Participating Facilities, as set forth in the Credentialing Plan and pursuant to Credentialing Authorities.
- “Credentialing Criteria” are those found in Section 4.0, 5.0 and 7.0 as applicable, and applicable attachments to this Credentialing Plan, as it may be amended from time to time.
- “Credentialing Entity” is United HealthCare Services, Inc. or its affiliates that adopts this Credentialing Plan. When “Credentialing Entity” is required to take some action by this Credentialing Plan, it may do so through delegation to the extent permitted by any Credentialing Authorities.
- “Decision Date” is the date on which the National Credentialing Committee makes its decision to indicate approval or denial of Credentialing or Recredentialing for an Applicant.
- “Delegated Entity” is a hospital, group practice, credentials verification organization (CVO), or other entity to which Credentialing Entity has delegated specific credentialing and recredentialing responsibilities under a Credentialing Delegation Agreement.
- “Credentialing Delegation Agreement” is a mutually agreed upon contract or other document by which Credentialing Entity delegates specified Credentialing responsibilities to Delegated Entity, and requires Delegated Entity to meet certain standards related to its Credentialing and Recredentialing responsibilities.
- “Facility” includes but is not limited to hospitals and ancillary providers such as home health agencies, skilled nursing facilities, behavioral health centers providing mental health and substance abuse services (inpatient, residential and ambulatory), Federally Qualified Health Centers, Rural Health Centers, free-standing surgical centers, and multispecialty outpatient surgical centers, or as otherwise defined by Credentialing Authority.
- “Hearing Panel” means a committee created by the Credentialing Entity to provide Appeals as required by Credentialing Authorities or the pertinent Participation Agreement.

- “Leased Network” means an existing organization of physicians, hospitals and other healthcare professionals that UnitedHealthcare contracts to allow access by Covered Persons and to which UnitedHealthcare has entered into a Credentialing Delegation Agreement.
- “Licensed Independent Practitioner” or “LIP” means any health care professional who is permitted by law to practice independently within the scope of the individual’s license or certification, and includes but is not limited to medical doctors (MDs), doctors of osteopathy (DOs), dentists (DDS or DMD), chiropractors (DCs), doctors of podiatric medicine (DPM), psychologists (PhDs), social workers, certified registered nurse practitioners (CRNPs), physician assistants (PAs), certified nurse midwives (CNMs), physical, speech, occupational therapists and all other non physician practitioners who have an independent relationship with the Credentialing Entity and provide care under a Benefit Plan.
- “Material Restriction” means a restriction that includes but is not limited to the following: a requirement to obtain a second opinion from another practitioner prior to patient diagnosis or treatment; a limitation on prescription drug writing; a limitation on providing examination, diagnosis or procedure without a second person present or approving the procedure; or restriction, suspension or involuntary termination of hospital staff privileges if the LIP’s specialty normally admits patients to a hospital; a restriction on or prohibition from performing a service or procedure typically provided by other practitioners in the same or similar specialty. The restrictions listed above are not exclusive. There may be other restrictions or conditions, not specifically identified in the definition above, that rise to the level of a material restriction.
- “NCQA” means The National Committee for Quality Assurance.
- “National Credentialing Committee” means a standing committee that implements the Credentialing Plan.
- “National Peer Review and Credentialing Policy Committee” is comprised of stakeholders from multiple UnitedHealthcare regions and meets regularly. The National Peer Review and Credentialing Policy Committee has the final decision making authority on all Quality of Care disciplinary actions recommended by the regional Peer Review Committee that affect restriction, suspension or termination of Network participation status.
- “Network” means LIP’s and Facilities contracted with UnitedHealthcare to provide or arrange for the provision of health care services to Covered Persons.
- “Newly Merged Network” means a network of LIP’s and Facilities that had contracts to participate with an HMO, insurer or other managed care entity that was acquired by or merged into Credentialing Entity or any affiliated UnitedHealth Group company.
- “Notice” means: (1) depositing correspondence in the United States mail, using first class or certified mail, postage prepaid, addressed to the other party at the last known office address given by the party to the other party; or (2) delivering the correspondence to an overnight courier, delivery to the other party prepaid, addressed to the other party at the last known office address given by the other party; or (3) sending a facsimile transmission to the other party at the last known office facsimile number given by the party to the other party, or (4) personally hand-delivering written notice to the other party.
- “NPDB” means the National Practitioner Data Bank.
- “NTIS” is the National Technical Information Service.
- “Participating LIP/Facility” means a Licensed Independent Practitioner or Facility who has entered into a Participation Agreement with the Credentialing Entity or as an employee of a Delegated Entity.
- “Participation Agreement” means a direct or indirect (such as an IPA or PHO) agreement between the Credentialing Entity and a LIP or a Facility that sets forth the terms and conditions under which the LIP or Facility participates in the Credentialing Entity’s Network.
- “PCP” means primary care physician, and always includes family practice, geriatrics, internal medicine, pediatric general practice and general practice physicians. In some states and for some Credentialing Entities, “PCP’s” may also include OB/GYNs and certified registered nurse practitioners.

- “Peer Review” is the evaluation or review of the performance of physicians, health care professionals or facilities by professionals with similar types and degrees of expertise (e.g., the evaluation of one physician’s practice by another physician).
- “Peer Review Committee (PRC)” is responsible for investigating and evaluating Covered Persons Quality of Care (QOC) Complaints and determining, or recommending to the National Peer Review and Credentialing Policy Committee, whether and what type of disciplinary action should be taken in relation to such QOC Complaints between the credentialing or recredentialing cycle. Complaints requiring investigation may involve a physician, health care professional or Facility that delivers health care to Covered Persons. The PRC shall comply with applicable state peer review requirements and is comprised of Medical Directors, participating physicians and QOC clinical staff.
- “Primary Source Verify” means to verify directly with an educational, accrediting, licensing, other entity, or NCQA approved entity that the information provided by Applicant is correct and current.
- “Protected Health Information” (PHI) has the same meaning it has under the Health Insurance Portability and Accountability Act and its implementing and interpretative regulations.
- “Quality Oversight Committee” means the Credentialing Entity committee that may review and approve changes to the Credentialing Plan required to meet regulatory requirements or other organizational and business needs. A Credentialing Entity may have a different name for this committee but the intent of the meaning applies.
- “Quality of Care (QOC)” means the degree to which health services for Covered Persons increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Dimensions of performance include, but are not limited to, the following: member perspective issues, safety of the health care environment, accessibility, appropriateness, continuity, effectiveness, efficacy and timeliness of care.
- “UnitedHealthcare Quality of Care Department” (QOC) means the department within UnitedHealthcare that receives, logs, investigates and documents resolution of quality of care and quality of service complaints.

Section 3.0

Responsibilities of Board of Directors, National Credentialing Committee, Medical Directors, Hearing Panels and Applicants.

Section 3.1 – Credentialing Entity Board of Directors (Board of Directors).

The Board of Directors is responsible for the administration of the Credentialing Plan and has delegated to the National Credentialing Committee the overall responsibility and authority for Credentialing and Recredentialing. Each Board of Directors has delegated to the Quality Oversight Committee the responsibility for providing oversight of Delegated Entities, including review and approval of Delegated Entities’ credentialing policies, as further described in Section 11 and in the Credentialing Entity’s Quality Improvement program description.

Section 3.2 – Medical Director.

The Credentialing Entity Medical Director is responsible for the administration of the Credentialing Plan and for other activities as defined by the Credentialing Entity or National Credentialing Committees. The Medical Director may approve initial Credentialing or Recredentialing files determined to meet all Credentialing Criteria or may determine that additional review by the National Credentialing Committee is required. The Medical Director may delegate these functions to a peer as appropriate.

Section 3.3 – National Credentialing Committee.

National Credentialing Committee has the responsibility to implement this Credentialing Plan. The National Credentialing Committee has the authority to interpret the terms of this Credentialing Plan and make any necessary professional judgments about medical practice and clinical issues.

The National Credentialing Committee will make Credentialing decisions pursuant to this Credentialing Plan and will communicate those decisions to the Credentialing Entity. If the National Credentialing Committee determines that any LIP or Facility (Facility only where required by Credentialing Authorities) has violated the terms of this Credentialing Plan, the National Credentialing Committee has the responsibility to report adverse Credentialing decisions to the Credentialing Entity. The Credentialing Entity will then follow the processes set forth in Section 9 of the Credentialing Plan and submit any required reports as described therein.

The National Credentialing Committee will be comprised of Participating LIPs from the Credentialing Entities, UnitedHealthcare Medical Directors, and a designated Medical Director Chairperson; unless a different committee composition is otherwise required by applicable Credentialing Authorities. A quorum of the National Credentialing Committee is required to make a Credentialing decision. A quorum requires at least five (5) voting members to be present.

Section 3.4—Process for Initial Credentialing and Recredentialing of LIPs.

Before forwarding an Application to the National Credentialing Committee, the Credentialing Entity staff will collect information to assess whether an Applicant meets Credentialing Entity’s minimum requirements for practice location, specialty and any other business needs.

A list of LIPs who meet Credentialing Criteria will be submitted to the Medical Director for review and approval by electronic signature. The Medical Director reviews shall be generally performed on a daily basis during normal business hours.

LIPs who do not meet Credentialing Entity’s established Credentialing Criteria are presented to the National Credentialing Committee. The information provided to the National Credentialing Committee includes the LIP’s profile and all documentation related to the issue or issues in question. The information provided to the National Credentialing Committees does not include references to age, gender, race, sexual orientation or type of procedure or patients in which the practitioner specializes, so decisions are made in a nondiscriminatory manner. The National Credentialing Committee may request further information from any persons or organizations, including the LIP, in order to assist with the evaluation process.

The National Credentialing Committee will not make any decision on an Applicant without a completed Application, as outlined in Attachment A. The National Credentialing Committee has discretion to ask for missing information or to deny the Application as incomplete. The National Credentialing Committee may request further information not covered by the Application if necessary to fulfill its obligations under applicable Credentialing Authorities.

The National Credentialing Committee has given the discretion and authority to National Credentialing Center staff to cease processing and/or recommend contract termination for any LIPs who have not, after multiple documented requests, submitted a complete Credentialing application.

Upon receipt of a complete Application, the National Credentialing Committee will render a decision in accordance to the timeframes as specified by the Credentialing Authority.

The National Credentialing Committee may delay action on an Application pending the outcome of an investigation of the Applicant by a hospital, licensing board, government agency, or any other organization or institution.

Section 3.5—Disclosing Reasons for Non-Acceptance or Termination.

When a LIP’s or Facility’s Application is not accepted or participation is terminated, the non-acceptance or termination letter will include the reason(s) for the decision. Each Credentialing Entity should contact its legal representative if it has questions about any specific Credentialing Authority that may require it to disclose reasons for non-acceptance or termination, or if it is not accepting an Applicant or is terminating participation for reasons relating to professional competence or conduct.

Section 3.6—Applicant.

Applicant is responsible for timely completion of the Application, providing all requested information, and disclosing all facts that a Credentialing Entity would consider in making a reasonable Credentialing decision. Applicant or a Participating LIP or Participating Facility must inform Credentialing Entity of any material change to the information on the Application including but not limited to: any change in staff privileges, prescribing ability, accreditation, ability to perform professional duties, change in

OIG sanction or GSA debarment status or Material Restrictions on licensure. Failure to inform Credentialing Entity immediately of a status change is a violation of this Credentialing Plan and the Participation Agreement, and may result in immediate suspension or termination from the Network.

Section 4.0

Initial Credentialing of Licensed Independent Practitioner Applicants.

Section 4.1—Scope of Licensed Independent Practitioner (LIP) Credentialing.

Credentialing is required for all LIPs to whom UnitedHealthcare directs Covered Persons to receive care under a Benefit Plan as part of UnitedHealthcare’s Network of Participating LIPs, including LIPs participating through a Leased Network agreement. In the event of Leased Networks, Credentialing may be delegated and will be subject to the requirements of Section 11 of this Credentialing Plan. Credentialing is generally not required for health care professionals who are permitted to furnish services only under the direct supervision of another LIP or for hospital-based or Facility-based health care professionals who provide service to Covered Persons incidental to hospital or Facility services. However, Credentialing is required for hospital or Facility-based LIPs to whom UnitedHealthcare directs Covered Persons to receive care under a Benefit Plan or if mandated by Credentialing Authorities.

Except as otherwise required by Credentialing Authorities, the Credentialing Entity will consider Applications from LIPs with an expressed interest in Network participation if the Credentialing Entity determines: (1) it needs additional LIPs; and/or (2) that other organizational or business needs may be satisfied by including additional LIPs or a particular LIP in the Network.

Section 4.2—Credentialing Criteria/Source Verification Requirements.

Each LIP must complete an Application with Credentialing Criteria as outlined in Attachment A with a signed attestation, which may be in an electronic format, within 180 days of the Decision Date or in accordance with Credentialing Authorities if it is a shorter time frame. Each LIP must meet the following Credentialing Criteria, which must be verified and approved within 180 days of the Decision Date or in accordance with Credentialing Authorities if it is a shorter time frame:

1. **Required medical or professional education and training.** MDs and DOs must graduate from allopathic or osteopathic medical school and successfully complete a residency program or other clinical training and experience as appropriate for specialty and scope of practice as determined by the Credentialing Committee. DCs must graduate from Chiropractic College; DDSs or DMDs must graduate from dental school; and DPMs must graduate from podiatry school and successfully complete a hospital residency program. All mid-level practitioners must graduate from an accredited professional school and successfully complete a training program. If Applicant claims to be board certified, Credentialing Entity will Primary Source Verify board certification from the most current edition of an NCQA approved source, but need not Primary Source Verify each level of education and training if the certifying board has already Primary Source Verified it. If Applicant is not board certified, then Primary Source Verification of the highest level of education listed on the Application is required, except that each level of education must be primary source verified for dentists.
2. **Verification of post-graduate education or training not listed in (1) above.** The Credentialing Entity will Primary Source Verify any post-graduate education or training disclosed in the Application and not considered in (1) above if relevant to LIP’s scope of practice (for example Fellowship).
3. **Current licensure or certification.** The Credentialing Entity will Primary Source Verify that the Applicant maintains current, valid licensure or certification, without Material Restrictions, conditions, or other disciplinary action, in all states where the applicant practices. Any finding that results in sanctions or restrictions on the LIP from any government agency or authority, including but not limited to a state licensing authority may result in denial of Credentialing. A committee may recommend accepting a LIP to the Network if the restriction does not limit or impact the LIP’s practice, except that a Committee cannot recommend accepting a LIP into the Network if the LIP has a Material Restriction.

4. **Valid DEA or Controlled Dangerous Substance Certificate or Acceptable Substitute.** Unless the Applicant's practice does not require it, the Applicant must have a current, valid DEA or Controlled Dangerous Substance Certificate in each state where the Applicant intends to practice, or, if the Applicant has a pending DEA application, an agreement with a Participating LIP with a valid DEA certificate in each state where the Applicant intends to practice to write prescriptions of the Applicant with the pending DEA application. The Credentialing Entity will verify that the Applicant meets this requirement by obtaining a copy of the Applicant's DEA or CDS Certificate in each state where the Applicant intends to practice, visually inspecting the certificate, or confirming with CDS or NTIS that the certificate is in force at the Decision Date.
5. **Medicare/Medicaid Sanctions Review.** Regardless of the contracted line of business, for example, Medicare, Medicaid or Commercial the Applicant must not be ineligible, excluded or debarred from participation in the Medicare and/or Medicaid and related state and federal programs, or terminated for cause from Medicare or any state's Medicaid or CHIP program and must be without any sanctions levied by the Office of Inspector General (OIG), the CMS Preclusion List or other disciplinary action by any federal or state entities identified by CMS. Credentialing Entity will, at a minimum, verify reported information from the Office of Inspector General (OIG), and the CMS Preclusion list and Medicare opt out.
6. **Work History.** The Credentialing Entity will obtain a five-year work history. Gaps longer than six months must be explained by the LIP and found acceptable by the Credentialing Committee.
7. **Insurance or state-approved alternative.** The Applicant must maintain errors and omissions (malpractice) insurance through insurers licensed in their State, or show similar financial commitments made through an appropriate State-approved alternative, in the minimum amounts required by United Health Group's Provider Guidelines Credentialing Entity may require a copy of the Applicant's current Certificate of Coverage or may allow the Applicant's attestation to current, adequate insurance of state-approved alternative. The pertinent Participation Agreement may require coverage that exceeds the minimum established by this Credentialing Plan.
8. **Malpractice History.** Credentialing Entity must obtain written confirmation of the past five years of history of malpractice settlements or judgements from the malpractice carrier or must query the NPDB. Malpractice claims history must be explained by the LIP and found acceptable by the Credentialing Entity.
9. **Passing score on site visit.** If required by Credentialing Authorities, Applicant must agree to allow the Credentialing Entity to conduct an office site visit of Applicant's practice, including staff interviews, and medical record-keeping assessments, as further documented in Attachment B, and must receive a passing score for the site assessment and medical record keeping assessment. Site visit must be completed prior to the Decision Date.

Any failed site visit will result in the Applicant being required to re-apply for Credentialing after at least six months have passed. The Credentialing Entity may agree to permit an Applicant to re-apply for Credentialing prior to the six month wait period if the Applicant can first demonstrate improvements in the areas previously found deficient by providing documentation of such improvements in an improvement action plan. If the Credentialing Entity accepts the improvement action plan, the Applicant must agree to allow the Credentialing Entity to conduct an office site visit of Applicant's practice as further documented in Attachment B, and must receive a passing score for the site visit as part of the initial Credentialing Criteria.

10. **Sanction and Limitation on Licensure.** In addition to primary source verification of license or certification as noted in section 4.3(3) above Credentialing Entity will obtain information about the Applicant through a review of NPDB or FSMB and state licensing Board reports. Any finding that results in Material Restriction on the LIP from any state licensing authority may result in denial of Credentialing.
11. No prior denials or terminations. At the discretion of the Credentialing Entity, the Applicant must not have been denied initial participation or had participation terminated (for reasons other than network need) by the Credentialing Entity or any Newly Merged Network within the preceding 24 months.
12. Hospital Staff Privileges. Applicant must have full hospital admitting privileges, without Material Restrictions, conditions or other disciplinary actions, at a minimum of one Participating (Network) hospital, or arrangements with a Participating LIP to admit and provide hospital coverage to Covered Persons at a Participating (Network) hospital, if the Credentialing

Entity determines that Applicant's practice requires such privileges. The Applicant's attestation is sufficient verification of this requirement unless otherwise required by Credentialing Authority. The National Credentialing Committee may recommend accepting a LIP to the Network if the restriction does not limit or impact the LIP's practice.

13. **Affirmative responses to Disclosure Questions on the Credentialing Application.** Applicant is required to provide details on all affirmative responses to Disclosure Questions on the Credentialing Application, which may be reviewed by a Medical Director, and at the discretion of the Medical Director, may be reviewed by Credentialing Committee for a determination of LIP's acceptance into Credentialing Entity's Network.

Section 4.3—Status of Applicant after National Credentialing Committee Decision Date.

Acceptance of an Applicant into the Credentialing Entity's Network is conditioned upon the Applicant's signature on the pertinent Participation Agreement. Indication by the National Credentialing Committee that the Applicant meets the Credentialing Criteria does not create a contract between the Applicant and the Credentialing Entity. The Applicant is not considered a Participating LIP on the Decision Date and is not entitled to treat Covered Persons or receive payment from Credentialing Entity until the Participation Agreement is signed by both parties with a specified Effective Date, and the Applicant's Agreement and demographic information are entered into all pertinent information systems.

Section 4.4—Consequences of License Suspension.

During any time period in which the Participating LIP's license is suspended Credentialing Entity will initiate immediate action to terminate provider from the Network in accordance with the Participation Agreement.

Section 5.0

Recredentialing of Participating Licensed Independent Practitioners.

Section 5.1—Recredentialing Participating LIPs: Application.

LIPs will be Recredentialled at least every 36 months. Participating LIPs must complete an Application with criteria as outlined in Attachment A.

Section 5.2—Recredentialing Criteria of Participating LIPs.

Each Participating LIP must continue to meet the following Credentialing Criteria to be considered for continued participation:

1. Applicants must meet all initial Credentialing Criteria as set forth in Section 4.2 at the time of the recredentialing Decision Date, with the exception that education (for LIPs that are not board certified) and work history need not be re-verified.
2. An Applicant for Recredentialing must have demonstrated compliance with all terms of the Participation Agreement, specifically including completion of individual action plans requested by Credentialing Entity.
3. Credentialing Entity must obtain written confirmation of the past three years of history of malpractice settlements or judgments from the malpractice carrier or must query the NPDB. Malpractice claims history must be explained by the LIP and found acceptable by the Credentialing Committee.
4. History of Quality of Care/quality of service concerns within the Recredentialing cycle will be reviewed by the Credentialing Committee and if substantiated the Applicant may be subject to denial of recredentialing.
5. Site visit if required by Credentialing Authority as outlined in Attachment E. Refer to Attachment B for site visit requirements.
6. Specialty change. A LIP who requests a specialty change must provide documentation of training and/or education in that specialty that conforms to the requirements by the Credentialing Entity for other specialists in the same area, and that information will be Primary Source Verified by the Credentialing Entity. Credentialing Entity is not required to accept a request for specialty change unless there is a Network need.

Section 6.0

Licensed Independent Practitioner Site Assessment.

If required by Credentialing Authority the Credentialing Entity will conduct a Site Assessment, including Medical Record Keeping Practices Assessment as outlined in Attachment B. See State and Federal Regulatory Addendum (Attachment E).

Section 7.0

Credentialing and Recredentialing of Facilities.

Section 7.1 – Criteria for Credentialing and Recredentialing Facilities.

Each Facility must meet the following criteria to be considered for credentialing or recredentialing:

1. Current required license(s).
2. Insurance. The Applicant must maintain general/comprehensive liability insurance as well as errors and omissions (malpractice) insurance for at least the “per occurrence” and aggregate limits established by UnitedHealth Group’s Provider Guidelines with an insurer licensed to provide medical malpractice insurance in the Applicant’s state of practice, or show similar financial commitments made through an appropriate State approved alternative, as determined by the Credentialing Entity. The pertinent Participation Agreement may require coverage that exceeds the minimum established by this Credentialing Plan.
3. Medicare/Medicaid Sanctions Review. Regardless of the contracted line of business, for example, Medicare, Medicaid or Commercial, the Applicant must not be ineligible, excluded or debarred from participation in the Medicare and/or Medicaid and related state and federal programs, or terminated for cause from Medicare or any state’s Medicaid or CHIP program and must be without any sanctions levied by the Office of Inspector General (OIG), the General Services Administration (GSA) and the CMS Preclusion list or other disciplinary action by any federal or state entities identified by CMS.
4. Appropriate Accreditation or Satisfactory Alternative. Credentialing Entity must obtain a copy of the accreditation report or evidence from the Accrediting Body.
 - a. If the Applicant is not accredited by an agency recognized by the Credentialing Entity in Attachment C, a site visit of the organization is required and results must be found to be satisfactory as defined by the Credentialing Entity in Attachment D.
 - b. In lieu of a site visit by the Credentialing Entity, a CMS or State quality review may be used if it is not more than three years old. The organization must provide evidence in the form of a final report or letter from CMS or the State, stating that it has been reviewed and passed inspection.

Section 7.2—Recredentialing Periodically Required.

Facilities will be recredentialed at least every 36 months. Participating Facilities must complete an Application in a timely manner. The National Credentialing Committee has given the discretion and authority to National Credentialing Center staff to cease processing and/or recommend contract termination for any Facilities who have not, after multiple documented requests, submitted a complete Credentialing application.

Section 7.3—Status of Applicant after National Credentialing Committee Decision.

Any acceptance of an Applicant into the Credentialing Entity’s Network is conditioned upon the Applicant’s agreement to accept the Credentialing Entity’s terms and conditions of participation and sign the pertinent Participation Agreement. Indication that the Applicant meets the Credentialing Criteria does not create a contract between the Applicant and the Credentialing Entity. The Applicant is not considered a Participating Facility on the Decision Date and is not entitled to treat Covered Persons or receive payment from Credentialing Entity until the Participation Agreement is signed by both parties with a specified Effective Date, and the Applicant’s Agreement and demographic information are entered into all pertinent information systems.

Section 8.0

Confidentiality and Applicant Rights.

Section 8.1 – Confidentiality of Applicant Information.

The Credentialing Entity believes information obtained in the credentialing process should be protected by the peer review privilege. Credentialing Entity will therefore maintain mechanisms to appropriately limit review of confidential credentialing information to circumstances where the practitioner authorizes release in writing, or as required or permitted by law. Credentialing Entity will also contractually require Delegated Entities to maintain the confidentiality of credentialing information.

Section 8.2 – Applicant Rights.

Applicants have the right to review certain information submitted in connection with their credentialing or recredentialing Application, including information received from any primary source and to correct erroneous information that has been obtained by Credentialing Entity. The Credentialing Entity will notify Applicant via phone call, fax or email of identification of any information that varies substantially from the information provided by the Applicant. At the time of notification, the Applicant will be advised where and within what time frame the Applicant must respond. Applicants must submit any corrections in writing as directed by the Credentialing Entity within 30 days of the Applicant's notification of the discrepancy, pending where the file is in process.

Applicants also have the right to obtain information about the status of their Application upon their request. The Applicant can check on the status of an application by calling the Enterprise United Voice Portal at 877-842-3210. Provide the TIN, and then follow the prompts. Credentialing Entity is not required to allow an Applicant to review personal or professional references, or other information that is peer review protected. Applicants have the right to be notified of the credentialing decision within 60 calendar days of the National Credentialing Committee's decision and recredentialing denials within 60 days of decision date, notwithstanding this provision, credentialing time frames and notification will not exceed timelines required by the Credentialing Authority.

Section 8.3 – Appeal Process.

The Credentialing Entity will permit Appeals from adverse credentialing or sanctions monitoring decisions only to the extent required by Credentialing Authority. The Credentialing Authority requirements will govern any request for an Appeal. Any appeal process related to the termination, suspension or non-renewal of Practitioners will be communicated to the affected Practitioner with the notice of termination, suspension or non-renewal.

Section 9.0

Ongoing Monitoring and Reporting.

Section 9.1 – National Peer Review and Credentialing Policy Committee.

Whenever the Credentialing Entity's Quality of Care Department staff receives information suggesting that suspension, restriction, or termination of a LIP's participation may be warranted based on a potential Quality of Care concern, it should compile all pertinent information and refer the matter to the Medical Director for review. If the Medical Director, determines that a failure to take action may present an urgent risk to patient health for any Covered Person, the Medical Director in conjunction with the Regional Peer Review Committee chairperson and the regional chief medical officer may summarily restrict or suspend the LIP's participation status in the network, as set out in the Summary Actions section of the Quality of Care Investigation, Improvement Action Plans and Disciplinary Actions Policy. If the Medical Director determines that immediate action is not warranted, the information is referred to the Peer Review Committee. If the Peer Review Committee decides that further information is needed, the Committee should obtain it from the LIP or from any other relevant and accessible source.

Following its deliberations, if the Peer Review Committee decides that no corrective action needs to occur, the meeting minutes should reflect the reasons for this decision. Alternatively, if the Peer Review Committee in its sole discretion decides to recommend to the National Peer Review and Credentialing Policy Committee a specific compliance improvement work plan or the suspension or termination of a LIP's participation, the meeting minutes should reflect this recommendation and the reasons for it. After receiving recommendations from the Peer Review Committee, the National Peer Review and Credentialing Policy Committee decides whether or not to approve the recommendations and whether or not to offer the LIP an opportunity to appeal. (See Section 9.4 of the Credentialing Plan for a description of the appeal process for adverse actions based on Quality of Care concerns.)

Section 9.2—Action by the National Peer Review and Credentialing Policy Committee.

The National Peer Review and Credentialing Policy Committee may affirm, reverse or modify the recommendation of the Peer Review or Hearing Panel, or it may return the matter to the appropriate committee for reconsideration.

If the National Peer Review and Credentialing Policy Committee acts to suspend, restrict, or terminate for cause a LIP's Network participation, the LIP should be notified in writing of the action. If the LIP was not previously offered an opportunity to request a hearing, the National Peer Review and Credentialing Policy Committee shall offer the LIP an opportunity to appeal the determination. (See Section 9.4 of the Credentialing Plan for a description of the appeal process for adverse actions based on Quality of Care concerns.)

Section 9.3—Fair Process Considerations.

To encourage and support the professional review activities of physicians and dentists and other practitioners, the Health Care Quality Improvement Act of 1986 ("HCQIA" or the "Act") was enacted. The HCQIA provides that the professional review bodies of health care entities (such as the Peer Review Committee and National Peer Review and Credentialing Policy Committee) and persons serving on or otherwise assisting such bodies are generally offered immunity from private damages in a civil lawsuit when they conduct professional review activities in the reasonable belief that they are furthering the quality of health care and with proper regard for fair process. HMOs and PPOs fall within the definition of "health care entity."

To receive immunity protection, a professional review action regarding the professional competence or professional conduct of a physician or dentist or other practitioner must be taken in accordance with all of the following standards:

- In the reasonable belief that the action is in the furtherance of quality health care;
- After a reasonable effort to obtain the facts of the matter;
- After adequate notice and hearing procedures are afforded to the LIP involved or after such other procedures are afforded as are fair to the LIP under the circumstances; and
- In the reasonable belief that the action is warranted after exercising a reasonable effort to obtain facts and after meeting the adequate notice and hearing requirement.

Although a health care entity may immediately suspend a LIP's privileges pending an investigation of the LIP's professional competence or conduct, the health care entity can take advantage of the HCQIA's immunity protection only by affording the LIP involved adequate notice and hearing procedures, unless the suspension lasts fewer than 30 days.

The Act sets forth sample notice and hearing criteria, including time frames, that are deemed to satisfy the adequate notice and hearing requirement. These criteria are incorporated into the Plan. Failure to follow the criteria will not, in itself, constitute failure to meet the notice and hearing requirement; provided that the procedures afforded the LIP under review are reasonable under the circumstances.

Section 9.4—Hearing Panel.

A. NPDB Reporting.

The National Peer Review and Credentialing Policy Committee establishes the Hearing Panel when the National Peer Review and Credentialing Policy Committee grants an appeal of an adverse action based on quality of care concerns. The Hearing Panel's responsibility is to conduct hearings or reviews and make determinations:

1. To uphold or overturn a decision of the National Peer Review and Credentialing Policy Committee to suspend, restrict or terminate an LIP's participation, or
2. To uphold or overturn a decision by a Medical Director, regional Peer Review Committee chairperson and regional chief medical officer to take summary action to suspend, restrict or terminate an LIP's participation per the Quality of Care Investigation, Improvement Action Plans and Disciplinary Actions Policy.
3. To uphold or overturn a decision of the National Practitioner Sanctions Committee to suspend an LIP's participation per the Imminent Threat to Patient Safety Policy.

The hearing is held before a Hearing Panel comprised of three (3) physicians or health care professionals who are appointed by UnitedHealthcare, who are not in direct economic competition with the physician or health care professional, and who have not acted as accuser, investigator, fact-finder, or initial decision-maker in the matter. At least one (1) person on the panel must be a peer of the affected physician or health care professional. For a physician who is contracted to provide healthcare services to UnitedHealthcare enrollees/members enrolled in a Medicare Advantage benefit plan, the panel will be comprised of a majority of peers of the affected Physician.

The Credentialing Entity will notify the LIP and document action taken by the Peer Review Committee, National Peer Review and Credentialing Policy Committee or Hearing Panel, including, but not limited to:

- Decisions to accept, deny, restrict or terminate participation.
- Decisions to offer or deny a hearing to an Applicant.
- Decisions regarding National Peer Review and Credentialing Policy Committee reconsideration.
- Decisions regarding corrective action.

Section 9.5—Reporting Requirements.

A. NPDB Reporting

The HCQIA requires health care entities to report to the NPDB certain professional review actions (“Adverse Action Reports”) with a copy of the NPDB report required to be filed with the applicable licensing board. Health care entities are required to report such actions for physicians and dentists. Health care entities may report such actions on other health care practitioners. It is UnitedHealthcare's policy to file NPDB reports, as appropriate, on all LIPs.

1. Reportable Actions

Actions taken by the Peer Review Committee or National Peer Review and Credentialing Policy Committee that fit into either of the following categories must be reported:

- › A professional review action based on the LIP's professional competence or professional conduct that adversely affects his or her clinical privileges for a period of more than 30 days.
- › Acceptance of the surrender or restriction of clinical privileges (1) while the LIP is under investigation or (2) in exchange for the health care entity not conducting an investigation relating to possible professional incompetence or improper professional conduct.
- › Revisions to any such actions described above.

The penalty to the health care entity for failing to make a required report is loss of immunity protection for three years. The Adverse Action Report must be submitted electronically to the NPDB with a copy sent to the applicable state licensing board.

The Health Care Quality Improvement Act leaves largely undefined the types of acts or omissions that relate to “competence or professional conduct.” The Act, however, makes it clear that certain factors, such as membership in a professional society, fees, advertising practices, competitive acts intended to solicit or retain business, or support for allied health professionals do not relate to professional competence or conduct. Failure to attend staff meetings or to complete medical records are not viewed as related to competence or professional conduct, unless they reach the point of adversely affecting the health or welfare of patients. The legislative history of the Act indicates that felonies or crimes of moral turpitude, illicit transactions

Involving drugs, serious sexual offenses, violent behavior and other similar acts are activities that could adversely affect patients. The form for reporting adverse actions offers some additional guidance by listing adverse action classification codes for certain types of activities.

If the action being taken is solely because of the LIP's failure to meet the minimum administrative requirements for credentialing and recredentialing or the termination is solely based on contractual noncompliance or breach, the action is not reportable to NPDB. Even if the action is being taken because of professional competence or conduct, the action is only reportable if the action or recommendation will reduce, restrict, suspend, revoke, or deny the LIP's status as a participant for a period longer than 30 days.

Before taking a final action and submitting a report, the Credentialing Entity should contact the legal representative about offering the LIP an opportunity for a hearing and to determine if reporting is required.

2. Timing of Report

Under the regulations, reportable actions must be submitted to NPDB within thirty (30) calendar days from the date the final adverse action was taken.

3. Prior to Reporting

Credentialing Entities should contact their assigned legal representative for consultation and advice prior to any reporting action.

Section 9.6—Ongoing Monitoring.

A. Sanctions Monitoring.

State and Federal reports will be reviewed within thirty days of their release in order to identify Participating LIPs who have had OIG sanctions on Medicare or Medicaid participation, GSA debarments, or other sanctions against their license or certification. If Credentialing Entity identifies a professional license that is not valid, an OIG sanction on Medicare or Medicaid participation, GSA debarment, CMS Preclusion List or other sanction against a license or certification, action shall be taken as outlined in the pertinent Participation Agreement. Sanction monitoring, tracking and reporting will be done in accord with UnitedHealthcare's policy. (See Section 8.3 of the Credentialing Plan for a description of the appeal process for adverse actions based on credentialing and sanctions monitoring determinations.)

B. Quality Monitoring.

Credentialing Entity will monitor Participating LIPs and Facilities for complaints, potential quality concerns or identified adverse events. Identified concerns will be identified, tracked and resolved in accord with Credentialing Entity's policy.

Compliance with Participation Agreement. An Applicant for recredentialing must have demonstrated compliance with all terms of the Participation Agreement, specifically including successful participation in quality improvement initiatives or completion of individual action plans requested by Credentialing Entity.

C. Imminent Threats to Patient Safety.

When Credentialing Entity is notified of a publicly verifiable report that a government agency has initiated an investigation related to a Participating LIP, which raises concerns regarding the potential for imminent harm to the safety of members/enrollees (Accusation), the matter will be investigated pursuant to Imminent Threat to Patient Safety Policy (the Policy). The government agency investigations may include but are not limited to: licensing board investigations, arrests and indictments. The Accusation will be referred to the Medical Director when there is a potential risk to patient safety. Pursuant to the Policy the Credentialing Entity may take action up to and including a suspension of LIP's participation status when it determines that there is an imminent threat to patient safety. (See Section 9.4 of the Credentialing Plan for a description of the appeal process for adverse actions based on Quality of Care concerns.)

D. Quality Site Visit.

As required by Credentialing Authority, Credentialing Entity in conjunction with the UnitedHealth Quality of Care Department or its designee (collectively "QOC Department") monitors complaints concerning Participating LIPs/Facilities. Complaints about an office site and Facilities are recorded, investigated and appropriate follow-up is conducted to assure that Covered Persons receive care in a clean, accessible and appropriate environment.

Applicant must agree to allow the Credentialing Entity to conduct an office site visit of Applicant's practice, including, but not limited to, physical accessibility, physical appearance, adequacy of waiting and exam rooms, availability of appointments and adequacy of medical record-keeping and must receive a passing score for the site assessment and medical record keeping assessment. Applicants whose office site or facility does not meet thresholds for site assessment and medical record keeping assessment will be offered actions to improve office site and facilities and effectiveness of offered actions will be assessed at least every six months. Credentialing Entity, in conjunction with the QOC Department, will monitor complaints concerning Applicant's practice and document follow-up visits that have had subsequent deficiencies.

E. Quality and Efficiency Performance Management.

UnitedHealthcare has committed to our customers, consumers and care providers to support the Triple Aim of Improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health care. In order to drive continuous improvement in the quality (such as HEDIS or STARS measures) and efficiency of healthcare, the Credentialing Entity may, from time to time, send reports to Participating LIPs regarding the LIP's performance, as compared to peers. To support physicians in their efforts, when practice patterns are identified that may represent opportunities to improve quality, and reduce unwarranted variation, UnitedHealthcare will identify those practice patterns and provide identified physicians with the tools and information to improve resource utilization in a way that is consistent with evidence-based medicine guidelines. In the event that unwarranted variation does not improve UnitedHealthcare may take actions up to and including termination of participation status.

Section 9.7 – Use of Participating Facilities.

Participating LIPs must be able to show Credentialing Entity that for services performed in a facility, they have admitting privileges and perform such procedures in an in-network facility. In the event that the facility in which they treat UnitedHealthcare enrollees becomes out of network and is no longer contracted with United Healthcare, the Participating LIP is expected to find another in-network facility to which they will admit UnitedHealthcare enrollees and perform facility based procedures. UnitedHealthcare will monitor such activity. An LIP's network participation may be terminated in the event that they are found to have no admitting privileges at an in-network facility at which they are able to perform facility based procedures.

Section 10.0

Newly Merged Networks.

Section 10.1 – Newly Merged Networks.

Because the need to minimize disruption of services to Covered Persons often does not allow for an immediate Credentialing of all LIPs and Facilities in a Newly Merged Network, the "to be merged" entity's Credentialing and Recredentialing activities and delegation oversight will be reviewed to assess its ability to meet Credentialing Authorities and UnitedHealthcare's Credentialing standards. A Delegation Agreement between the Credentialing Entity and "to be merged" entity is not necessary unless otherwise required by Credentialing Authorities. If the "to be merged" Credentialing activities meet Credentialing Entity's standards, Credentialing Entity will place the LIPs and Facilities of the Newly Merged Networks on this Credentialing Plan's regular monitoring and Recredentialing schedule. If the "to be merged" entity's Credentialing plan was less rigorous than this Credentialing Plan, Credentialing Entity may place Newly Merged Network's LIPs and Facilities on an expedited Recredentialing schedule. In the event the "to be merged" entity's Credentialing activities do not meet Credentialing Entity's requirements, Credentialing Entity will require every LIP or Facility in the "to be merged" entity to meet the Credentialing requirements under this Credentialing Plan before becoming eligible to participate in its Network. LIPs and Facilities of Newly Merged Networks are subject to this Credentialing Plan.

Section 10.2 – Status of "merged" LIPs and Facilities.

Any acceptance of a LIP or Facility who was a participant in a Newly Merged Network into the Network is conditioned upon the LIP or Facility signing the pertinent Participation Agreement. The "merged" LIP or Facility is not considered a Participating LIP or Facility on the Decision Date or after special administrative review, and is not entitled to treat Covered Persons or receive payment from Credentialing Entity, until the Participation Agreement is signed or assigned to Credentialing Entity and the LIP's or Facility's contract and demographic information is entered into all pertinent information systems.

Section 11.0

Delegated Credentialing.

Section 11.1—Delegated Credentialing Authorized.

Credentialing Entity may delegate responsibility for specific Credentialing and Recredentialing functions to another entity (the Delegated Entity), although Credentialing Entity retains the ultimate right to sign a Participation Agreement with, reject, terminate or suspend LIPs or Facilities from participation in the Network.

Section 11.2—Credentialing Delegation Agreement.

Any delegation of responsibility by the Credentialing Entity must be evidenced by a Credentialing Delegation Agreement that requires compliance with Credentialing Authorities and includes, but is not limited to:

- The responsibilities of the Credentialing Entity and Delegated Entity;
- The activities delegated, including the responsibilities for any sub-delegated activities;
- The process by which the Credentialing Entity evaluates the performance of the Delegated Entity;
- The Credentialing Entity retains the right to approve, suspend and terminate LIPs or Facilities;
- The remedies, including revocation of the delegation, available to the Credentialing Entity if the Delegated Entity does not fulfill its obligations.

If the delegated activities include the use of Protected Health Information by the Delegated Entity, the Delegation Agreement must also include the necessary provisions as defined by Credentialing Authorities and the Health Insurance Portability and Accountability Act (HIPAA).

Section 11.3—Sub-delegation.

Under certain circumstances, Credentialing Entity may allow Delegated Entity to sub-delegate all or part of its Credentialing activities to another entity. Prior to any sub-delegation arrangement, Delegated Entity must enter into a Credentialing delegation agreement with the sub-delegate. The delegation agreement must meet the requirements of Credentialing Authorities and all Credentialing Criteria of this Credentialing Plan, including Credentialing Entity's right of final approval on any recommendations by the sub-delegate. The Delegated Entity must complete a preassessment, annual assessment and other audits of the sub-delegate for those activities it has sub-delegated to another entity in accordance with the requirements of this Credentialing Plan and Credentialing Authorities. Delegated Entity is responsible for receiving and reviewing reports on LIPs and Facilities Credentialed and Recredentialed by the sub-delegate for the delegated activities outlined in the Credentialing delegation agreement.

Credentialing Entity retains its responsibilities for conducting oversight of its Delegated Entities in accordance with Credentialing Authorities requirements.

Section 11.4—Preassessment Responsibilities of Credentialing Entity.

The Credentialing Entity will follow Credentialing Authorities' requirements for the preassessment evaluation review and analysis of an entity being considered for delegation.

Prior to execution of the Credentialing Delegation Agreement, Credentialing Entity shall complete a preassessment evaluation to determine the potential Delegated Entity's ability to meet Credentialing Authorities' and Credentialing Entity's standards for the functions being delegated. Credentialing Entity's preassessment responsibilities are outlined below:

A. NCQA Accredited or Certified potential Delegated Entities:

1. Verification of the potential Delegated Entity's accreditation or certification by NCQA.
2. A pre-delegation assessment of the potential Delegated Entity's ability to meet Credentialing Authorities' and Credentialing Entity's standards, including, but not limited to: Credentialing and Recredentialing policies and procedures, Credentialing and Recredentialing application and attestation, and other relevant Credentialing and Recredentialing

documents or files, including those related to suspension and/or restriction actions, termination and notification to authorities, confidentiality, provision for the protection of Protected Health Information, if applicable, and for the elements not certified or accredited by NCQA.

B. Non-NCQA Accredited or Certified potential Delegated Entities:

- Review of the potential Delegated Entity’s ability to meet Credentialing Authorities’ and Credentialing Entity’s standards, including, but not limited to: Credentialing and Recredentialing policies and procedures, Credentialing and Recredentialing application and attestation, and other relevant Credentialing and Recredentialing documents or files, including those related to suspension and/or restriction actions, termination and notification to authorities, confidentiality, provision for the protection of Protected Health Information, if applicable, and appeals.
- Review of the potential Delegated Entity’s methods and sources for collecting and verifying credentials.
- Review of the potential Delegated Entity’s blinded Credentialing Committee minutes.
- Policies and Procedures related to office site assessment and medical record-keeping assessment, if required by Credentialing Authorities.

Section 11.5—Annual Evaluation.

For Delegation Agreements that have been in effect for 12 months or longer, the Credentialing Entity will perform a file review and substantive evaluation of delegated activities against Credentialing Authorities’ and Credentialing Entity expectations. For NCQA accredited or certified Delegated Entities, the annual evaluation will include an evaluation of any elements not included in the Delegated Entity’s accreditation or certification, in accordance with NCQA requirements. An audit of the Delegated Entity’s documents and files for the Credentialing elements that have been NCQA certified or accredited is not required; however, Credentialing elements not accredited or certified by NCQA may require oversight for additional Credentialing Entity, state, federal, or other requirements.

Section 11.6—Review of Oversight and Monitoring Reports.

Credentialing Entity will review and analyze, at least semi-annually, reports that are designed to provide oversight and monitoring of the Delegated Entity. At a minimum, reports include a listing of newly Credentialed and terminated LIPs and Facilities and LIP and Facility demographic changes. Information about LIPs and Facilities must meet Credentialing Entity’s minimum database requirements. Reports should be submitted to the Roster Manager at delprov@uhc.com or to the email address provided to the Delegated Entity from the Roster Manager.

Section 11.7—Required Follow-up.

When Credentialing Entity’s preassessment or annual evaluations, or periodic monitoring, identify opportunities for Delegated Entity to improve its compliance with the Credentialing Delegation Agreement or Credentialing Authorities’ and Credentialing Entity’s expectations, Delegated Entity will develop a plan for improvement that includes its performance goals and time frames to achieve them.

Section 11.8—Process for Acceptance/Rejection of Delegated Entity’s Approved LIPs and Facilities.

Acceptance of the Delegated Entities’ approved LIPs and Facilities into the Credentialing Entity’s Network is contingent upon the Applicant signing a Participation Agreement or otherwise participating in the Network under another Participation Agreement as required by the Credentialing Entity.

Section 11.9—Credentialing and Recredentialing after Termination of Credentialing Delegation Agreement.

Upon termination of a Credentialing Delegation Agreement, Credentialing Entity will place the LIPs or Facilities in a queue for Recredentialing if the Delegated Entity provides Participating LIP and Facility Credentialing and Recredentialing files to the Credentialing Entity and the files are found to be compliant with Credentialing Entity requirements. If the Delegated Entity does not provide Credentialing and Recredentialing files, or the files do not meet Credentialing Entity requirements, LIPs or Facilities will be placed in a queue for initial Credentialing by the Credentialing Entity to be completed within six months of the

Credentialing Delegation Agreement termination date. Acceptance of Credentialing or Recredentialing of LIPs and Facilities from terminated Credentialing Delegation Agreements is contingent upon the Credentialing Entity's Network needs and the LIP's or Facilities willingness to sign a Participation Agreement.

Section 11.10—Procedure when LIP or Facility has Contracts with both Credentialing Entity and Delegated Entity.

In cases where a LIP or Facility is contracted with a Delegated Entity and also has a Participation Agreement with UnitedHealthcare, Credentialing Entity may accept the Credentialing of the Delegated Entity if Delegated Entity's Credentialing meets all the requirements of Credentialing Entity and Credentialing Authorities for the LIPs outlined in the Participation Agreements. The Delegated Entity maintains a Credentialing file and the Credentialing Entity maintains a participation contract file on that LIP or Facility.

Section 11.11—Delegated Functions.

Unless otherwise specified in a specific Credentialing Delegation Agreement, Credentialing activities described in Sections 4.0 (with the exception of 4.2.11 and 4.3), 5.0, 6.0, 7.1, 7.2, 8.0 and 11.0 under this Credentialing Plan shall be considered delegated. UnitedHealthcare will retain the responsibility to query the CMS Preclusion List.

Attachment A.

LIP Application Credentialing Criteria.

1. A release granting the Credentialing Entity permission to review the records of and to contact any professional society, hospital, insurance company, present or past employer, professional peer, clinical instructor, or other person, entity, institution, or organization that does or may have records or professional information about the Applicant.
2. A release from legal liability for any such person, entity, institution, or organization that provides information as part of the application process.
3. The Application must include information on the type of professional license(s) or certification(s) held, the state where issued, certification and/or license number, effective date, and date of expiration.
4. A copy of the Applicant's current Drug Enforcement Agency ("DEA") and Controlled Dangerous Substance ("CDS") Certificate in each state where the Applicant intends to practice, if applicable.
5. A five year professional liability claims history that resulted in settlements or judgments paid by or on behalf of the Applicant, and history of liability insurance coverage, including any refusals or denials to cover Applicant or cancellations of coverage.
6. Educational history and degrees received relevant to the Applicant's area of practice, licensure, or certification, including dates of receipt. Not required at the time of recredentialing unless it has changed and will impact the LIP's specialty.
7. A listing of degrees or certifications received from appropriate professional schools, residency training programs, or other specialty training programs appropriate for the type of participation sought, if applicable. Not required at the time of recredentialing unless it has changed and will impact the LIP's specialty.
8. A listing of professional licenses received, whether current or expired, and licensing history, including any challenges, restrictions, conditions, or other disciplinary action taken against such license or voluntary relinquishment of such licensure.
9. Current certifications, where such certification is required, for participation in Medicare, Medicaid, or other federal programs and certification history for such participation, including restrictions, conditions, or other disciplinary action.
10. A five year employment history, including periods of self-employment and the business names used during this time, and a history of voluntary or involuntary terminations from employment or professional disciplinary action or other sanction by a managed care plan, hospital, other health care delivery setting, medical review board, licensing board, or other administrative body or government agency.
11. A completed Application, including a signed statement, which may be in an electronic format, attesting to:
 - a. Hospital admitting privileges, or coverage arrangements.
 - b. Applicant's current professional liability insurance policy, including the name of insurer, policy number, expiration date, and coverage limits;
 - c. Limitations on ability to perform functions of the position with or without accommodation;
 - d. History of loss or limitation of privileges or disciplinary activity;
 - e. Absence of current, illegal drug use;
 - f. History of loss of license and felony convictions; and
 - g. Completeness and accuracy of the information provided in the Application.

Authorization to allow Credentialing Entity to conduct a review, satisfactory to Credentialing Entity, of Applicant's practice, including office visits, staff interviews, and medical record-keeping assessments, in accordance with Credentialing Authority.

Any other documents or information that the Credentialing Entity determines are necessary for it to effectively and/or efficiently review the Applicants' qualifications.

**The State and Federal Regulatory Addendum will include any state-mandated Credentialing forms; use of those forms, and, if necessary, any additional questions/requirements or other additional information as permitted or required by Credentialing Authority. If no state-mandated form is required, the CAQH Universal Application form includes all these criteria.

Attachment B.

Site Assessment and Medical Record Keeping Assessment.

Credentialing/Recredentialing Requirements for LIPs.

All provider types as specified by Credentialing Authority will have an office site visit unless the office is located in an accredited or certified facility acceptable to the Credentialing Entity as outlined in Attachment C. The Credentialing Entity must verify accreditation or certification.

Any failed site visit will result in the Applicant being required to re-apply for credentialing after at least six months have passed. The Credentialing Entity or Delegated Entity may agree to permit an Applicant to re-apply for credentialing prior to the six month wait period if the Applicant can first demonstrate improvements in the areas found deficient by providing documentation of such improvements in an improvement action plan. If the Credentialing Entity or Delegated Entity accept the improvement action plan, the Applicant must agree to allow the Credentialing Entity or Delegated Entity to conduct an office site visit of Applicant's practice, including staff interviews, and medical record-keeping assessments, as further documented in Attachment B, and must receive a passing score for the site visit as part of the initial Credentialing Criteria.

Any failed site visit at the time of Recredentialing will require the LIP to demonstrated demonstrate improvements in the areas found deficient by providing documentation of such improvements in an improvement action plan.

Credentialing/Recredentialing Site Assessment Criteria and Credentialing/ Recredentialing Medical Record-Keeping Assessment.

- An office site visit must include a separate threshold for Medical Record-Keeping and Site Assessment as well as a composite score of the following:
 - Physical accessibility to the building, exam rooms, and bathrooms including accommodations for the handicapped.
 - Physical appearance to provide a safe clean environment for patients, visitors and staff
 - Adequacy of waiting room space to accommodate the average number of patients seen per LIP per hour
 - Adequacy of exam room space including provisions for privacy during examinations or procedures
 - Availability of appointments if applicable
 - Adequacy of medical/treatment record-keeping

The Credentialing Entity will conduct an assessment of the medical record-keeping practices on all provider types as specified by applicable law or regulation or pursuant to Participation Agreement unless the office is located in an accredited or certified facility acceptable to the Credentialing Entity. The Credentialing Entity must verify accreditation or certification. A medical record-keeping assessment of one blinded medical record or one model medical record will be reviewed to address the extent to which medical record-keeping practices support the following:

- Confidentiality of the record
- Consistent organization of the record

Attachment C.

Facility Required Credentialing.

Facility	Most Common Accrediting Bodies
Hospitals	JC, AOA, HFAP, AAAHC, DNV NIAHO, CIHQ
Skilled Nursing Facility, Nursing Home	CARF, CHAPS, JC
Home Health Care	CHAPS, JC, ACHC
Surgi-Care Centers	AAAASF, AOA, HFAP, AAAHC, IMQ, JC
CMS Institutional Provider/Facility	Accrediting Body Or Alternative Certification
Hospice	ACHC, CMS Certification
Clinical laboratories	AABB, A2LA, ASHI, CAP, CLIA Certification*** COLA, JC, CMS Certification
Comprehensive outpatient rehabilitation facilities (CORF)	CARF, CMS Certification
Outpatient physical therapy providers	** , CMS Certification
Speech pathology providers	JC, CMS Certification
End-stage renal disease services providers	JC, CMS Certification
Outpatient diabetes self-management training providers	** , CMS Certification
Portable x-ray suppliers	ACR, CMS Certification
Rural health clinics (RHC)	*JC, CMS Certification
Federally qualified health centers (FQHC)	*JC, CMS Certification

* Individual physicians/providers will be credentialed if the FQHC or RHC is contracted for UnitedHealthcare Community Plan (Medicaid).

** Individual providers may be credentialed rather than the facility.

*** Evidence of acceptable accreditation or evidence of CLIA certification is required for all free standing commercial labs.

Acceptable Accreditation Entities:

AABB	American Association of Blood Banks/Immigration DNA Diagnostic Center
A2LA	American Association for Laboratory Accreditation
AAAASF	American Association for Accreditation of Ambulatory Surgery Facilities
AAAHC	Accreditation Association for Ambulatory Health Care
ACHC	Accreditation Commission for Health Care, Inc.
ACR	American College of Radiology
AOA	American Osteopathic Association
ASHI	American Society for Histocompatibility and Immunogenetics
CAP	College of American Pathologists
CARF	Commission on Accreditation of Rehabilitation Facilities
CHAPS	Community Health Accreditation Program
CIHQ	Center for Improvement in Healthcare Quality
COLA	Commission on Office Laboratory Accreditation
DNV NIAHO	Det Norske Veritas National Integrated Accreditation for Healthcare organizations
HFAP	Healthcare Facilities Accreditation Program
IMQ	Institute for Medical Quality
JC	Joint Commission

Organizations Not Accredited or Certified as noted above.

If the Organization is not accredited or certified by an agency recognized by the Credentialing Entity, a site visit of the organization prior to contracting is required by the Credentialing Entity. Results must be found to be satisfactory as defined by the Credentialing Entity.

In lieu of a site visit by the Credentialing Entity, a CMS or State quality review may be used if it is not more than three years old. The Credentialing Entity by virtue of approval of this Credentialing Plan has certified that CMS requirements for facilities fully meet the Credentialing Entities facility site requirements. The Credentialing Entity must obtain a copy of the CMS or State Agency’s report from the Facility.

Attachment D.

Facility Site Visits for Credentialing/Recredentialing.

If the Facility is not accredited or certified by an agency recognized by the Credentialing Entity, a site visit is required and the Facility must pass with at least 85% of the possible score. Any failed site assessment (defined as a less than 85% score) will result in the Applicant being required to reapply for credentialing after a waiting period of at least six months or the Facility can demonstrate improvements in the areas previously found deficient.

If a Facility has satellite facilities that follow the same policies and procedures as the provider, the organization may limit site visits to a main facility.

A site visit is not required if the facility is in a rural area, as defined by the U.S. Census Bureau, and the state or CMS has not conducted a site review.

If a CMS Institutional Provider/Facility type is not located in a rural area and is not CMS Certified then the provider may complete a self-assessment using United's Facility Site Visit tool.

The following minimum criteria must be reviewed:

- Physical accessibility to the building, exam rooms, and bathrooms including accommodations for the handicapped.
- Physical appearance to provide a safe clean environment for patients, visitors and staff.
- Adequacy of waiting and exam room space including provisions for privacy during examinations or procedures.
- Presence of medical equipment logs.
- Safety of medication administration including assessing expiration dates of medications and drugs including samples are inaccessible to patients or other unauthorized personnel.
- Office or facility staffing including the numbers, qualifications, competence and training of clinical staff.
- Acceptable verification of licensure for all licensed clinical staff with applicable licensing board.
- CLIA and/or appropriate radiology certification/licensure, if lab and or radiology services performed in the facility.
- Medical Staff Services or other credentialing and privileging policies for the Facility's LIPs.

Attachment E.

State and Federal Regulatory Addendum.

The attached State and Federal Regulatory Addendum includes credentialing requirement variation based on:

- State specific insurance and HMO regulation
- State Specific Medicaid regulatory or contractual requirements
- Federal requirements

UnitedHealthcare reserves the right to revise the Credentialing Plan and the associated regulatory amendments to comply with requirements of Credentialing Authorities.

Attachment F.

UnitedHealthcare Community Plan Peer Review Addendum.

This UnitedHealthcare Community Plan Peer Review Addendum replaces, for select UnitedHealthcare Community Plans, Sections 9.1 and 9.2 of the Credentialing Plan.

UnitedHealthcare Community Plan has the right to restrict, suspend or terminate any Licensed Independent Practitioner's or Facility's participation in the network for issues relating to the Quality Management Program, including Quality of Care Concerns (as defined in Section 2.0).

The Community Plan Quality Management (QM) staff will refer all potential Quality of Care Concerns to a UnitedHealthcare Community Plan Medical Director and/or designee. When a Quality of Care Concern is identified, the QM staff notifies the appropriate provider(s), including where appropriate the Medical Group for practitioners who participate under a Medical Group Agreement, and requests a response, along with any supporting documentation, within a specified period of time in accordance with the relevant State requirements.

UnitedHealthcare Community Plan may terminate a provider's (See Section 2.0 for definitions of UnitedHealthcare Community Plan and for Provider) participation in the network for failure to comply with certain contractual obligations or Quality Management requirements. Depending on the circumstances, termination may be immediate or allow for an appeals process.

UnitedHealthcare may immediately terminate a provider's participation in the network if it determines that immediate termination of the Provider's agreement with UnitedHealthcare is in the best medical interest of the members as in instances of imminent threat to an enrollee/member's safety. UnitedHealthcare Community Plan may also initiate termination proceedings for the provider's failure to implement and comply with his/her corrective action plan or refusal to make medical records available for examination.

In the case of immediate termination and terminations for failure to comply with Quality Management requirements Medical Director will send the provider a certified letter notifying him/her of the intent to terminate his/her network participation privileges. Terminations, suspensions and restrictions due to competence or professional conduct will be reported to the appropriate federal and state authorities, as required, including the National Practitioner Data Bank (NPDB), as appropriate and as outlined in Section 9.4.

Addition to Section 2.0 Definitions

"UnitedHealthcare Community Plan" refers to UnitedHealthcare's health plans and managed care organizations that hold contracts with various States to coordinate health care services for Medicaid and related government health care programs (including, but not limited to, Children Health Insurance Programs or CHIP, Family Health Plus Programs and certain Dual Eligible (Medicare and Medicaid) Programs).

UnitedHealthcare Community Plan "Provider" is any Licensed Independent Practitioner or Facility.