CREDENTIALING PLAN
SECTION ONE
INDIVIDUAL PROVIDERS

I. STATEMENT OF POLICY

A. The purpose of Avera Credentialing Verification Service (CVS) is to provide credentialing and recredentialing primary source credential verification services to contracted entity, according to JCAHO and NCQA Standards, for all existing practitioners and those seeking initial and renewal of clinical privileges or participation status with a contracted entity in accordance with term of a delegated agreement and applicable state laws

B. Avera CVS desires to credential providers who meet established credentialing standards. Enforcement of such credentialing standards is necessary to allow Avera CVS to represent to contracting groups that participating providers have been credentialed under such standards.

C. This CVS services shall include: (a) verification from original sources of practitioner's professional licensure, education, training and/or experience, malpractice claims history, professional review actions, and other items relevant to practitioner's credentials and qualifications. For every practitioner, CVS agrees to certify that all information was verified with primary sources and to indicate the date of the verification; (b) absent causes beyond control of CVS, CVS will provide the information in its possession regarding each practitioner on or before ninety (90) days following receipt by CVS of a completed request form from the contracted entity; (c) notification to contracted entity by CVS of licensure expiration, revocations, or sanctions imposed on practitioners will occur within two weeks of receipt by CVS; (d) CVS will act as a designated agent for the required National Practitioner Data Bank query and forward original response from NPDB to contracted entity; and CVS shall provide copies to contracted entity of all other primary source documents obtained by the CVS

D. The Credentialing Plan may be changed upon approval by the Credentials Committee and the Avera Health Plans Board of Directors. Any change in legal, regulatory or accreditation requirements shall automatically be incorporated into the Plan and all applicable policies and procedures as of the requirements effective date. Changes shall be effective for all new and existing providers from the effective date of the change.

II. SCOPE

A. The scope of the CVS is to provide timely credentialing verification services in a cost-effective manner and to serve as a physician centralized databank to the Avera Health system. The mission of the Avera CVS is realized by the following:

1. Centralized Credentials Verification
    - Provide centralized credentials documentation process for providers of the Avera Health System and other contracted entities.
    - To streamline and manage the essential credentialing elements and eliminate redundancy. The credentialing program involves the initial and ongoing collection, verification, and review of information necessary for selection and retention of providers meeting Avera CVS credentialing standards.
2. Centralized Physician Database Visual Cactus
    - Provide a centralized practitioner database for use by the Avera Health System facilities and departments
3. Credentialing Research and Education
    - Offer credentialing education programs and industry research to meet accreditation standards for the Avera Health System facilities
    - Research credentialing issues in response to the needs of MSOs for accreditation standards, legal issues, and national trends in credentialing practices.
4. Credentials Compliance Monitoring
    - Monitor compliance with accreditation standards, state and federal regulations, laws and managed care health plan delegated credentialing agreements
    - Standardize compliance processes with input from corporate compliance, risk management, and legal counsel.

B. Only those providers meeting Avera CVS Criteria for Participation are included. In addition to the credentialing standards, selection criteria may be considered in contracting with providers. Providers are credentialed prior to approval of clinical privileges and/or acceptance into the network and at a minimum every twenty-four (24) months.

C. Avera CVS credentialing program applies to physicians and certain other independent practitioners (those permitted by law to provide patient care without direction or supervision) who wish to provide services in a contracted facility or contract for the network. Certain allied health practitioners who cannot practice independently are also subject to credentialing. Providers included are:

1. Physicians (MD and DO)
2. Physician Assistants
3. Advanced Registered Nurse Practitioners
4. Chiropractors

5. Podiatrists
6. Masters Level Behavioral Health Providers
7. Licensed Psychologists
8. Optometrists
9. Dentists/Oral Surgeons
10. Physical Therapists
11. Occupational Therapists and Audiologists
12. Speech Therapists
13. Board Certified Behavior Analysts
14. Genetic Counselors

III. OBJECTIVES. Avera Health System has designed and implemented a comprehensive Credentials Verification Service (CVS), providing verification of education, training experience, licensure, adverse actions and sanctions on all independent and allied health practitioners practicing in our Avera contracted entities. This information is used by Avera facilities for decisions on initial applications and at least every two years, to assure that the practitioners possess the credentials to provide patients with the quality of care consistent with the mission of each participating organization.

In addition, the CVS have been designed and implement to assure that requirements of regulatory and licensing agencies are met. Avera CVS strives to meet NCQA and JCAHO standards and the requirements of the State of South Dakota. Credentials verification services are provided for any Avera facility that is interested in participating and other organizations that have established delegated credentialing agreements.

The CVS also maintains a comprehensive database of pertinent information about providers practicing in the Avera Health system. This database provides individual and summary information for both internal and external use, including physician demographic information, medical staff analysis and planning information, and regulatory reporting.

IV. CRITERIA FOR PARTICIPATION

A. Providers are credentialed using criteria designed to assess the qualifications and background that impact their ability to deliver care. Criteria includes, but not limited to evaluation of their licensure, training and experience, current competence, practice history, disclosure of any reasons for an inability to perform the essential functions of his/her position, with or without accommodation, evidence of substance abuse and personal knowledge of an applicant by a member of the Credentials Committee. During the recredentialing process, additional information derived from Avera Health and Avera Health Plans experience with the provider may also be assessed. This may include but not limited to complaints, out of Network referrals, and utilization management statistics.

B. Avera CVS has developed criteria for all providers as defined in II. Scope. The specific criteria and verification requirements for each type of provider can be found under the Section Seven, Criteria for Participation.

V. NON DISCRIMINATION. Participation in Avera CVS contracted facilities shall not be denied on the basis of sex, race, age, creed, national origin, or disability unrelated to the capability to fulfill the duties and responsibilities of the provider's profession and the Plan Participating Provider Agreement per Avera Health Plans Credentialing Policy CRD-021-03

VI. CONFLICT OF INTEREST. The process of evaluating a provider's credentials requires objective assessment of the provider's qualifications and factual presentation of relevant information. To that end, an Avera CVS employee or a Credentials Committee member who is a partner, associate, relative, employee, employer or in direct economic competition is expected to abstain in the investigation, deliberations, or votes regarding such applicant if the employee or committee member believes participation in the process represents a conflict of interest. The President or Medical Director can excuse the employee or Committee member from participation if the President or Medical Director is aware that a conflict of interest may exist.

VII. ACCOUNTABILITY OF CREDENTIALING

A. Avera Health Plans Board of Directors. Policies and procedures regarding credentialing are approved by the Board and reviewed on an annual basis. The Avera Health Plans Board of Directors has the authority for approval or denial of providers' participation. Other Avera CVS affiliated networks (e.g. Avera CVS of Minnesota, Avera CVS Benefit Administrators, Avera Health Managed Care Network) have also delegated their respective credentialing authority to the Avera Health Plans Board of Directors

B. Credentials Committee

1. Authority. The Credentials Committee is accountable to the Avera Health Plans Board of Directors. The Credentials Committee operates as a peer review organization pursuant to state and federal laws and professional review organizations pursuant to the Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11101 et seq. Recommendations for participation will be presented to the Board.

2. Committee Membership

a. The Credentials Committee consists of not less than four (4) providers selected by the Medical Director from the Avera Health Plans panel of Participating Practitioners and includes, but is not limited to, providers from multiple disciplines including medicine, podiatry, optometry, behavioral health, and advanced nursing practice.

b. The Medical Director is the Chairperson of the Credentials

Committee and is a voting member.

c. Ex-officio non-voting membership shall include, but not limited to the Chairperson of the Board and the Director of Network Services and Director of Managed Care Services.

3. Meetings. At a minimum, meetings are held monthly. Meetings are held more often at the call of the Chairperson. Minutes are recorded for all meetings.

4. Quorum and Voting. The presence of 50% or more of the Committee members at any meeting shall constitute a quorum. Each member shall be entitled to one vote. The majority vote at a meeting where a quorum is present shall be the action of the Credentials Committee. In case of equality of votes, the chair of the Credentials Committee shall have a second or deciding vote.

5. Consultation. The Credentials Committee may, at its discretion, request advice and consultation regarding an applicant's credentials or professional practice history from appropriate Plan Providers whose specialty or discipline is not represented on the Committee.

6. Functions. The Committee functions are as follows:

a. Develop and administer the Avera Health Plan's Criteria for Participation.

b. Establish a provider-credentialing program for the purpose of evaluating provider's qualifications and compliance with the Criteria for Participation.

c. Adopt and implement a Policy and Procedure Manual (the "Credentialing Manual") for Provider Credentialing in accordance with the Credentialing Plan.

d. Review the credentials of practitioners who do not meet the AHP Level 1 Credentialing Criteria

e. Review and take action on recommendations from the Utilization Management Committee for imposing sanctions on a physician for noncompliance with utilization review procedures or unacceptable practices.

f. Review and take action on patient complaints related to network providers involving quality of care, clinical practice, or referral patterns.

g. Review and make final determination on reconsideration requests of providers denied or terminated due to failure to meet the Criteria

for Participation.

h. To evaluate the Provider Credentialing Plan and make recommendations for changes to the Board of Directors.

Reporting annually, and more often as required, to the Board of Directors regarding the credentialing process to include number of applications received, number of providers approved, number of denials, number of reconsiderations, and the results of the reconsiderations, or any other information requested by the board.

C. Medical Director/Chief Medical Officer or equally qualified physician. The Medical Director/CMO or equally qualified Physician is responsible for the overall program of provider credentialing to include:

1. Chairperson of the Credentials Committee.
2. Responsible for all clinical aspects of the credentialing and recredentialing process.
3. Review for approval provider applications that meet both AHP Level 1 and Level 2 Credentialing Criteria.
4. Interfacing and communicating with applicants regarding credentialing and recredentialing issues and problems.
5. Select, train, and monitor members of the Credentials Committee.
6. Participate in the reconsideration process of any denied or terminated provider.
7. Serve as liaison between participating providers and Avera CVS in the credentialing process
8. Leads Avera CVS in overseeing the activities of delegates performing credentialing and recredentialing activities.

D. Credentialing Coordinator. Responsible for administration of the credentialing program. Ensure credentialing procedures are carried out in a consistent, accurate, and complete manner through training, documentation, and quality assurance/improvement activities. Report any provider who does not meet the Criteria for Participation to the Medical Director and the Credentials Committee for their consideration and determination of waiver. Ensure credentialing program compliance to assure the credentialing activities are complete and effective and report results of monitoring activities to Credentials Committee on regular basis. Coordinate the timely and appropriate flow of information between appropriate departments.

E. Credentialing Specialists: Implement the credentialing process under the direction of the Credentialing Coordinator. Verify and investigate the credentials for all providers making application to Avera CVS for the purpose of determining the providers' compliance with the Criteria for Participation.

F. Health Services Division. Evaluates quality of care and services provided to members through on-site office visits, medical record surveys, and

compliance with preventive health measures. Tracking, documenting, and responding to member complaints regarding quality of provider services.

G. Appeals Committee: An Appeals Committee shall be composed of no fewer than three (3) individuals selected on an ad hoc basis the Medical Director or his/her designee. The Appeals Committee shall hear selected appeals from practitioners after the Credentials Committee has recommended denial or termination of participation status or other discipline based on professional conduct or competence. The Appeals Committee may conduct hearings and recommend upholding, rejecting, or modifying the recommendations of the Credentials Committee and may exercise other powers given to it by the Avera CVS Board of Directors. Avera CVS shall use its best efforts to ensure that the majority of the members of the Appeals Committee are peers of the practitioner who is the subject of the hearing, but who are not in direct economic competition Members of the Appeals Committee may be network practitioners or members of Avera Health Plan's Pharmacy and Therapeutics Committee, Utilization Management Committee and;/or Regional Care Councils. Members of the Appeals Committee for any particular appeal will be individuals who are not, in the judgment of Avera CVS in direct economic competition with the practitioner who is subject of the hearing. Avera CVS employees, Credentials Committee members and members of the Avera CVS Board of Directors shall not serve on the Appeals Committee. The Appeals Committee shall elect a chairperson from among its members.

H. Hearing Officer: The Hearing Officer will be appointed by Board of Directors and who is not in direct competition with the Applicant or Provider involved.

VIII. PROCESS TO AMEND CREDENTIALING PLAN. The Credentialing Plan and Policies are reviewed annually and amended as necessary. Revisions are based on national accreditation standards and Avera CVS business needs and requirements. The following process is employed:

A. Review of the Credentialing Plan by Director of Managed Care Services and other relevant authorities.

B. Presentation of the Credentialing Plan with any recommended changes to the Avera Credentials Committee for review, modification, and approval.

C. Presentation of the Credentialing Plan approved by the Credentials Committee to the Avera Health Plans Board of Directors.

IX. CREDENTIALING PROCESS

A. Initial Credentialing

1. Applications

a. Applicants for participation in Avera CVS must complete an application on a prescribed application form - either an Avera

CVS application form, or an application form approved by Avera CVS.

b. Supporting documentation must be included with the application and consists of the following:

    i. Copy of current state professional licenses and/or certificate showing expiration date. Copy of license/certificate required for each state where the practitioner intends to provide covered services.
    ii. Copy of current professional liability insurance certificate in an amount not less than $1,000,000 per occurrence and $3,000,000 aggregate through provide insurance coverage or through a combination of private insurance and state sponsored coverage.
    iii. Copy of current Federal Drug Enforcement Agency (DEA) registration, if applicable.
    iv. Copy of current state controlled substance license, if applicable.
    v. Copy of documentation for board certification, if applicable.
    vi. Work history, at a minimum a 5 year work history included on application or curriculum vitae (CV) and must be in mm/yy format.

c. The provider must complete the 'Questionnaire' section of the application concerning any sanctions including, but not limited to, loss of licensure, loss or limitation of hospital privileges, history of felony convictions, or any disciplinary actions. The provider must disclose any reasons for an inability to perform the essential function of the position, with or without accommodation, and any current substance abuse. The provider must furnish a detailed written description of the circumstances surrounding any affirmative response to questions in the 'Questionnaire' section of the application or any other such questions on any other Avera CVS approved application.
d. An attestation by the applicant to the correctness and completeness of the application must be signed and dated. The applicant also signs and dates a release allowing Avera CVS to verify and investigate credentials. Faxed, digital, electronic, scanned or photocopied signatures are acceptable, but signature stamps are not accepted.
e. Applications are not accepted and are closed and returned to the provider with a written explanation as to the reasons for non-acceptance under the following circumstances:

    i. The application is from a type of provider that Avera does not include in the network.

ii. The applicant does not have a valid license to practice.
iii. The applicant does not meet the minimum liability insurance requirements.
iv. Avera has met network access needs for provider type in accordance to selection factors (Sec 3).

f. Incomplete applications are held open for 30 days to allow the applicant an opportunity to supply any required missing information or documentation. This would include, but is not limited to, the following:

i. The provider has not provided an explanation for any affirmative response to questions in the 'Questionnaire' section of the application, or any other such questions on any other Avera CVS approved application.
ii. The provider has not provided necessary copies of documents such as license, insurance certificates, board certification certificates, work history, etc.
iii. The 'Questionnaire' section of the application is not completed.
iv. The application 'Release and Attestation' is not signed and dated. Stamped signatures are not accepted.
v. The provider has failed to comply with any other procedure or provide any other information necessary to process the application.

g. Application processing will not begin until all missing documentation/information is received in Avera CVS office. If information is not received within 30 days of the request for missing/additional information, the application is considered withdrawn and returned to the provider.

2. Credentials Verification. Credentials verification is conducted to ensure the information furnished by the provider is complete, current, and accurate.

a. Avera CVS verifies through primary and/or secondary sources the following items, when applicable to the provider:

i. Licensure
ii. DEA/CSR
iii. Professional Liability Coverage
iv. Board Certification
v. Education/training
vi. Post-graduate training
vii. Clinical privileges
viii. Professional liability claims history
ix. Work history

b. In addition, information regarding the provider is obtained from the following, as applicable:

   i. National Practitioner Data Bank
   ii. Federation of State Medical Boards
   iii. Federation of Chiropractic Licensing Boards
   iv. Federation of Podiatric State Medical Boards
   v. Healthcare Integrity and Protection Data Bank (HIPDB)
   vi. Other credible information made known to Credentials Committee Members.

c. The specific criteria and verification requirements for each type of provider can be found under the Section Seven, Criteria for Participation.

d. Time sensitive factors, such as verifications cannot be more than 180 days old at the time of approval as specified in the "Administrative Work Instructions (CRDWI-002).

3. Office Site Quality Review

Avera has adopted the NCQA standards and performance thresholds for the offices of all providers. These standards assure practitioners meet standards for: physical accessibility, physical appearance, adequacy of waiting and exam room space, availability of appointments and adequacy of medical/treatment record keeping practices. Avera can conduct office site quality reviews as a mechanism to verify office standards and performance thresholds are met. The office site quality reviews can be incorporated into the credentialing decision making, quality improvement and performance monitoring processes. Office site visits can also be conducted to practitioners whom relocate their practice locations.

Upon initial contact with applicant, the Office Site Quality standards and sent to the provider, Exhibit C of the standards contains an Office Site Quality Review Agreement that must be signed and returned to the CVS to become part of the practitioner's electronic record and paper file.

Member Complaint

For a location that receives a member complaint as outlined in policy CRD-008, an Office Site Quality Review will be conducted accordingly. If deficiency is identified the CVS will outline the quality improvement activities and the provider's office must implement an action plan to comply within six months of the initial visit.

4. Credentialing Decision

   a. Credentialing Information Time Limits

i. All credentialing information must be available to the Credentials Committee or its designee at the time a decision regarding participation is made except as outlined under XX. Provisional Credentialing for Physicians. Under no circumstances will a provisional status be offered in lieu of complete credentialing information and completion of the credentialing process.

ii. To assure the Credentials Committee has current information regarding a provider's credentials, verifications must be completed within the time limits specified in the "Administrative Work Instructions (CRDWI-002).

b. Streamlined Credentialing

i. "Streamlined Credentialing" refers to the process used a Avera CVS discretion when a practitioner subject to the Credentialing Plan has submitted all required application materials to Avera CVS. Avera CVS Credentialing staff has determined that such a practitioner meets all of the participation criteria set forth in Section Seven Level One and Level Two category for practitioner appropriate specialty, and Avera CVS has the capability to complete the credentialing process for the practitioner before the next scheduled Credentials Committee. Such a practitioner's completed application and supporting documentation shall be submitted for review by the Medical Director on behalf of the Credentials Committee. An applicant desiring streamlined process review must be in good standing at a participating facility or clinic.

ii. Streamlined Process Review". An applicant must submit a completed application form, signed release, and a signed attestation and must supply any additional information requested by the Medical Director. The Medical Director may approve an applicant for participation in the event the Medical Director determines such practitioner meets all of the participation criteria set forth in Section Seven Level One and Level Two category. In the event the Medical Director does not approve a practitioner's application for participation, such application shall proceed to the Credentials Committee for review.

c. Credentials Committee Review

i. The Credentials Committee reviews completed applications. In order to be eligible for participation, the provider or, in the case of a group of providers i.e., group practice, PHO, IPA, independent network, or any other organized arrangement of providers, each individual provider who has a contract to provide professional services through such group, and for whom the group desires to provide Covered Services under Avera CVS, must continuously meet all the criteria designated as Level I. The provider must meet criteria designated as Level II, unless the Board, after full disclosure by the provider and a recommendation from the Credentials Committee, waives such requirement.

ii. Upon review of the applications, the Committee makes the following recommendations:

(a) The applicant has met Level I and Level II criteria to be approved for participation, or
(b) The applicant has met Level I criteria, has not met all Level II criteria, however a waiver is granted; and the applicant is recommended for approved for participation, or
(c) The applicant has met Level I criteria, has not met all Level II criteria, a waiver is not granted; and the applicant is recommended for denial for participation, or
(d) Additional information is needed before further evaluation can be completed.

c. Granting of Waiver

i. Waivers may be granted to providers who do not meet Level II criteria if, based on the Credentials Committee evaluation, it does not appear that the applicant's ability to perform professional duties is impaired and it does not appear there is likelihood of probable future substandard performance or the Committee believes sufficient monitoring, evaluation, and corrective action is in place by regulatory or other such entity with authority over the provider.

ii. The Committee can request review of a provider's credentials, as often as deemed necessary to assure there is not a pattern of potentially substandard performance.

d. Approval of Participation. The recommendation date of the Medical Director or Credentials Committee is used as the effective date of the provider's participation and the provider is sent written notification of the approval within 10 calendar days of the approval. The recommendation then is presented to the Board of Directors for final ratification. Providers also receive a signed Provider Agreement and a Provider Manual when applicable.

e. Denial of Participation. New applicants whose participation is denied are notified via certified mail of the denial and the basis for the decision within ten working days of the denial. A description of the reconsideration procedures is included in the letter.

f. Reconsideration. An applicant whose application is denied based on the Criteria for Participation is offered an opportunity to request reconsideration. The provider must make known to the Medical Director thirty- (30) days after notice of the denial of the desire to request reconsideration. The notice must be in writing and must specify the reasons why the applicant believes the Criteria for Participation has been met and may include any supplemental information. The reconsideration is to the body that determined the Criteria for Participation were not met, that being either the Credentials Committee or the Board of Directors, as appropriate. The Credentials Committee or the Board of Directors may appoint a committee or an individual to consider the applicant's reconsideration and make a recommendation to the Credential Committee or the Board, and such committee or individual may in its discretion meet with the applicant or others with relevant information and require the applicant to submit additional information. Upon receipt of a recommendation from such committee or individuals, the Credentials Committee or the Board of Directors makes its decision, and notifies the applicant in writing. The decision is final and not subject to further review or appeal. There is no appeal for denials based on selection factors. Providers are evaluated on an individual basis.

g. Group Practice of Physicians or Practitioners. When a group practice of physicians or other practitioners (whether organized as a partnership, professional corporation, nonprofit corporation, business corporation, or limited liability company) applies to participate as a Participating Provider with Avera, an application is completed for each physician or practitioner who provides professional services through such group practice and for whom the group practice desires to provide covered services. Avera CVS determines whether each individual meets the Criteria for Participation, and the Provider

Agreement applies only to those individuals who meet the Criteria for Participation.

h. Reapplication after Denial of Participation. An applicant whose application has been denied may not reapply for participation until twelve (12) months after the decision denying the application has become final. After the twelve (12) month period, the provider may submit an application for participation, which shall be processed as an initial application. Such an applicant must furnish evidence that the basis for the denial no longer exists and/or satisfactory evidence to the Credentials Committee that would allow them to grant a waiver and approve the applicant's participation.

B. Recredentialing

1. Automatic Expiration Unless Renewed. Participation with Avera generally extends for a no more than a 36 month cycle pursuant to a cycle established for each Provider. Participation automatically expires at the end of such period unless renewed by Avera and/or contracted entity. Prior to renewal of participation, Avera CVS formally recredentials the provider for the purpose of establishing whether the provider continues to meet the Criteria for Participation.

2. Requests for Renewal of Participation

a. A renewal application (Recredentialing Application) is mailed to the provider at least one hundred twenty (120) days before the expiration of the last credentialing date.

b. The provider is asked to update the demographic information on the application. In addition, the provider is required to disclose any reasons for an inability to perform the essential functions of the position, with or without accommodation, and any current substance abuse. Other areas covered include, but are not limited to, sanctions in relation to licensure, professional liability claims, felony convictions, hospital privileges, and other disciplinary actions occurring since last credentialing period.

c. An attestation by the applicant to the correctness and completeness the application must be signed and dated. The applicant also signs and dates a release allowing Avera CVS to verify and investigate credentials. Faxed, digital, electronic, scanned or photocopied signatures are acceptable, but signature stamps are not accepted.

d. A detailed explanation of any affirmative response to the questionnaire, the updated renewal application, supporting

documentation, and the release and attestation must be submitted to the offices of Avera CVS thirty (30) days from the date the renewal application was mailed to the provider.

e. Supporting documentation required for recredentialing includes:

   i. Copy of current state professional license and/or certificate showing expiration date. Copy of license/certificate required for each state where the practitioner intends to provide covered services.
   ii. Copy of current professional liability insurance certificate in an amount not less than $1,000,000 per occurrence and $3,000,000 aggregate through provide insurance coverage or through a combination of private insurance and state sponsored coverage.
   iii. Copy of current Federal Drug Enforcement Administration (DEA) registration, if applicable.
   iv. Copy of current state controlled substance license, if applicable.
   v. Copy of documentation for board certification, if applicable.
   vi. Work history since last credentialed.

3. Failure to Respond. Follow up is conducted on renewal applications not received within thirty (30) days. Follow up procedures include:

   a. Second Request. A second request is sent to the provider if the renewal application is not received within thirty (30) days of the original mailing date. The provider is asked to submit an application within fifteen (15) days from the date of the second request.

   b. Third Request. A third and final request is sent fifteen (15) days after the second request. The third and final request is sent certified mail with notification that participation is subject to termination if the application is not received within thirty (30) days.

   c. Notice of Termination. Failure to respond to the third request will result in termination of the provider's participation. Upon reaching the end of the credentialing cycle, the practitioner's participation status/privileges would be allowed to expire without further notification.

4. Incomplete Applications

a. Incomplete applications are held open for thirty (30) days from receipt to allow the applicant to supply any required information or documentation that is missing. This would include, but is not limited to, the following:

    i. The provider has not documented the circumstances surrounding any affirmative response to questions in the 'Disclosure Questionnaire' section of the application, or any other such questions on any other Avera CVS approved application.
    ii. The provider has not included with the application required copies of documents such as license, insurance certificates, board certification certificates, work history, etc.
    iii. The 'Questionnaire' section of the application is not completed.
    iv. The application 'Release and Attestation' is not signed and dated. Stamped signatures are not accepted.
    v. The provider has failed to comply with any other procedure or provide any other information necessary to process the application.

b. Application processing will not begin until all missing documentation/information is received in Avera CVS office. If information is not received within thirty (30) days of the request for missing/additional information, the provider shall be treated as having withdrawn the request for Renewal of Participation and will be terminated according to the terms and conditions of the Plan Provider Agreement.

5. Credentials Verification. Credentials verification is conducted, as part of the renewal process to ensure the information furnished by the provider is complete, current and accurate.

    a. Avera CVS verifies the following items, when applicable to the provider:
        i. Licensure
        ii. DEA/CSR
        iii. Professional Liability Coverage
        iv. Board Certification
        v. Clinical privileges
        vi. Professional liability claims history

    b. In addition, information regarding the provider is obtained from the following, as applicable:

        i. National Practitioner Data Bank
        ii. Federation of State Medical Boards
        iii. Federation of Chiropractic Licensing Boards

iv. Federation of Podiatric State Medical Boards
v. Healthcare Integrity Protection Data Bank (HIPDB)
vi. Other Credible information made known to the Credentials Committee Members

c. The specific criteria and verification requirements for each type of provider can be found under the Section Six, Criteria for Participation.

d. To assure the Credentials Committee has current information regarding a provider's credentials, verifications must be completed within the time limits specified in the "Administrative Work Instructions (CRDWI-002).

e.

6. Medical Record Reviews

a. Medical record reviews are completed for all practitioner specialties.

b. Medical record reviews are ongoing, in order to identify and trend patterns, benchmarking, and for identifying Quality of Care issues or potential Quality of Care issues. Reports are provided quarterly by the Utilization Management organization for tracking purposes and Quality of Care and Case Reviews are managed through the Credentials Committee, in accordance to Administrative Work Instruction, CRDWI-024

7. Recredentialing Decision

a. Recredentialing Information Time Limits

i. All recredentialing information must be available to the Committee at the time a decision regarding renewal of participation is made.
ii. To assure the Credentials Committee has current information regarding a provider's credentials; verifications must be completed within the time limits specified in the Credentialing Plan and Policies. .

b. Credentials Committee Review

i. The Credentials Committee receives and must review at a minimum, the credentials of practitioner's that do not meet the organizations's established criteria . In order to be eligible for continued participation, the provider or, in the case of a group of providers i.e., group practice, PHO, IPA, independent network, or any other

organized arrangement of providers, each individual provider who has a contract to provide professional services through such group, and for whom the group desires to provide Covered Services under Avera CVS, must continuously meet all the criteria designed as Level I. The provider must meet criteria designated as Level II, unless the Board, after full disclosure by the provider and a recommendation from the Credentials Committee, waives such requirement.

ii. Upon review of the renewal applications, the Committee makes the following determinations:

(a) The applicant continues to meet Level I and Level II criteria and is approved for continued participation, or
(b) The applicant continues to meet Level I criteria, does not met all Level II criteria, however a waiver is granted; and the applicant is approved for continued participation, or
(c) The applicant continues to meet Level I criteria, does not meet all Level II criteria, a waiver is not granted, and the applicant is denied continued participation, or
(d) Additional information is needed before further evaluation can be completed.

iii. In addition to the criteria for participation, data regarding member complaints, utilization management statistics, referral patterns, and medical record/site surveys (as applicable) may be incorporated in the decision making process. Along with the recredentialing decision, the committee may recommend initiation of corrective action and/or monitoring of a provider when applicable.

c. Granting of Waiver

i. Waivers may be granted to providers who do not meet Level II criteria if, based on the Credentials Committee evaluation, it does not appear that the applicant's ability to perform professional duties is impaired and it does not appear there is a likelihood of probable future substandard performance or the committee believes sufficient monitoring, evaluation, and corrective action is in place by regulatory or other such entity with authority over the provider.

ii. The committee can request review of a provider's credentials as often as deemed necessary to assure there is not a pattern of potentially substandard performance

d. Approval of Continued Participation. When deemed appropriate by the Committee , providers are notified of any corrective actions necessary or any corrective actions or areas of concern such as a pattern of out of network referrals, office or medical record corrective actions, etc. This notification will be sent within 10 day of approval, otherwise the providers participation is documented in the providers credentials file.

e. Denial of Continued Participation. Providers whose continued participation is denied are notified via certified mail of the denial and the basis for the decision within five working days. A description of the reconsideration procedures is included in the letter. Providers are terminated in accord with the terms and conditions of the Plan Practitioner Agreement.

f. Reconsideration. An applicant whose application for renewal is denied based on the Criteria for Participation is offered an opportunity to request reconsideration. The provider must make known to the Medical Director thirty (30) days after notice of the denial of a desire to request reconsideration. The notice must be in writing and must specify the reasons why the applicant believes the Criteria for Participation has been be met and may include any supplemental information. The reconsideration is to the body that determined the Criteria for Participation were not met, that being either the Credentials Committee or the Board of Directors, as appropriate. The Credentials Committee or the Board of Directors may appoint a committee or an individual to consider the applicant's reconsideration and make a recommendation to the Credential Committee or the Board, and such committee or individual may in its discretion meet with the applicant or others with relevant information and require the applicant to submit additional information. Upon receipt of a recommendation from such committee or individuals, the Credentials Committee or the Board of Directors makes its decision, and notifies the applicant in writing. The decision is final and not subject to further review or appeal. There is no appeal for denials based on selection factors.

g. Group Practice of Physicians or Practitioners. When a group practice of physicians or other practitioners is the Plan Physician or Practitioner, it shall complete a Request for Renewal of Participation for each individual physician or practitioner who has a contract to provide professional services through such group practice and for whom the group practice

desires to provide covered services under Avera CVS. Avera CVS shall determine whether each individual who has a contract to provide professional services through such group practice and for whom the group practice desires to provide services under Avera CVS continues to meet the Criteria for Participation. Any renewal of participation of such group practice and its Plan Physician or Practitioner Agreement shall apply only as to the individual physicians or practitioners who continue to meet the Criteria for Participation.

h. Reapplication after Denial of Continued Participation. An applicant whose application for continued participation has been denied may not reapply for participation until twelve (12) months after the decision denying the application has become final. After the twelve (12) month period, the provider may submit an application for participation, which shall be processed as an initial application. Such an applicant must furnish evidence that the basis for the denial no longer exists and/or satisfactory evidence to the Credentials Committee that would allow them to grant a waiver and approve the applicant's participation.

X. NOTIFICATION OF CONFLICTING INFORMATION. If information is obtained during credentials verification that varies substantially from the information submitted by the provider, Avera CVS contacts the provider via letter with notification of the discrepancy. The notification is sent promptly after the discrepancy is detected. When a substantial discrepancy is identified, the credentialing specialist will notify the applicant of the discrepancy and the applicant is given the opportunity to submit in writing, within 15 days, any corrections of erroneous information obtained from other sources or an explanation of discrepancies. This explanation will be place in the file. The foregoing does not require AHP to alter or delete information contained in the file. AHP will keep the corrected information and documentation on file with the original application. Examples of instances where the provider will be notified of discrepancies include, but are not limited to, actions on a license, disciplinary actions, malpractice claims history, hospital privilege restrictions or termination, or board-certification status.

XI. RIGHT TO CORRECT ERRONEOUS INFORMATION. The provider has a right to correct any erroneous information submitted by another party. The corrections must be in writing, must be sent to the Medical Director, and must be received within thirty (30) days of the date the notification of a discrepancy was sent to the provider. If the provider does not respond, the application is considered withdrawn.

XII. PROVIDER'S RESPONSIBILITY TO PROVIDE INFORMATION. The provider bears the burden of producing current, accurate, and sufficient information for the Credentials Committee to properly evaluate his or her qualifications and shall have the burden of resolving any doubts about his or her qualifications for participation. The provider shall verify that information submitted is accurate and complete and shall have the

burden of updating the information, if necessary, to keep it current during the application process.

XIII. MISREPRESENTATION OF INFORMATION. The provision of information from the provider containing significant misrepresentations, misstatements, omissions or inaccuracies, whether intentional or not, and/or failure to sustain the burden of producing adequate information, will be grounds for automatic and immediate rejection of an application, or if discovered after participation has been granted, for immediate termination of such participation.

XIV. PROVIDER'S RIGHT TO REVIEW APPLICATION INFORMATION. Providers have a right to review information obtained to evaluate their credentialing application. This evaluation includes information obtained from any outside primary source (malpractice insurance carriers, state licensing boards). This does not include disclosure of information prohibited by law or references or recommendations or other information that is peer review protected. The review is conducted in the offices of Avera CVS by appointment.

XV. PROVIDER'S RIGHT TO BE INFORMED OF STATUS OF CREDENTIALING OR RECREDENTIALING. Upon request, Providers have a right to be informed of the status of their credentialing or recredentialing application. The applying provider can complete a request for information regarding status via written request or phone. Requests for current status information will be directed to the Credentialing Specialist assigned to and responsible for processing the application. Application status information will be discussed with the provider including, but is not limited to, missing information, requests for additional information, contract return, and credentialing time frames. Status information does not include disclosure of information prohibited by law, references, recommendations or information that is peer reviewed protected.

XVI. CONFIDENTIALITY

A. Avera CVS shall comply with all state and federal laws and regulations regarding the confidentiality of individual medical records and provider information. Provider information obtained from any source during the credentialing process is considered strictly confidential and is used only for the purpose of determining the provider's eligibility to participate with Avera CVS and to carry out the duties and obligations of Avera CVS, except as otherwise provided by law. This information is shared only with those persons or organizations who have authority to receive such information, or who have a need to know in order to perform credentialing related functions.

B. Documents in custody of Avera CVS, which may contain confidential patient or provider's information shall be destroyed when such information is no longer necessary for Avera CVS credentialing functions, or when no longer required to be maintained by law.

C. Individual provider paper files containing credentialing information including history of sanctions and disciplinary actions are stored in locked cabinets.

Access to electronic credentialing information is restricted to authorized personnel via sign-on security. All credentialing department employees and Credentials Committee members sign confidentiality statements.

D. All information and data collected, developed, or considered by the Credentials Committee is kept confidential and not disclosed except as required to be disclosed under applicable law. The proceedings of the committee are also confidential.

E. Information not considered confidential includes the following:

1. Provider name
2. License designation
3. Degree
4. Gender
5. Practice name
6. Practice address
7. Practice phone number
8. Board certification status
9. Specialty
10. Hospital affiliations

XVII. PROVIDER SANCTIONS. Sanctions include any restrictions on participation of a Plan Physician or Plan Practitioner, up to and including termination of participation.

A. The grounds for sanctions and the process include:

1. Failure to cooperate with and participate in the utilization review process and procedures.
2. Failure to cooperate with and participate in any quality assurance or quality improvement activities including, but not limited to office site and medical records survey when applicable.
3. Inappropriate practice patterns. Inappropriate practice patterns consist of continued practice patterns inconsistent with the monitoring criteria, and/or an individual instance involving a serious discrepancy from the monitoring criteria.

4. Failure to comply with contractual obligations as outlined in the Plan Practitioner Agreements.

B. Disciplinary actions include, but are not limited to:

1. Monitoring the practitioner for a specified period of time, followed by a determination as to whether noncompliance with Avera CVS requirements is continuing;
2. Warning the practitioner that disciplinary action will be taken in the future if noncompliance with Avera CVS requirements continues or reoccurs;
3. Requiring the practitioner to submit and adhere to a corrective action

plan;

4. Levying a monetary fine against the practitioner;
5. The recoupment of overpayments to a practitioner as determined by an internal and external claims audit or reviews;
6. Administrative suspension or termination of the practitioner's participation status for noncompliance with the participation criteria set forth in Section Eight Level One and Level Two.
7. Limiting the practitioner's scope of practice in treating Avera CVS members
8. Requiring the practitioner to obtain training or use peer consultation in specified type(s) of care;
9. Temporarily suspending the practitioner as a Avera CVS participating provider for non compliance with participating criteria
10. Require the practitioner or clinic to execute an amendment to a participation or a separate agreement related to the disciplinary action; and
11. Terminating the practitioner's participation status as described in Section Five.

C. Recommendations shall be referred to the Credentials Committee for imposition of sanctions.

D. The practitioner shall be informed in writing of the imposition of any disciplinary action. Avera CVS shall determine if any adverse decision is based on professional conduct or competence. Such determination shall be made in accordance with such policies and procedures, as the Credentials Committee shall adopt. If the adverse decision is based on professional competence or conduct, which could adversely affect patient care, the applicant may be offered the right to appeal such decision prior to presentation of such decision to the Board of Directors. If the applicant appeals the Credentials Committee's decision, the decision will be forwarded to the Appeals Committee for review pursuant to the appeals process. The Appeals Committee recommendation shall be forwarded to the Board of Directors, along with the decision of the Credentials Committee, for final review and action. Avera CVS may, in its sole discretion, provide an administrative reconsideration of disciplinary action, suspension or termination not related to professional conduct or competence.

XVIII. ADVERSE ACTION REPORTING. Avera CVS shall determine, based upon the provisions of the Health Care Quality Improvement Act of 1986, 42 U.S.C. § 401 et seq., and relevant state and federal statutes and regulations whether and when any adverse decision shall be reported to the National Practitioner Data Bank and/or the HealthCare Integrity and Protection Data Bank, the South Dakota Board of Medical Examiners or other appropriate agency. Avera CVS shall be entitled to make its determination in its sole discretion, in accordance with such policies and procedures as the Credentials Committee shall adopt provided, however, that the determination shall be made in good faith. The Credentials Committee shall notify the affected practitioner, in writing, in the event such a report is made.

XIX. SPECIAL RULES FOR EMERGENCY ROOM AND URGENT CARE PHYSICIANS.

A. ER Physician means a physician who provides emergency department physician services at an AHP Participating Hospital, when such services are billed for and collected by the AHP Participating Hospital, except for those physicians who have otherwise qualified as a Participating Physician, and when the AHP participating Hospital has entered into an agreement with the AHP in accordance with this section and which provides that all services of such physicians are billed and collected by the AHP Participating Hospital. As to all such ER Physicians, the criteria for participation shall be modified and the applicable process for application and approval waived, and the following substituted in its place.

B. The Plan Hospital shall, under oath, represent and warrant that: (a) the ER Physician has a current, valid, active license to practice medicine in the state in which the service of the ER Physician is provided, and is a member of the medical staff of the AHP Participating Hospital; with appropriate privileges to provide emergency room services. In granting such membership and privileges or applying such credentialing standards, the AHP Participating Hospital has complied with the requirements of its medical staff bylaws/credentialing plan, including making inquiry of the National Practitioner Data Bank where required under such bylaws/plan; (b) the ER Physician is eligible to provide covered services under the Medicare and Medicaid programs; (c) the ER Physician maintains malpractice insurance as required by AHP; (d) the AHP Participating Hospital will immediately notify AHP whenever the representations and warranties about the ER Physician are no longer accurate and complete; and (e) the terms and conditions of the AHP Participating Provider Agreement apply to all ER Physicians at the AHP Participating Hospital office who are not otherwise AHP Participating Providers. The representations and warranties by the Plan Hospital or Plan Physician office may be included in the Plan Hospital Agreement or the Plan Physician Agreement as applicable, and therefore, apply to all ER Physician at the Plan Hospital or Plan Physician office who are not otherwise Plan Physicians, or may be an individual representation and warranty by the Plan Hospital of Plan Physician office as the an individual ER Physician.

C. Participation by such ER Physicians shall be subject to the following:

The Plan reserves the right to immediately terminate, at its sole discretion, such participation by any ER Physician at any time.

XX. Provisional Approval of Physicians

It is Avera CVS policy that all credentialing information is available to the Credentials Committee or Medical Director at the time a decision regarding participation is made. However, for physicians completing residency or fellowship training, or those practitioners who apply to the Avera CVS for the first time, all required credentialing data might not be readily available. In this limited circumstance it is in the interest of members to approve network participation before the entire credentialing process is

completed. For this purpose provisional credentialing process is followed for physicians who have completed their residency or fellowship requirements for their particular specialty area within 12 months or whom are applying to Avera CVS for the first time, prior to review by the Credentials Committee or Medical Director. At a minimum the following elements must be present:

1. Primary-source verification of a current valid license to practice, and
2. Primary-source verification of the past five years of malpractice claims or settlements from the malpractice carrier, or the results of the National Practitioner Data Bank (NPDB) query, and
3. A current and signed application with attestation.
4. To assure the Credentials Committee has current information regarding a provider's credentials, verifications must be completed within the time limits specified in the "Administrative Work Instructions (CRDWI-002).

Provisional approval is effective for not more than 60 calendar days.

XXI. REAPPLICATION AFTER TERMINATION/REINSTATEMENT

If Avera CVS terminates a practitioner that it later wishes to reinstate, and the break is 30 days or more, the practitioner will be initially credentialed. Avera CVS will re-verify credential elements that are no longer within the credentialing time limits with the exception of static information (i.e. Graduation from Medical School or residency completion). The Credentials Committee or Medical Director will review all credentials and make a final determination prior to the practitioner's reentry into the organization.

XXII. CREDENTIALING DATA MAINTENANCE

Avera CVS will maintain and update the provider database in a timely and consistent manner to assure quality information is provider to our customers through the provider directory, accurate electronic downloads and current Customer Service information.

Data included in the maintenance of the database may include, but is not limited to:

- Provider Name
- Provider, Degree
- Provider, Specialty
- Practice Name
- Federal TIN #
- Practice Address, City, State, Zip Code
- Practice Telephone Number
- Billing Address, City, State, Zip Code
- Billing Address Telephone Number
- Fee Schedule assignment
- License designation
- Languages spoken
- Gender
- Board certification status and type
- Hospital affiliations

- Provider Education, including post graduate when applicable

In order to provide Avera CVS members and customers with consistent and timely data information, the Credentialing department will:

A. Maintain database integrity through a series on internal and IT driven maintenance reports on a monthly basis. The internal reports will focus on networks and contracts, incorrect and missing address information and formats, degree and provider types, board certification information, education, specialty listings and invalid or missing provider degrees, and invalid or missing provider ID numbers.

B. The CVS will also compile a monthly Quality Assurance Report "Board Report" to provide a quality analysis for initial, recredentialing and delegated providers, hospitals and facilities, and changes and terminations, which is created by the Credentialing Specialist and given to another support specialist to audit.

C. To provide the CVS with additional maintenance data. Policies and Procedures have been established internally to process discrepancies found between claims data, data in other systems or through the Call Center Representatives. The shared Policies and Procedures establish a guidance system for filtering provider data to the Credentialing Department to research and complete updates to the provider database. The tracking of communication will be maintained through the PowerQ workflow database, which includes the following departments:

- Call Center
- Claims/Operations
- Enrollment
- Provider Relations/Network Services
- Credentialing
- Health Services

XXII. REVIEW OF CREDENTIALING INFORMATION

Avera CVS reviews credentialing information for completeness, accuracy, and conflicting information before forwarding to the Credentials Committee for consideration Prior to forwarding the provider information, each file is initially reviewed by the Credentialing Specialist who did the initial credentialing. The Credentialing Specialist completes the Credentialing Checklist, and places the checklist in the provider file. The file is then submitted to a member of the credentialing staff other than the person that did the initial credentialing work or the Credentialing Specialist. The reviewer/Specialist checks each file to ensure that all necessary information is present. If deficiencies are noted, the provider's file is returned to the Credentialing Specialist for correction. Once the file has been reviewed and approved, documentation to that effect is placed in the provider file and the provider information is submitted to the Medical Director/equivalent or the Credentials Committee for review. If not deficiencies are noted, the provider's file

and the provider information is submitted to the Medical Director/equivalent or the Credentials Committee for review.

XXIII. DETERMINATION OF SPECIALTY

A provider's medical specialty listing in a database and provider directory is determined based on verification's of education, board certification and evidence of specialized training certifications. Avera recognizes the American Board of Medical Specialties as the standard guidelines for specialty listings. Board certification is not required, as part of criteria for participation, but may be used as a factor in the determination of a provider's specialty listing in the member materials or physician database.

SECTION TWO
INSTITUTIONAL PROVIDERS

I. SCOPE

A. Credentialing is a process used to develop and maintain a network of providers qualified to deliver appropriate, medically necessary, and cost effective health care to Avera members. The credentialing program involves the initial and ongoing collection, verification, and review of information necessary for selection and retention of providers meeting Avera CVS credentialing standards.

B. Only those providers meeting the credentialing standards developed by Avera CVS and approved by the Board of Directors are included in the network. In addition to the credentialing standards, selection criteria may be considered in contracting with providers. Providers are credentialed prior to acceptance into the network and at a minimum of every thirty-six (36) months. Avera CVS assess the following types of facilities prior to contracting:

1. Hospitals
2. Home Health Agencies
3. Skilled Nursing Facilities
4. Free-standing ambulatory surgical centers
5. Behavioral Health Facilities providing inpatient, residential and ambulatory mental health and substance abuse services.
6. Independent Diagnostic Testing Facilities (IDTFs)

II. CRITERIA FOR PARTICIPATION

A. Only those providers meeting Avera Criteria for Participation are credentialed. In addition to the credentialing standards, selection criteria may be considered in contracting with providers. Providers are credentialed prior to acceptance into the network and every two years thereafter.

B. Avera CVS credentialing applies to organizations and facilities that wish to contract for the network. Providers included are:

- Hospitals
- Home Health Agencies
- Skilled Nursing Facilities
- Free-standing surgical centers

- Behavioral Health Facilities providing inpatient, residential and ambulatory mental health and substance abuse services.
- Independent Diagostic Testing Facilities (IDTFs)

A. Hospitals. In order to be eligible to be a Participating Hospital, the hospital must continuously meet the following requirements:

1. The hospital must hold a current, valid, active license from the state in which it is located.
2. The hospital must be certified for participation in the Medicare and Medicaid programs.
3. The hospital must present a copy o their current professional liability insurance certificate.

1. Be approved by a recognized accrediting body no more than every three years i.e. Joint Commission on Accreditation of Healthcare Organizations (JCAHO), American Osteopathic Association (AOA) or Commission on Accreditation of Rehabilitation Facilities (CARF). If in the cases of non-accredited institutions Avera CVS will substitute a Centers for Medicare and Medicaid Services ("CMS") or state review as a site visit unless the provider is located in a rural area, as defined by the US Census Bureau. If the provider has not been reviewed by an accrediting body in the last three years, AHP will conduct an onsite quality assessment using the Hospital Site Review Tool, based on the requirements set forth by NCQA.

4.

5. The hospital must have negative responses to each of the following questions, unless Avera CVS, after full disclosure by the hospital waive the requirement.

a. Has the Hospital's license to operate been limited, suspended, revoked, or placed on probation, within the last ten years?

b. Has the Hospital's federal or state pharmacy permits been limited, suspended, revoked, or placed on probation, within the last ten years?

c. Has the Hospital been subject to sanctions by a professional standards review organization (PSRO) or by a utilization and quality control peer review organization (PRO), within the last ten years?

d. Has the Hospital been convicted of any crime, whether felony or misdemeanor, in the last ten years?

e. Has the Hospital's participation in Medicare or Medicaid been limited, suspended, revoked, or placed on probation, within the last ten years?

f. Have civil monetary penalties under the Medicare or Medicaid program been assessed against the Hospital, within the last ten years?

g. Has the Hospital's accreditation by any accrediting organization (including the Joint Commission for Accreditation of Healthcare Organizations) been limited, suspended, revoked, or placed on probation, within the last ten years?
h. Have sanctions of any kind been imposed on the Hospital by any other health care licensure or accreditation organization, within the last ten years?
i. Has the Hospital voluntarily accepted any of the above sanctions or restrictions under threat of same, or voluntarily resigned from any such organization, under the threat of same, within the last ten years?
j. Have any medical malpractice judgments been entered against the Hospital or settled with payment made by the Hospital, or on its behalf, within the last ten years? Are there any pending malpractice suits against the hospital?

B. Other Facilities. In order to be eligible to be a Participating Facility, the facility must continuously meet each of the following requirements:

1. The facility must hold a current, valid active license by the state in which it is located.
2. The facility must be certified for participation in the Medicare and Medicaid programs, and maintains an agreement to participate as such.

2. Be approved by a recognized accrediting body no more than every three years i.e. Joint Commission on Accreditation of Healthcare Organizations (JCAHO), American Osteopathic Association (AOA) or Commission on Accreditation of Rehabilitation Facilities (CARF). If in the cases of non-accredited institutions Avera CVS will substitute a CMS or state review as a site visit unless the provider is located in a rural area, as defined by the US Census Bureau. . If the provider has not been reviewed by an accrediting body in the last three years, AHP will conduct an onsite quality assessment using the Hospital Site Review Tool, based on the requirements set forth by NCQA.

3.
4. The facility must have in effect appropriate agreements with a Plan Hospital for handling emergencies and transfers.
5. The facility must have negative responses to each of the following questions, unless the Board, after full disclosure by the facility and a recommendation from the Credentials Committee, waives the requirement:

a. Has the facility's license to operate been limited, suspended, revoked, or placed on probation, within the last ten years?
b. Has the facility been subject to sanctions by a professional standards review organization (PSRO) or by a utilization and quality control peer review organization (PRO), within the last ten years?

c. Has the facility's participation in Medicare or Medicaid been limited, suspended, revoked, or placed on probation, within the last ten years?
d. Have civil monetary penalties under the Medicare or Medicaid program been assessed against the facility, within the last ten years?
e. Has the facility's accreditation by any accrediting organization (including the voluntary accrediting organizations) been limited, suspended, revoked, or placed on probation, within the last ten years?
f. Have sanctions of any kind been imposed on the facility by any other health care licensure or accreditation organization, within the last ten years?
g. Has the facility voluntarily accepted any of the above sanctions or restrictions under threat of same, or voluntarily resigned from any such organization, under the threat of same, within the last ten years?
h. Have any medical malpractice judgments been entered against the facility or settled with payment made by the Hospital, or on its behalf, within the last ten years? Are there any pending malpractice suits against the facility?

C. Independent Diagnostic Testing Facilities. In order to be eligible to be a Participating Independent Diagnostic Testing Facility (IDTF), the IDTF must continuously meet the following requirements, these standards, in their entirety can be found in Medicare 42 C.R.F.§410.33 (g):

a. The IDTF must operate its business in compliance with applicable state and federal licensure and regulatory requirements for health and safety of patients.
b. Provide complete and accurate information on its enrollment application. Changes in ownership, changes of location, changes in general supervision, and adverse legal actions must be reported to Avera within 30 calendar days of the change. All other changes to the enrollment application must be reported within 90 days.
c. Maintain a physical facility on an appropriate site. For purposes of this standard, a post office box, commercial mail box, hotel or motel is not considered an appropriate site.
    1. The physical facility, including mobile units, must contain space for equipment appropriate to the services designated on the enrollment application, facilities for both hand-washing, adequate patient privacy accommodations, and the storage of both business records and current medical records within the office

setting of the IDTF or IDTF home office, not within the actual mobile unit.

2. IDTF suppliers that provide services remotely and do not see beneficiaries at their practice location are exempt from providing hand washing and adequate patient privacy accommodations.

d. Have all applicable diagnostic testing equipment available at the physical site excluding diagnostic testing equipment. A catalog of portable diagnostic testing equipment serial numbers, must be maintained at the physical site. This information must be made available to Avera upon request and notification of any changes in equipment within 90 days.

e. Maintain a primary business phone under the name of the designated business. The primary business phone must be located at the designated site of business or within the home office of the mobile IDTF units. The telephone number or toll free numbers must be available in a local director or directory assistance.

f. Have a comprehensive liability policy of at least $300,000 per location that covers both the place of business and all customers and employees of the IDTF. The policy must be carried by a non-relative owned company. IDTF suppliers are responsible for providing a certificate of Coverage to Avera. The IDTF must ensure that the insurance policy must remain in effect at alltimes and provide coverage of at least $300,000 per incident, and notify Avera of any policy changes or cancellations.

g. IDTF must only accept patients who are referred for diagnostic testing by an attending physician, who is furnishing a consultation or treating beneficiary for specific medical problems and who uses the results in the management of the beneficiary's specific medical problem. Nonphysician practitioner's may order tests as set forth in Medicare billing privileges 42 C.R.F. § 410.32 (a)(3).

h. Answer, document and maintain documentation of a clients clinical complaint at the physical site of the IDTF (for mobile IDTFs, this documentation would be stored at their home office.)

i. Post Medicare standards for review by patients and public

j. Disclose any person having ownership, financial or control interest or any other legal interest in IDTF at time of enrollment or within 30 days of a change.

k. Have the equipment calibrated and maintained per equipment instructions and its compliance with

applicable manufacturers suggested maintainence and calibration standards.

l. Technical staff must have appropriate credentials to perform tests. The IDTF must be able to produce the applicable Federal or state licenses or certifications of the individuals performing these services

m. Have proper medical record storage and be able to retrieve medical records upon request within two business days.

n. Allow Avera or CMS to conduct unannounced on-site inspections to confirm the IDTF's compliance with these standards. The IDTF must be accessible during regular business hours and maintain a visible sign posting the normal business hours of the IDTF.

o. With the exception of a hospital based and mobile IDTF, a fixed base IDTF does not include the following:
   1. Sharing a practice location with another Medicare-enrolled individual or organization.
   2. leasing or subleasing its operations or its practice location to another Medicare enrolled individual or organization.
   3. Sharing diagnostic testing equipment using in the initial diagnostic test with another Medicare-enrolled individual or organization.

III. CREDENTIALING PROCESS

A. Initial Credentialing

4. Applications

a. Applicants for participation must complete an application on a prescribed application form (either an Avera CVS application form, or an application form approved by Avera CVS) and submit all required supporting documentation and information. In addition, the provider must complete the 'Questionnaire' section of the application and must furnish a detailed written description of the circumstances surrounding any affirmative response to questions in the 'Questionnaire' section of the application or any other such questions on any other Avera CVS approved application. Finally, a release must be signed and dated along with the attestation by the applicant of the correctness and completeness of the application.

b. Applications are immediately closed and returned to the provider under the following circumstances:

    i. The 'Questionnaire' section of the application is not completed.
    ii. The application 'Release and Attestation' is not signed and dated. Stamped signatures are not accepted.
    iii. The application is from a provider that Avera CVS does not include in the network.
    iv. The applicant does not meet the minimum liability insurance requirements.

c. Incomplete applications are held open for thirty (30) days to allow the applicant an opportunity to supply any required missing information or documentation. This would include, but is not limited to, the following:

    i. The provider has not provided an explanation for any affirmative response to questions in the 'Questionnaire' section of the application, or any other such questions on any other Avera CVS approved application.
    ii. The provider has not provided necessary copies of documents such as license, insurance certificates, etc.
    iii. The provider has failed to comply with any other procedure or provide any other information necessary to process the hospital or facility application.

d. Application processing will not begin until all missing documentation/information is received in Avera CVS office. If information is not received within thirty (30) days of the request for missing/additional information, the application is closed and returned to the provider.

5. Review of Criteria for Participation. The Credentials Committee shall review the application and any additional information in accordance with the Criteria for Participation. In the event the Credentials Committee finds the application meets the criteria and does not require a waiver, the Credentials Committee shall recommend for approval under the Criteria for Participation. In the event that the Credentials Committee determines the application requires a waiver of a question for which the applicant must have a negative response or that it does not meet the Criteria for Participation, the Credentials Committee shall make a recommendation to the Board, and the Credentials Committee may require the applicant to submit additional information in support of the waiver and may require the applicant to have an interview with

the Medical Director, or the Board or one or more of the Board's members.

6. Notification of Credentialing Decision.

   The recommendation date of the Medical Director or Credentials Committee is used as the effective date of the provider's participation and the provider is sent written notification of the approval within 10 calendar days of the approval. The recommendation then is presented to the Board of Directors for final ratification. Providers also receive a signed Provider Agreement and a Provider Manual when applicable.

   b. Denial of Participation. New applicants whose participation is denied are notified via certified mail of the denial and the basis for the decision within five working days of the denial. A description of the reconsideration procedures is included in the letter.

7. Reconsideration. A provider whose application is denied based on the Criteria for Participation may request reconsideration upon sending a notice to the Medical Director within thirty (30) days after notice of the denial. The notice must be in writing and must specify the reasons why the applicant believes the Criteria for Participation has been met and may include any supplemental information. The reconsideration is to the body that determined the Criteria for Participation were not met, that being either the Credentials Committee or the Board of Directors, as appropriate. The Credentials Committee or the Board of Directors may appoint a committee or an individual to consider the applicant's reconsideration and make a recommendation to the Credential Committee or the Board, and such committee or individual may in its discretion meet with the applicant or others with relevant information and require the applicant to submit additional information. Upon receipt of a recommendation from such committee or individuals, the Credentials Committee or the Board of Directors makes its decision, and notifies the applicant in writing. The decision is final and not subject to further review or appeal. There is no appeal for denials based on Selection Factors.

8. Reapplication after Denial of Participation. An applicant whose application for participation has been denied may not reapply for participation until twelve (12) months after the decision denying the application has become final. After the twelve (12) month period, the provider may submit an application for participation, which shall be processed as an initial application. Such an applicant must furnish

evidence that the basis for the denial no longer exists and/or satisfactory evidence to that would allow granting of a waiver.

B. Recredentialing

1. Automatic Expiration Unless Renewed. Participation generally extends for a two-year period pursuant to a cycle established for each Provider. Participation expires at the end of such period unless renewed. Prior to renewal of participation, Avera CVS formally recredentials the provider for the purpose of establishing whether the provider continues to meet the Criteria for Participation.

2. Requests for Renewal of Participation

    a. A renewal application (Recredentialing Application) is mailed to the provider at least one hundred twenty (120) days before the expiration of participation.

C. The provider is asked to update the demographic information on the application. In addition, the provider is required to complete the 'Questionnaire' section of the application and provide a detailed explanation of any affirmative response to the 'Questionnaire'. The updated renewal application, any required documents, and a release with an attestation by the applicant of the correctness and completeness of the application must be submitted to the offices of Avera CVS sixty (60) days prior to the provider's expiration of participation. Faxed, digital, electronic, scanned or photocopied signatures are acceptable, but signature stamps are not accepted.

    a. A second request is sent to the provider if the renewal application is not received within thirty (30) days of the original mailing date. If there is no response by the expiration of participation, the provider's participation will be terminated.

    b. Applications are immediately returned if the 'Questionnaire' section of the application is not completed or the 'Release and Attestation' is not signed and dated. Stamped or electronic signatures are not accepted.

    c. Incomplete applications are held open for thirty (30) days from receipt to allow the applicant to supply any required information or documentation that is missing. This would include, but is not limited to, the following:

        i. The provider has not documented the circumstances surrounding any affirmative response to questions in

the 'Disclosure Questionnaire' section of the application, or any other such questions on any other Avera CVS approved application.

ii. The provider has not included with the application required copies of documents such as license, insurance certificates, etc.

iii. The provider has failed to comply with any other procedure or provide any other information necessary to process the application.

f. Application processing will not begin until all missing documentation/information is received in Avera CVS office. If information is not received within thirty (30) days of the request for missing/additional information, the provider will be contacted by phone to request submission of the information. If there is no response by the expiration of the participation, the provider shall be treated as having withdrawn the request for renewal of participation and will be terminated for lack of response.

3. Review of Criteria for Participation. The Medical Director shall review the renewal application and any additional information in accordance with the Criteria for Participation. In the event the Medical Director finds the application continues to meets the criteria and does not require a waiver, the Medical Director shall approve the application under the Criteria for Participation. In the event that the Medical Director determines the application requires a waiver of a question for which the applicant must have a negative response or that it does not continue to meet the Criteria for Participation, the Medical Director shall make a recommendation to the Avera CVS Board, and the Medical Director or the Avera CVS may require the applicant to submit additional information in support of the waiver and may require the applicant to have an interview with the Medical Director, or the Avera CVS Board or one or more of the Board's members.

4. Notification of Recredentialing Decision. Providers whose participation is not renewed receive written notification. Providers whose renewal of participation is denied are notified via certified mail of the denial and the basis for the decision within five (5) working days.

5. Reconsideration. A provider whose application for renewal is denied based on the Criteria for Participation may request reconsideration upon sending a notice to the Medical Director within thirty (30) days after notice of the denial. The notice must be in writing and must specify the reasons why the applicant believes the Criteria for

Participation continue to be met and may include any supplemental information. The reconsideration is to the body that determined the Criteria for Participation were not met, that being either the Credentials Committee or the Board of Directors, as appropriate. The Credentials Committee or the Board of Directors may appoint a committee or an individual to consider the applicant's reconsideration and make a recommendation to the Credential Committee or the Board, and such committee or individual may in its discretion meet with the applicant or others with relevant information and require the applicant to submit additional information. Upon receipt of a recommendation from such committee or individuals, the Credentials Committee or the Board of Directors makes its decision, and notifies the applicant in writing. The decision is final and not subject to further review or appeal. There is no appeal for denials based on Selection Factors.

6. Reapplication after Denial of Continued Participation. An applicant whose application for continued participation has been denied may not reapply for participation until twelve (12) months after the decision denying the application has become final. After the twelve (12) month period, the provider may submit an application for participation, which shall be processed as an initial application. Such an applicant must furnish evidence that the basis for the denial no longer exists and/or satisfactory evidence to that would allow granting of a waiver.

SECTION THREE
PROVIDER SELECTION FACTORS

I. SELECTION FACTORS. In determining whether to contract with a hospital or other facility, or a physician or group practice of physicians, or other health care practitioners or group practice of health care practitioners, Avera CVS may consider the following factors:

A. The geographical location of the applicant in relation to other participating providers.

B. The extent to which Avera CVS has or plans to have contracts with contracting groups with members, insured, or employees for access to services of the applicant.

C. Requests by contracting groups or their members, insured, or employees for access to services of the applicant.

D. The ability of other participating providers to provide similar services as the applicant, without undue inconvenience to the patient.

E. Any special expertise or skill or specialized services that Avera CVS desires to have available.

F. The effect of including the applicant as a participating provider on existing participating providers, including the impact on the pricing from such other providers to Avera CVS.

G. The existing referral relationships of the applicant with participating providers, and the continuity of care, which exists between the applicant and existing participating providers.

H. The extent to which total charges to a contracting group can be lowered or contained by the addition of the applicant.

I. The willingness of the applicant to abide by and support the purposes of Avera CVS, including the utilization review plan of Avera CVS.

J. The cost effectiveness of the services provided by the applicant.

K. The willingness of the applicant to provide preferred or discounted pricing to Avera CVS.

L. The judgment of the Board as to what is in the best interests of Avera CVS.

M. Any other factors reasonably related to the goals of Avera CVS.

II. SELECTION FACTOR PROCESS. All hospital and healthcare facility applications are evaluated using the Selection Factors. Other provider applications may be evaluated under the Selection Factors at the discretion of the Director of Network Services or the Board of Directors. The Director of Network Services and Operations reviews the providers' applications and any additional information in accordance with the Selection Factors and makes a recommendation to the President of Avera CVS as to the appropriateness of contracting with each applicant. If the Director of Network Services and Operations recommends approval the recommendation is presented to the President (or in the President's discretion, a Selection Committee appointed by the President) who approves the application, recommend denial to the President or determine that the President should consider the application. If the Director of Network Services and Operations recommends denial or if the President (or the Selection Committee) recommends denial, or determines the consideration is appropriate, the recommendation is presented to the Board. If the Director of Network Services and Operations recommends denial of the applications, the Director of Network Services and Operations may defer review of the Criteria of Participation pending a determination by the Board that the application is approved pursuant to the Selection Factors.

III. ACTION BY THE BOARD

In the event an application is presented to the Board of Directors, the Board of Directors will then consider the application and such recommendations and determine either:

1. The applicant has met the Criteria of Participation, that approval of the application is consistent with the Selection Factors; and, that the applicant, upon signing the Agreement, shall be a Participating Provider.
2. The applicant has not met the Criteria for Participation and that the application is therefore denied.
3. The applicant does not meet the Selection Factors and that the application is there fore denied.
4. The application is incomplete and directs the Director of Network Services and Operations to so notify the applicant and provide an opportunity for the applicant to submit additional information.

The applicant is notified in writing of the decision of the Board of Directors. Denials made based on Selection Factors are not subject to reconsideration. The Selection Factor Review Process can be applied, at the discretion of the Director of Network Services and Operations, to initial contracting decisions as well as determination of continued contracting at the time of renewal.

SECTION FOUR
I.

ONGOING PERFORMANCE MONITORING
Avera includes as part of the formal evaluation process a reappraisal of professional performance, judgment, and clinical competence, objective evidence considering the assessment of the practitioner's performance while working with Avera.
Ongoing monitoring of a practitioner's performance is conducted by Utilization Management in collaboration with the Network Services Department. These activities may include, but are not limited to:

A. Completion of additional site visits when opportunities for improvement are identified on an initial site visit or the practitioner has relocated or opened a new site that has not previous been approved.
B. Review of practitioner specific quality of care and quality of service
C. Monitoring of sanctions, and/or adverse actions and complaints and any other data related to provider improvement activities.

This information is included in supporting information for the Credentials Committee for review and consideration at time of credentialing decision.

SECTION FIVE
TERMINATION OF PROVIDERS

I. PROCESS FOR TERMINATION. Avera may terminate a provider's participation at any time when the Board, the Credentials Committee (in the case of physicians or other practitioners), or the Medical Director determines that a provider no longer meets the Criteria for Participation. Except for a timely reconsideration pursuant to II. Reconsideration below, the decision of the Board of Directors or the Credentials Committee (or in the case of physicians or other practitioners) shall be final and not subject to appeal. The provider shall be notified in writing of the decision of the Board of Directors or the Credentials Committee.

II. RECONSIDERATION. A provider whose termination has been based on the Criteria for Participation is offered an opportunity to request reconsideration. The provider must make known to the Medical Director of Avera within thirty (30) days after notice of termination of a desire to request reconsideration. The notice must be in writing and must specify the reasons why the provider believes the Criteria for Participation continue to be met and may include any supplemental information. The reconsideration is to the body that determined the Provider's participation should be terminated, that being either the Credentials Committee or the Board of Directors, as appropriate. The Credentials Committee or the Board of Directors may appoint a committee or an individual to consider the provider's reconsideration and make a recommendation to the Credentials Committee or the Board, and such Committee or individual may in its discretion meet with the provider or others with relevant information and require the applicant to submit additional information. Upon receipt of a recommendation from such Committee or individuals, the Credentials Committee or the Board of Directors makes its decision, and notifies the provider in writing. The decision is final and not subject to further review or appeal.

III. REAPPLICATION AFTER TERMINATION. A provider whose participation has been terminated may not reapply for participation until twelve (12) months after the decision denying the application has become final. After the twelve (12) month period, the provider may submit an application for participation, which shall be processed as an initial application. Such an applicant must furnish evidence that the basis for the termination no longer exists and/or satisfactory evidence to the Credentials Committee that would allow them to grant a waiver and approve the applicant's participation.

IV. DUTY OF PROVIDER TO NOTIFY WHEN CRITERIA FOR PROVIDER PARTICIPATION NO LONGER MET. Each Provider is responsible to notify the Medical Director if the

Provider no longer meets the Criteria for Provider Participation or would do so only if granted a waiver. Each Participating Provier shall notify AHP within five (5) business days of any changes to the following, failure without good cause to provide this information is deemed a voluntary termination from AHP:

1. Licensure or certification;
2. Professional liability insurance;
3. Professional liability claims history;
4. Hospital clinical privileges

V. GROUP PRACTICE OF PHYSICIANS OR PRACTITIONERS. In the case where the group practice of providers is the Plan Physician or Practitioner, Avera may terminate the Plan Physician or Practitioner Agreement as to any individual physician or practitioner who has a contract to provide professional services through such group practice, when, as provided above, the provider no longer meets the Criteria for Participation, in which case the Plan Physician or Practitioner agreement shall apply only to those individual providers who continue to meet the Criteria for Participation.

VI. IMMEDIATE THREAT OR LICENSE REVOCATION.SUSPENSION. In the case of a provider whose license to practice medicine is revoked, suspended or if the provider exhibits an immediate threat to the health and safety of the consumer, the Board of Directors delegates authority to he Medical Director or Credentials Committee to approve immediate termination.

VII. REAPPLICATION AFTER TERMINATION/REINSTATEMENT:

If Avera terminates a practitioner that it later wishes to reinstate, and the break is 30 days or more, the practitioner will be initially credentialed. Avera will re-verify credential elements that are no longer within the credentialing time limits with the exception of static information (i.e. Graduation from Medical School or residency completion). The Credentials Committee or Medical Director will review all credentials and make a final determination prior to the practitioner's reentry into the organization.

SECTION SIX
DELEGATED CREDENTIALING

I. STATEMENT OF POLICY. In certain circumstances Avera delegates all or part of the provider credentialing process to a PHO, IPA or other qualifying credentialing entity. This may involve delegation of information gathering, verification of some or all of the credentialing elements, or it can include delegation of the entire credentialing process, including decision-making.

II. DELEGATED CREDENTIALING PROCESS

A. Prior to entering into a delegated credentialing agreement, Avera evaluates the capability of the delegated entity to perform the credentialing functions according to Avera standards, applicable state standards and those established by the National Committee for Quality Assurance (NCQA). The evaluation includes review of the following:

1. The delegate's credentialing criteria, policies, and procedures to assure they meet or exceed those of Avera applicable state standards and those established by the National Committee for Quality Assurance (NCQA). .
2. Minutes of the delegate's Credentials Committee meetings to verify critical review of the providers' credentials.
3. Five percent (5%) or twenty-five (25) of individual providers' credentialing files, whichever is less. A minimum of ten (10) initial credentialing files and (10) ten recredentialing files are audited.

B. The Avera Credentials Committee review the audit results. The recommendation of the Credentials Committee is presented to the Board of Directors, and if delegated credentialing is approved, an agreement is executed between the parties outlining the responsibility of each and the specific activities that are delegated. The agreement also includes the process Avera will use to evaluate the delegate's performance and the consequences of the delegate's failure to meet the terms of the agreement. As part of the agreement, the delegate is required to notify Avera within thirty (30) days of any changes in the status of the participating providers. This includes, but is not limited to, additions, terminations, resignations, and changes in privileges, probation, or other disciplinary action.

III. ANNUAL EVALUATION.

A. Avera annually evaluates the delegated entity's credentialing process to assure it continues to meet or exceed Avera standards applicable state standards and those established by the National Committee for Quality Assurance (NCQA) Avera and its expectations. The evaluation includes review of the following:

1. The delegate's credentialing criteria, policies and procedures to assure they meet or exceed those of Avera applicable state standards and those established by the National Committee for Quality Assurance (NCQA). .
2. Minutes of the delegate's Credentials Committee meetings to verify critical review of the provider's credentials.
3. Five percent (5%) or Fifty (50) of the individual providers' credentialing files, whichever is less. A minimum of ten (10) initial credentialing files and (10) ten recredentialing files are audited.

B. The Avera Medical Director and the Credentials Committee review results of the annual audit. If deficiencies are found during the evaluation, Avera works with the delegated entity to develop a plan for improvement with specified time frames and actions to achieve Avera standards. If the improvement process is unsuccessful, Avera reserves the right to revoke the delegation arrangement.

III. Sub delegation. Should Avera authorize the delegate to assign any credentialing duty to another entity, the delegate must agree that the sub delegate will be subject to the terms of the Delegated Credentialing Agreement. Delegates who sub delegate credentialing to another entity are required to carry out oversight activities. The oversight activities will be reviewed as part of the initial and annual evaluation.

IV. Right to Approve Avera retains the right to approve new providers and to terminate, place on probation, or take any other action related to the individual provider's participation.

V. Reports. At least twice a year, following the initial evaluation all delegates will be required to submit a report. This report will include, but is not limited to the organizations progress in conducting credentialing and recredentialing activities, its performance improvement activities, the list of credentialed and recredentialed practitioners, data analysis, committee meeting minutes and any other reports designed exclusively for the contracted relationships. The reports will be evaluated semi annually.

VI. Contract for Delegation. Avera will maintain signed written agreements with all delegated credentialing entity that describe the scope of the business arrangement. The contract will specifically address the following:

1. The contract will list those responsibilities delegated to the delegated entity and those retained by Avera.
2. The contract will require that services of the delegated entity be performed in accordance with Avera's requirements and national credentialing standards.

3. The contract will require notification to Avera of any material change in the delegated entity performance of the delegated functions.
4. The contract will specify that Avera may conduct surveys of the delegated entity, as needed
5. The contract will require that the delegated entity submit periodic reports to Avera regarding the performance of its delegated responsibilities.
6. The contract will specify that, if the delegated entity submit periodic reports to Avera regarding the performance of its delegated credentialing responsibilities
7. The contract will specify that, if the delegated entity further delegates organizational functions, those functions will be subject to the terms of the agreement between the delegated entity and Avera in accordance with national credentialing standards.
8. The contract will specify recourse and/or sanctions if the delegated entity doesn't not make corrections to identified problems within a specified period.
9. The contract will specify the circumstances under which the delegated entity may further delegate activities.
10. Allowed use of PHI
11. A description of delegate safeguards to protect the information from inappropriate use or further disclosure
12. A stipulation that the delegate will ensure the sub-delegates have similar safeguards
13. A stipulation that the delegate will provide individuals with access to their PHI
14. A stipulation that the delegate will inform the organization if inappropriate uses of the information occur.
15. A stipulation that the delegate will ensure that PHI is returned, destroyed, or protected if the delegation agreement ends.

SECTION SEVEN
CRITERIA FOR PARTICIPATION

Criteria for Participation

Physician (MD, DO)

In order to be eligible for participation, the physician or, in the case of a group of physicians i.e., group practice, PHO, IPA, independent network, or any other organized arrangement of physicians, each individual physician who provides professional services through such group, and for whom the group desires to provide Covered Services under Avera, must continuously meet the following requirements:

LEVEL I CRITERIA
(may not be waived)

Element	Criteria for Participation	Verification Source
Licensure	The physician must hold a current, valid, active license to practice medicine in the state(s) in which the physician intends to provide Covered Services.	•State licensing agency
DEA Registration	The physician must hold a current and active DEA Registration. Physicians who do not, as part of their practice, prescribe medications are exempt from this requirement. This would include such specialties as radiologist and pathologist.	•Copy of current DEA •NTIS •Documented Visual inspection of the original certificate •Confirmation from the state pharmaceutical

		licensing agency, if applicable. •AMA Physician Master File
Professional Education	The physician must be a graduate of an accredited school of medicine or osteopathy, or hold a valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG).	•Highest level of education **OR** •Board Certification ABMS AOA **OR** •ECFMG
Utilization Review	The physician must agree to participate in and abide by the utilization review program as established by the Board of Directors.	•Release and attestation on application and/or contract
Office Site/Medical Records Evaluation	The physician must agree to cooperate with and participate in the office site and medical records evaluation, if applicable	•Release and attestation on application and/or contract
Liability Insurance	The physician must have current professional liability coverage of at least $1 million per claim or occurrence, and $3 million aggregate.	•Copy of liability insurance face sheet showing dates and coverage amounts •application attestation on application including dates & amount of current malpractice insurance coverage •Federal Tort Coverage requires a copy of the federal tort letter or an attestation from the practitioner of federal tort

		coverage

LEVEL II CRITERIA

Physicians must meet the following requirements, unless the Plan, after full disclosure by the physician, waives such requirement.

Element	Criteria for Participation	Verification Source
Professional Liability Claims History	In the five (5) years prior to making application, the physician has no history of professional liability claim settlements or judgments, and there are no pending cases at the current time.	•Application questionnaire •NPDB
Work History	The physician has no unexplained gaps of six (6) months or greater in his/her work history.	•Work history on application and/or curriculum vitae
Disciplinary Actions - License	The physician has not had any action taken by a state medical board where the physician has practiced medicine that would affect the physician's license to practice. If a physician was licensed in more than one state in the most recent five year period, the query must include all states in which the physician practiced.	•Application questionnaire •State licensing agency •FSMB •NPDB •HIPDB
Felony Convictions	The physician has never been convicted of a felony.	•Application questionnaire •State licensing agency •FSMB •HIPDB
Clinical Staff Membership	The physician has never been refused membership on a hospital or healthcare facility medical staff for reasons other than closure of that staff to the physician's specialty.	•Application questionnaire •Hospital/Healthcare facility •NPDB
Clinical Privileges	The physician must have clinical privileges in good standing, as defined by that	•Application

	institution, at an AHP Participating Hospital in a category and with privileges appropriate for such physician. The physician's privileges at any hospital or healthcare facility have never been suspended, diminished, revoked, not renewed or acted upon in any other way whatsoever. If the physician does not, as a part of the practice, have a need to admit patients to a hospital, clinical privileges are not required, but if as part of practice the potential for privileges is required a letter of agreement with a participating provider must be maintained and documentation presented to AHP of such agreement.	questionnaire •Hospital/Healthcare facility •NPDB • Hospital • Letter of agreement, if applicable
DEA Registrations	The physician's DEA registration has never been suspended, restricted, or revoked or acted upon in any other way whatsoever.	•Application questionnaire •State licensing agency •NPDB •FSMB
Liability Insurance	The physician's liability insurance has never been denied, suspended, canceled, or not renewed.	•Application questionnaire •Liability insurance carrier •NPDB
Medical Organization	The physician has never been subjected to disciplinary action in any medical organization.	•Application questionnaire •NPDB
Sanctions	The physician has never had sanctions imposed or voluntarily accepted any sanctions by any health care institution, professional health care organizations, licensing authority, governmental entity, professional standards review organization (PRO), utilization and quality assurance peer review organization (PRO).	•Application questionnaire •FSMB •NPDB •HIPDB
Medicare/Medicaid	The physician has never been convicted of any crimes related to the practice of medicine, including Medicare or Medicaid related crimes. The physician has never been subjected to civil money penalties under the Medicare or Medicaid program or been suspended from participation in Medicare or Medicaid.	•Application questionnaire •FSMB •NPDB (MD & DO) •HIPDB

		• Cumulative Sanction Internet Sites •Medicare & Medicaid Sanctions and reinstatement reports, distributed by federally contracting organizations •Federal Employees Health Benefits Plan Program department record, published by the Office of Personnel Management, Office of the Inspector General •American Medical Association (AMA) Physician Master File entry •state Medicaid agency or intermediary and the Medicare intermediary
Investigations	The physician has never been the object of an administrative, civil, or criminal complaint or investigation.	•Application questionnaire
Health Status	The physician does not have any condition that would impact the ability to perform the essential functions of the position, with or without accommodation, and without exposing the physician or others to health and safety risks. The physician is not currently abusing medications, other drugs or substances, including alcohol.	•Application questionnaire •Treating provider
Office Site Review	The physician must meet the threshold for the office site visit, when applicable.	•Site audit results
Medical Record Review	The physician must meet the threshold for the medical record review, when	•Medical record audit

	applicable.	results

Criteria for Participation

Dentists/Oral Surgeons (DMD, DDS)

In order to be eligible for participation, the physician or, in the case of a group of physicians i.e., group practice, PHO, IPA, independent network, or any other organized arrangement of physicians, each individual physician who has a contract to provide professional services through such group, and for whom the group desires to provide Covered Services under Avera, must continuously meet the following requirements:

LEVEL I CRITERIA
(may not be waived)

Element	Criteria for Participation	Verification Source
Licensure	The physician or dentist must hold a current, valid, active license to practice medicine in the state(s) in which the physician or dentist intends to provide Covered Services.	•State licensing agency
DEA Registration	The physician or dentist must hold a current and active DEA Registration. Physicians or dentists who do not, as part of their practice, prescribe medications are exempt from this requirement.	•Copy of current DEA •NTIS •Documented Visual inspection of the original certificate •Confirmation from the state pharmaceutical licensing agency, if applicable. •AMA Physician Master File
Professional Education	The physician or dentist must be a graduate of an accredited school of medicine, osteopathy, or dentistry or hold a valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG).	•Highest level of education **OR**

		•Board Certification ABMS AOA **OR** •ECFMG
Utilization Review	The physician or dentist must agree to participate in and abide by the utilization review program as established by the Board of Directors.	•Release and attestation on application and/or contract
Office Site/Medical Records Evaluation	The physician or dentist must agree to cooperate with and participate in the office site and medical records evaluation, if applicable	•Release and attestation on application and/or contract
Liability Insurance	The physician must have current professional liability coverage of at least $1 million per claim or occurrence, and $3 million aggregate.	•Copy of liability insurance face sheet showing dates and coverage amounts •application attestation on application including dates & amount of current malpractice insurance coverage •Federal Tort Coverage requires a copy of the federal tort letter or an attestation from the practitioner of federal tort coverage

LEVEL II CRITERIA

Physicians must meet the following requirements, unless the Plan, after full disclosure by the physician, waives such requirement.

Element	Criteria for Participation	Verification Source
Professional Liability Claims History	In the five years prior to making application, the physician or dentist has no history of professional liability claim settlements or judgments, and there are no pending cases at the current time.	•Application questionnaire •NPDB
Work History	The physician or dentist has no unexplained gaps of six months or greater in his/her work history.	•Work history on application and/or curriculum vitae
Disciplinary Actions - License	The physician or dentist has not had any action taken by a state medical/dentistry board where the physician or dentist has practiced that would affect the physician or dentist's license to practice. If a physician or dentist was licensed in more than one state in the most recent five year period, the query must include all states in which the physician or dentist worked.	•Application questionnaire •State licensing agency •FSMB •NPDB •HIPDB
Felony Convictions	The physician or dentist has never been convicted of a felony.	•Application questionnaire •State licensing agency •FSMB •HIPDB
Clinical Staff Membership	The physician or dentist has never been refused membership on a hospital or healthcare facility medical staff for reasons other than closure of that staff to the physician's specialty.	•Application questionnaire •Hospital/Healthcare facility •NPDB
Clinical Privileges	The physician or dentist must have clinical privileges in good standing, as defined by that institution, at an AHP Participating Hospital in a category and with privileges appropriate for such physician. The physician's privileges at any hospital or healthcare facility have never been suspended, diminished, revoked, or not renewed. If the physician or dentist does not, as a part of the practice, have a need to admit patients to a hospital, clinical privileges are not required, but if as part of practice	•Application questionnaire •Hospital/Healthcare facility •NPDB • Hospital • Letter of agreement, if applicable

	the potential for privileges is required a letter of agreement with a participating provider must be maintained and documentation presented to AHP of such agreement..	
DEA Registrations	The physician or dentist's DEA registration has never been suspended, restricted, or revoked.	•Application questionnaire •State licensing agency •NPDB •FSMB
Liability Insurance	The physician's or dentist's liability insurance has never been denied, suspended, canceled, or not renewed.	•Application questionnaire •Liability insurance carrier •NPDB
Medical Organization	The physician or dentist has never been subjected to disciplinary action in any medical organization.	•Application questionnaire •NPDB
Sanctions	The physician or dentist has never had sanctions imposed or voluntarily accepted any sanctions by any health care institution, professional health care organizations, licensing authority, governmental entity, professional standards review organization (PRO), utilization and quality assurance peer review organization (PRO).	•Application questionnaire •FSMB •NPDB •HIPDB
Medicare/Medicaid	The physician or dentist has never been convicted of any crimes related to the practice of medicine, including Medicare or Medicaid related crimes. The physician has never been subjected to civil money penalties under the Medicare or Medicaid program or been suspended from participation in Medicare or Medicaid.	•Application questionnaire •FSMB •NPDB (MD & DO) •HIPDB • Cumulative Sanction Internet Sites •Medicare & Medicaid Sanctions and reinstatement reports, distributed by federally

		contracting organizations •Federal Employees Health Benefits Plan Program department record, published by the Office of Personnel Management, Office of the Inspector General •American Medical Association (AMA) Physician Master File entry •state Medicaid agency or intermediary and the Medicare intermediary
Investigations	The physician or dentist has never been the object of an administrative, civil, or criminal complaint or investigation.	•Application questionnaire
Health Status	The physician or dentist does not have any condition that would impact the ability to perform the essential functions of the position, with or without accommodation, and without exposing the physician or others to health and safety risks. The physician or dentist is not currently abusing medications, other drugs or substances, including alcohol.	•Application questionnaire •Treating provider
Medical Record Review	The physician or dentist must meet the threshold for the medical record review, when applicable.	•Medical record audit results

Criteria for Participation

Podiatrist (DPM)

In order to be eligible for participation, the podiatrist or, in the case of a group of podiatrists i.e., group practice, PHO, IPA, independent network, or any other organized arrangement of podiatrists, each individual podiatrist who has a contract to provide professional services through such group, and for whom the group desires to provide Covered Services under Avera, must continuously meet the following requirements:

LEVEL I CRITERIA
(may not be waived)

Element	Criteria for Participation	Verification Source
Licensure	The podiatrist must hold a current, valid, active license to practice podiatry in the state(s) in which the podiatrist intends to provide Covered Services.	•State licensing agency
DEA Registration	The podiatrist must hold a current and active DEA Registration. Podiatrists who do not, as part of their practice, prescribe medications are exempt from this requirement.	•Copy of current DEA •NTIS •Documented Visual inspection of the original certificate •Confirmation from the state pharmaceutical licensing agency, if applicable.
Professional Education	The podiatrist must be a graduate of an accredited school of podiatry.	•Highest level of education **OR** •Board Certification -American Board of Podiatric Orthopedic and

		Primary Podiatric Medicine -American Board of Podiatry Surgery
Utilization Review	The podiatrist must agree to participate in and abide by the utilization review program as established by the Board of Directors.	•Release and attestation on application and/or contract
Liability Insurance	The podiatrist must have current professional liability coverage of at least $1 million per claim or occurrence, and $3 million aggregate.	•Copy of liability insurance face sheet showing dates and coverage amounts •application attestation on application including dates & amount of current malpractice insurance coverage •Federal Tort Coverage requires a copy of the federal tort letter or an attestation from the practitioner of federal tort coverage

LEVEL II CRITERIA

Podiatrists must meet the following requirements, unless the Plan, after full disclosure by the podiatrist, waives such requirement.

Element	Criteria for Participation	Verification Source
Professional Liability Claims History	The podiatrist has no history of professional liability claim settlements or judgments, and there are no pending cases at the current time.	•Application questionnaire •NPDB
Work History	The podiatrist has no unexplained gaps of six months or greater in his/her work	•Work history on

	history.	application and/or curriculum vitae
Disciplinary Actions - Licensure	The podiatrist has no not had any action taken by a state podiatry board where the podiatrist has practiced that would affect the podiatrist's license to practice. If a podiatrist was licensed in more than one state in the most recent five year period, the query must include all states in which the podiatrist worked.	•Application questionnaire •State licensing agency •NPDB •Federation of Podiatric Medical Boards •HIPDB
Felony Convictions	The podiatrist has never been convicted of a felony.	•Application questionnaire •State licensing agency •Federation of Podiatric Medical Boards •HIPDB
Clinical Staff Membership	The podiatrist has never been refused membership on a hospital or healthcare facility medical staff for reasons other than closure of that staff to the podiatrist's specialty.	•Application questionnaire •Hospital/Healthcare Facility •NPDB
Clinical Privileges	The podiatrist must have clinical privileges in good standing, as determined that institution, at a Plan Hospital in a category and with privileges appropriate for such podiatrist. If the podiatrist does not, as a part of the practice, have a need to admit patients to a hospital, clinical privileges are not required. The podiatrist's privileges at any hospital or healthcare facility have never been suspended, diminished, revoked, or not renewed.	•Application questionnaire •Hospital/Healthcare Facility •NPDB Hospital
DEA Registrations	The podiatrist's DEA registration has never been suspended, restricted, or revoked or acted upon in any way whatsoever.	•Application questionnaire •State licensing agency •NPDB

		•Federation of Podiatric Medical Boards
Liability Insurance	The podiatrist's liability insurance has never been denied, suspended, canceled, or not renewed.	•Application questionnaire •Liability insurance carrier •NPDB
Podiatric Organization	The podiatrist has never been subjected to disciplinary action in any podiatric organization.	•Application questionnaire •NPDB
Sanctions	The podiatrist has never had sanctions imposed or voluntarily accepted any sanctions by any health care institution, professional health care organizations, licensing authority, governmental entity, professional standards review organization (PRO), utilization and quality assurance peer review organization (PRO).	•Application questionnaire •NPDB •Federation of Podiatric Medical Boards •HIPDB
Medicare/Medicaid	The podiatrist has never been convicted of any crimes related to the practice of podiatry, including Medicare or Medicaid related crimes. The podiatrist has never been subjected to civil money penalties under the Medicare or Medicaid program or been suspended from participation in Medicare or Medicaid.	•Application questionnaire •FSMB •NPDB (MD & DO) •HIPDB • Cumulative Sanction Internet Sites •Medicare & Medicaid Sanctions and reinstatement reports, distributed by federally contracting organizations •Federal Employees Health Benefits Plan Program department record, published by the

		Office of Personnel Management, Office of the Inspector General •American Medical Association (AMA) Physician Master File entry •state Medicaid agency or intermediary and the Medicare intermediary
Investigations	The podiatrist has never been the object of an administrative, civil, or criminal complaint or investigation.	•Application questionnaire
Health Status	The podiatrist does not have any condition that would impact the ability to perform the essential functions of the position, with or without accommodation, and without exposing the podiatrist or others to health and safety risks. The podiatrist is not currently abusing medications, other drugs or substances, including alcohol.	•Application questionnaire •Treating provider

Criteria for Participation

Chiropractor (DC)

In order to be eligible for participation, the chiropractor or, in the case of a group of chiropractors i.e., group practice, PHO, IPA, independent network, or any other organized arrangement of chiropractors, each individual chiropractor who has a contract to provide professional services through such group, and for whom the group desires to provide Covered Services under Avera, must continuously meet the following requirements:

LEVEL I CRITERIA
(may not be waived)

Element	Criteria for Participation	Verification Source
Licensure	The chiropractor must hold a current, valid, active license to practice medicine in the state(s) in which the chiropractor intends to provide Covered Services.	•State licensing agency
Clinical Registration/Privileges	When applicable, the chiropractor's clinical registration/privileges at a Plan Hospital must be in good standing, as determined by that institution, in the appropriate category. Clinical privileges are not required.	•Hospital
Professional Education	The chiropractor must be a graduate of an accredited chiropractic college.	•Confirmation from chiropractic college
Utilization Review	The chiropractor must agree to participate in and abide by the utilization review program as established by the Board of Directors.	•Release and attestation on application
Liability Insurance	The chiropractor must have current professional liability coverage of at least $1 million per claim or occurrence, and $3 million aggregate.	•Copy of liability insurance face sheet showing dates and coverage amounts •application attestation on application including dates & amount of current malpractice insurance

		coverage •Federal Tort Coverage requires a copy of the federal tort letter or an attestation from the practitioner of federal tort coverage

LEVEL II CRITERIA

Chiropractors must meet the following requirements, unless the Plan, after full disclosure by the chiropractor, waives such requirement.

Element	Criteria for Participation	Verification Source
Professional Liability Claims History	The chiropractor has no history of professional liability claim settlements, judgments, or pending cases.	•Application questionnaire •NPDB
Work History	The chiropractor has no unexplained gaps of six months or greater in his/her work history.	•Work history on application and/or curriculum vitae
Disciplinary Actions - License	The chiropractor has not had any action taken by a state chiropractic board where the chiropractor has practiced that would affect the chiropractor's license to practice. If a chiropractor was licensed in more than one state in the most recent five year period, the query must include all states in which the chiropractor worked.	•Application questionnaire •State licensing agency •CIN-BAD •NPDB •HIPDB
Felony Convictions	The chiropractor has never been convicted of a felony.	•Application questionnaire •State licensing agency •CIN-BAD •HIPDB

Clinical Staff Membership	The chiropractor has never been refused membership on a hospital or healthcare facility medical staff for reasons other than closure of that staff to the chiropractor's specialty.	•Application questionnaire •Hospital/Healthcare facility •NPDB
Clinical Privileges	The chiropractor's privileges at any hospital or healthcare facility have never been suspended, diminished, revoked, or not renewed.	•Application questionnaire •Hospital/Healthcare facility •NPDB
Liability Insurance	The chiropractor's liability insurance has never been denied, suspended, canceled, or not renewed.	•Application questionnaire •Liability insurance carrier •NPDB
Medical Organization	The chiropractor has never been subjected to disciplinary action in any chiropractic organization.	•Application questionnaire •NPDB
Sanctions	The chiropractor has never had sanctions imposed or voluntarily accepted any sanctions by any health care institution, professional health care organizations, licensing authority, governmental entity, professional standards review organization (PRO), utilization and quality assurance peer review organization (PRO).	•Application questionnaire •CIN-BAD •NPDB •HIPDB Cumulative Sanction Internet Sites
Medicare/Medicaid	The chiropractor has never been convicted of any crimes related to his or her practice, including Medicare or Medicaid related crimes. The chiropractor has never been subjected to civil money penalties under the Medicare or Medicaid program or been suspended from participation in Medicare or Medicaid.	•Application questionnaire •FSMB •NPDB (MD & DO) •HIPDB • Cumulative Sanction Internet Sites

		•Medicare & Medicaid Sanctions and reinstatement reports, distributed by federally contracting organizations •Federal Employees Health Benefits Plan Program department record, published by the Office of Personnel Management, Office of the Inspector General •American Medical Association (AMA) Physician Master File entry •state Medicaid agency or intermediary and the Medicare intermediary
Investigations	The chiropractor has never been the object of an administrative, civil, or criminal complaint or investigation.	•Application questionnaire
Health Status	The chiropractor does not have any condition that would impact the ability to perform the essential functions of the position, with or without accommodation, and without exposing the chiropractor or others to health and safety risks. The chiropractor is not currently abusing medications, other drugs or substances, including alcohol.	•Application questionnaire •Treating provider

Criteria for Participation

Optometrist (OD)

In order to be eligible for participation, the optometrist or, in the case of a group of optometrists i.e., group practice, PHO, IPA, independent network, or any other organized arrangement of optometrists, each individual optometrist who has a contract to provide professional services through such group, and for whom the group desires to provide Covered Services under Avera, must continuously meet the following requirements:

LEVEL I CRITERIA
(may not be waived)

Element	Criteria for Participation	Verification Source
Licensure	The optometrist must hold a current, valid, active license to practice optometry in the state(s) in which the optometrist intends to provide Covered Services.	•State licensing agency
DEA Registration	The optometrist must hold a current and active DEA Registration. Optometrists who do not, as part of their practice, prescribe medications are exempt from this requirement.	•Copy of current DEA •NTIS •Documented Visual inspection of the original certificate •Confirmation from the state pharmaceutical licensing agency, if applicable.
Clinical Privileges	When applicable, the optometrist's clinical privileges at a Plan Hospital must be in good standing in the appropriate category. Clinical privileges are not required.	•Hospital
Professional Education	The optometrist must be a graduate of an accredited school of optometry.	•Confirmation from school of optometry

Utilization Review	The optometrist must agree to participate in and abide by the utilization review program as established by the Board of Directors.	•Release and attestation on application and/or contract
Liability Insurance	The optometrist must have current professional liability coverage of at least $1 million per claim or occurrence, and $3 million aggregate.	•Copy of liability insurance face sheet showing dates and coverage amounts •application attestation on application including dates & amount of current malpractice insurance coverage •Federal Tort Coverage requires a copy of the federal tort letter or an attestation from the practitioner of federal tort coverage

LEVEL II CRITERIA

Optometrists must meet the following requirements, unless the Plan, after full disclosure by the optometrist, waives such requirement.

Element	Criteria for Participation	Verification Source
Professional Liability Claims History	The optometrist has no history of professional liability claim settlements or judgments, and there are no pending cases at the current time.	•Application questionnaire •NPDB
Work History	The optometrist has no unexplained gaps of six months or greater in the optometrist's work history.	•Work history on application and/or curriculum vitae
Disciplinary Actions - Licensure	The optometrist has not had any action taken by a state optometry board where the	•Application

	optometrist has practiced optometry that would affect the optometrist's license to practice. If an optometrist was licensed in more than one state in the most recent five year period, the query must include all states in which the optometrist worked.	questionnaire •State licensing agency •NPDB •HIPDB
Felony Convictions	The optometrist has never been convicted of a felony.	•Application questionnaire •State licensing agency •HIPDB
Clinical Staff Membership	The optometrist has never been refused membership on a hospital or healthcare facility medical staff for reasons other than closure of that staff to the optometrist's specialty.	•Application questionnaire •Hospital/Healthcare facility •NPDB
Clinical Privileges	The optometrist's privileges at any hospital or healthcare facility have never been suspended, diminished, revoked, or not renewed.	•Application questionnaire •Hospital/Healthcare facility •NPDB
DEA Registrations	The optometrist's DEA registration has never been suspended, restricted, or revoked or acted upon in any way whatsoever.	•Application questionnaire •State licensing agency •NPDB
Liability Insurance	The optometrist's liability insurance has never been denied, suspended, canceled, or not renewed.	•Application questionnaire •Liability insurance carrier •NPDB
Professional Organization	The optometrist has never been subjected to disciplinary action in any professional organization.	•Application questionnaire •NPDB
Sanctions	The optometrist has never had sanctions imposed or voluntarily accepted any sanctions by any health care institution, professional health care organizations,	•Application questionnaire

	licensing authority, governmental entity, professional standards review organization (PRO), utilization and quality assurance peer review organization (PRO).	•NPDB •HIPDB
Medicare/Medicaid	The optometrist has never been convicted of any crimes related to the practice of optometry, including Medicare or Medicaid related crimes. The optometrist has never been subjected to civil money penalties under the Medicare or Medicaid program or been suspended from participation in Medicare or Medicaid.	•Application questionnaire •FSMB •NPDB (MD & DO) •HIPDB • Cumulative Sanction Internet Sites •Medicare & Medicaid Sanctions and reinstatement reports, distributed by federally contracting organizations •Federal Employees Health Benefits Plan Program department record, published by the Office of Personnel Management, Office of the Inspector General •American Medical Association (AMA) Physician Master File entry •state Medicaid agency or intermediary and the Medicare intermediary
Investigations	The optometrist has never been the object of an administrative, civil, or criminal complaint or investigation.	•Application questionnaire

Health Status	The optometrist does not have any condition that would impact the ability to perform the essential functions of the position, with or without accommodation, and without exposing the optometrist or others to health and safety risks. The optometrist is not currently abusing medications, other drugs or substances, including alcohol.	•Application questionnaire •Treating provider

Criteria for Participation

Nurse Practitioner (NP)
(Including ARNP, CRNA, CNP, CNM, CCNS, CFNP, FNP)

LEVEL I CRITERIA
(may not be waived)

In order to be eligible for participation, the NP or, in the case of a group of NPs i.e., group practice, PHO, IPA, independent network, or any other organized arrangement of NPs, each individual NP who has a contract to provide professional services through such group, and for whom the group desires to provide Covered Services under Avera, must continuously meet the following requirements:

Element	Criteria for Participation	Verification Source
Licensure	The NP must hold a current, valid, active license to practice in the state(s) in which the NP intends to provide Covered Services.	•State licensing agency
DEA Registration	The NP must hold a current and active DEA Registration. NPs who do not, as part of their practice, prescribe medications are exempt from this requirement.	•Copy of current DEA •NTIS •Documented Visual inspection of the original certificate •Confirmation from the state pharmaceutical licensing agency, if applicable.
Professional Education	The NP must have completed an accredited nurse practitioner program.	•Confirmation from accredited NP program

Board Certification	The NP must be currently certified by the American Nurses Credentialing Center, American Academy of Nurse Practitioners, The National Certification Corporation, American Midwifery Certification Board, or the National Board of Certification & Recertification for Nurse Anesthetists	•Confirmation from the Certification Program •State licensing agency, if the organization provides documentation that the State agency performs primary source verification
Utilization Review	The NP must agree to participate in and abide by the utilization review program as established by the Board of Directors.	•Release and attestation on application and/or contract
Liability Insurance	The NP must have current professional liability coverage of at least $1 million per claim or occurrence, and $3 million aggregate.	•Copy of liability insurance face sheet showing dates and coverage amounts •application attestation on application including dates & amount of current malpractice insurance coverage •Federal Tort Coverage requires a copy of the federal tort letter or an attestation from the practitioner of federal tort coverage

LEVEL II CRITERIA

NPs must meet the following requirements, unless the Plan, after full disclosure by the NP waives such requirement.

Element	Criteria for Participation	Verification Source
Professional Liability Claims History	The NP has no history of professional liability claim settlements or judgments, and there are no pending cases at the current time.	•Application questionnaire •NPDB
Clinical Registration/Privileges	When applicable, the NP's clinical registration/privileges at a Plan Hospital must be in good standing in the appropriate category. Clinical privileges are not required.	•Hospital
Work History	The NP has no unexplained gaps of six months or greater in his/her work history.	•Work history on application and/or curriculum vitae
Disciplinary Actions - Licensure	The NP has not had any action taken by a state medical or nursing board where the NP has practiced that would affect the NP's license to practice. If a NP was licensed in more than one state in the most recent five year period, the query must include all states in which the NP worked.	•Application questionnaire •State licensing agency •NPDB •HIPDB
Felony Convictions	The NP has never been convicted of a felony.	•Application questionnaire •State licensing agency •HIPDB
Clinical Staff Membership	The NP has never been refused membership on a hospital or other healthcare facility staff for reasons other than closure of that staff to the NP's specialty.	•Application questionnaire •Hospital/Healthcare Facility •NPDB
Clinical Privileges	The NP's privileges at any hospital or healthcare facility have never been suspended, diminished, revoked, or not renewed.	•Application questionnaire •Hospital/Healthcare Facility •NPDB
DEA Registrations	The NP's DEA registration has never been suspended, restricted, or revoked or	•Application

	acted upon in any way whatsoever.	questionnaire •State licensing agency •NPDB
Liability Insurance	The NP's liability insurance has never been denied, suspended, canceled, or not renewed.	•Application questionnaire •Liability insurance carrier •NPDB
Professional Organization	The NP has never been subjected to disciplinary action in any professional organization.	•Application questionnaire •NPDB
Sanctions	The NP has never had sanctions imposed or voluntarily accepted any sanctions by any health care institution, professional health care organizations, licensing authority, governmental entity, professional standards review organization (PRO), utilization and quality assurance peer review organization (PRO).	•Application questionnaire •NPDB •HIPDB
Medicare/Medicaid	The NP has never been convicted of any crimes related to the practice including Medicare or Medicaid related crimes. The NP has never been subjected to civil money penalties under the Medicare or Medicaid program or been suspended from participation in Medicare or Medicaid.	•Application questionnaire •FSMB •NPDB (MD & DO) •HIPDB • Cumulative Sanction Internet Sites •Medicare & Medicaid Sanctions and reinstatement reports, distributed by federally contracting organizations •Federal Employees Health Benefits Plan Program department record, published by the Office of Personnel

		Management, Office of the Inspector General •American Medical Association (AMA) Physician Master File entry •state Medicaid agency or intermediary and the Medicare intermediary
Investigations	The NP has never been the object of an administrative, civil, or criminal complaint or investigation.	•Application questionnaire
Health Status	The NP does not have any condition that would impact the ability to perform the essential functions of the position, with or without accommodation, and without exposing the NP or others to health and safety risks. The NP is not currently abusing medications, other drugs or substances, including alcohol.	•Application questionnaire •Treating provider

Criteria for Participation

Physician Assistant (PA)

LEVEL I CRITERIA
(may not be waived)

In order to be eligible for participation, the PA or, in the case of a group of PAs i.e., group practice, PHO, IPA, independent network, or any other organized arrangement of PAs, each individual PA who has a contract to provide professional services through such group, and for whom the group desires to provide Covered Services under Avera, must continuously meet the following requirements:

Element	Criteria for Participation	Verification Source
Licensure	The PA must hold a current, valid, active license to practice in the state(s) in which the PA intends to provide Covered Services.	•State licensing agency
DEA Registration	The PA must hold a current and active DEA Registration. PAs who do not, as part of their practice, prescribe medications are exempt from this requirement.	•Copy of current DEA •NTIS •Documented Visual inspection of the original certificate •Confirmation from the state pharmaceutical licensing agency, if applicable. •AMA Physician Master File
Professional Education	The PA must be a graduate of an accredited PA program.	•Confirmation from accredited PA program

Board Certification	The PA must be currently certified by the National Commission on Certification of Physician Assistants (NCCPA)	•Copy of current Certification •Confirmation from the Certification Program
Utilization Review	The PA must agree to participate in and abide by the utilization review program as established by the Board of Directors.	•Release and attestation on application and/or contract
Liability Insurance	The PA must have current professional liability coverage of at least $1 million per claim or occurrence, and $1 million aggregate.	•Copy of liability insurance face sheet showing dates and coverage amounts •application attestation on application including dates & amount of current malpractice insurance coverage •Federal Tort Coverage requires a copy of the federal tort letter or an attestation from the practitioner of federal tort coverage
Supervising Physician	Supervising physician who is an Avera Plan Physician.	•Name of supervising physician

LEVEL II CRITERIA

PAs must meet the following criteria, unless the Plan, after full disclosure by the PA, waives such requirement.

Element	Criteria for Participation	Verification Source

Professional Liability Claims History	The PA has no history of professional liability claim settlements or judgments, and there are no pending malpractice or negligence cases at the current time..	•Application questionnaire •NPDB
Clinical Registration/Privileges	When applicable, the PA's clinical registration/privileges at a Plan Hospital must be in good standing in the appropriate category. Clinical privileges are not required.	•Hospital
Work History	The PA has no unexplained gaps of six months or greater in his/her work history.	•Work history on application and/or curriculum vitae
Disciplinary Actions - Licensure	The PA has not had any action taken by a state medical board where the PA has practiced medicine that would affect the physician's license to practice. If a PA was licensed in more than one state in the most recent five year period, the query must include all states in which the PA worked.	•Application questionnaire •State licensing agency •NPDB •FSMB •HIPDB
Felony Convictions	The PA has never been convicted of a felony.	•Application questionnaire •State licensing agency •FSMB •HIPDB
Clinical Staff Membership	The PA has never been refused membership on a hospital or healthcare facility staff for reasons other than closure of that staff to the PA's specialty.	•Application questionnaire •Hospital/Healthcare facility •NPDB
Clinical Privileges	The PA's privileges at any hospital or healthcare facility have never been suspended, diminished, revoked, or not renewed.	•Application questionnaire •Hospital/Healthcare facility •NPDB
DEA Registrations	The PA's DEA registration has never been suspended, restricted, or revoked or	•Application

	acted upon in any way whatsoever.	questionnaire •State licensing agency •NPDB •FSMB
Liability Insurance	The PA's liability insurance has never been denied, suspended, canceled, or not renewed.	•Application questionnaire •Liability insurance carrier •NPDB
Professional Organization	The PA has never been subjected to disciplinary action in any professional organization.	•Application questionnaire •NPDB
Sanctions	The PA has never had sanctions imposed or voluntarily accepted any sanctions by any health care institution, professional health care organizations, licensing authority, governmental entity, professional standards review organization (PRO), utilization and quality assurance peer review organization (PRO).	•Application questionnaire •NPDB •FSMB •HIPDB
Medicare/Medicaid	The PA has never been convicted of any crimes related to the practice, including Medicare or Medicaid related crimes. The PA has never been subjected to civil money penalties under the Medicare or Medicaid program or been suspended from participation in Medicare or Medicaid.	•Application questionnaire •FSMB •NPDB (MD & DO) •HIPDB • Cumulative Sanction Internet Sites •Medicare & Medicaid Sanctions and reinstatement reports, distributed by federally contracting organizations •Federal Employees Health Benefits Plan Program department

		record, published by the Office of Personnel Management, Office of the Inspector General •American Medical Association (AMA) Physician Master File entry •state Medicaid agency or intermediary and the Medicare intermediary
Investigations	The PA has never been the object of an administrative, civil, or criminal complaint or investigation.	•Application questionnaire
Health Status	The PA does not have any condition that would impact the ability to perform the essential functions of the position, with or without accommodation, and without exposing the PA or others to health and safety risks. The PA is not currently abusing medications, other drugs or substances, including alcohol.	•Application questionnaire •Treating provider

Criteria for Participation

Psychologist

LEVEL I CRITERIA
(may not be waived)

In order to be eligible for participation, the psychologist or, in the case of a group of psychologists i.e., group practice, PHO, IPA, independent network, or any other organized arrangement of psychologists, each individual psychologists who has a contract to provide professional services through such group, and for whom the group desires to provide Covered Services under Avera, must continuously meet the following requirements:

Element	Criteria for Participation	Verification Source
Licensure	The psychologist must hold a current, valid, active license to practice in the state(s) in which the psychologist intends to provide Covered Services.	•State licensing agency
Professional Education	The psychologist must have a doctoral degree in psychology from an accredited college or university.	•Confirmation from accredited college or university
Liability Insurance	The psychologist must have current professional liability coverage of at least $1 million per claim or occurrence, and $3 million aggregate.	•Copy of liability insurance face sheet showing dates and coverage amounts •application attestation on application including dates & amount of current malpractice insurance coverage •Federal Tort Coverage requires a copy of the federal tort letter or an attestation from the practitioner of federal tort coverage

Utilization Review	The psychologist must agree to participate in and abide by the utilization review program as established by the Board of Directors.	•Release and attestation on application and/or contract

LEVEL II CRITERIA

Psychologists must meet the following criteria, unless the Plan, after full disclosure by the Psychologist, waives such requirement.

Element	Criteria for Participation	Verification Source
Professional Liability Claims History	The psychologist has no history of professional liability claim settlements or judgments, and there are no pending cases at the current time.	•Application questionnaire •NPDB
Work History	The psychologist has no unexplained gaps of six months or greater in work history.	•Work history on application and/or curriculum vitae
Disciplinary Actions - Licensure	The psychologist has not had any action taken by a state licensing board where the psychologist has practiced medicine that would affect the psychologist's license to practice. If a psychologist was licensed in more than one state in the most recent five year period, the query must include all states in which the psychologist worked.	•Application questionnaire •State licensing agency •NPDB •HIPDB
Felony Convictions	The psychologist has never been convicted of a felony.	•Application questionnaire •State licensing agency •HIPDB
Clinical Registration/Privileges	When applicable, the psychologists/clinical registration privileges at a Plan Hospital must be in good standing in the appropriate category. Clinical privileges are not required.	Hospital
Clinical Staff Membership	The psychologist has never been refused membership on a hospital or other healthcare facility staff for reasons other than closure of that staff to the	•Application questionnaire

	psychologist's specialty.	•Hospital •NPDB
Clinical Privileges	The psychologist's privileges at any hospital or other healthcare facility have never been suspended, diminished, revoked, or not renewed.	•Application questionnaire •Hospital/facility •NPDB
Liability Insurance	The psychologist's liability insurance has never been denied, suspended, canceled, or not renewed.	•Application questionnaire •Liability insurance carrier •NPDB
Professional Organization	The psychologist has never been subjected to disciplinary action in any professional organization.	•Application questionnaire •NPDB
Sanctions	The psychologist has never had sanctions imposed or voluntarily accepted any sanctions by any health care institution, professional health care organizations, licensing authority, governmental entity, professional standards review organization (PRO), utilization and quality assurance peer review organization (PRO).	•Application questionnaire •NPDB •HIPDB
Medicare/Medicaid	The psychologist has never been convicted of any crimes related to the practice of psychology, including Medicare or Medicaid related crimes. The Psychologist has never been subjected to civil money penalties under the Medicare or Medicaid program or been suspended from participation in Medicare or Medicaid.	•Application questionnaire •FSMB •NPDB (MD & DO) •HIPDB • Cumulative Sanction Internet Sites •Medicare & Medicaid Sanctions and reinstatement reports, distributed by federally contracting organizations •Federal Employees

		Health Benefits Plan Program department record, published by the Office of Personnel Management, Office of the Inspector General •American Medical Association (AMA) Physician Master File entry •state Medicaid agency or intermediary and the Medicare intermediary
Investigations	The psychologist has never been the object of an administrative, civil, or criminal complaint or investigation.	•Application questionnaire
Health Status	The psychologist does not have any condition that would impact the ability to perform the essential functions of the position, with or without accommodation, and without exposing the psychologist or others to health and safety risks. The psychologist not currently abusing medications, other drugs or substances, including alcohol.	•Application questionnaire •Treating provider

Criteria for Participation

Masters Level Behavioral Health Practitioner

LEVEL I CRITERIA
(may not be waived)

In order to be eligible for participation, the behavioral health practitioner or, in the case of a group of behavioral health practitioners i.e., group practice, PHO, IPA, independent network, or any other organized arrangement of behavioral health practitioners, each individual behavioral health practitioners who has a contract to provide professional services through such group, and for whom the group desires to provide Covered Services under Avera, must continuously meet the following requirements:

Element	Criteria for Participation	Verification Source
Licensure	The behavioral health practitioner must hold a current, valid, active license to practice in the states in which the practitioner intends to provide Covered Services.	•State Board/licensing agency
Professional Education	The behavioral health practitioner must have a master's degree in a behavioral health discipline from an accredited college or university.	•Confirmation from accredited college or university
Liability Insurance	The behavioral health practitioner must have current professional liability coverage of at least $1 million per claim or occurrence, and $3 million aggregate.	•Copy of liability insurance face sheet showing dates and coverage amounts •application attestation on application including dates & amount of current malpractice insurance coverage •Federal Tort Coverage requires a copy of the federal tort letter or an attestation from the

		practitioner of federal tort coverage
Utilization Review	The behavioral health practitioner must agree to participate in and abide by the utilization review program as established by the Board of Directors.	•Release and attestation on application and/or contract
Supervising Physician	Means supervising, collaborating and/or consulting Licensed Psychologist or qualified Physician who is also a Plan Practitioner. Supervising provider must have five years of post-master's clinical experience to supervise staff members who make clinical decisions. A psychiatrist or a licensed doctoral level clinical psychologist oversees triage and referral decisions.	• Attestation from the consulting/supervising/ collaborating practitioner

LEVEL II CRITERIA

Behavioral health practitioners must meet the following criteria, unless the Plan, after full disclosure by the Behavioral health practitioner waives such requirement.

Element	Criteria for Participation	Verification Source
Professional Liability Claims History	The behavioral health practitioner has no history of professional liability claim settlements or judgments, and there are no pending cases at the current time.	•Application questionnaire •NPDB
Work History	The behavioral health practitioner has no unexplained gaps in work history.	•Work history on application and/or curriculum vitae
Disciplinary Actions - Licensure	The behavioral health practitioner has not had any action taken by a state licensing board where the practitioner has practiced that would affect the practitioner's license. If a behavioral health practitioner was licensed in more than one state in the most recent five year period, the query must include all states in which the practitioner worked.	•Application questionnaire •State licensing agency •NPDB •HIPDB
Felony Convictions	The behavioral health practitioner has never been convicted of a felony.	•Application

		questionnaire •State licensing agency •HIPDB
Clinical Staff Membership	The behavioral health practitioner has never been refused membership on a hospital or other health care facility staff for reasons other than closure of that staff to the behavioral health practitioner's specialty.	•Application questionnaire •Hospital •NPDB
Clinical Registration/Privileges	When applicable, the behavioral health practitioner's clinical registration privileges at a Plan Hospital must be in good standing in the appropriate category. Clinical privileges are not required.	•Hospital
Clinical Privileges	The behavioral health practitioner's privileges at any hospital or other health care facility have never been suspended, diminished, revoked, or not renewed.	•Application questionnaire •Hospital/facility •NPDB
Liability Insurance	The behavioral health practitioner's liability insurance has never been denied, suspended, canceled, or not renewed.	•Application questionnaire •Liability insurance carrier •NPDB
Professional Organization	The behavioral health practitioner has never been subjected to disciplinary action in any professional organization.	•Application questionnaire •NPDB
Sanctions	The behavioral health practitioner has never had sanctions imposed or voluntarily accepted any sanctions by any health care institution, professional health care organizations, licensing authority, governmental entity, professional standards review organization (PRO), utilization and quality assurance peer review organization (PRO).	•Application questionnaire •NPDB •HIPDB
Medicare/Medicaid	The behavioral health practitioner has never been convicted of any crimes related to the practice of optometry, including Medicare or Medicaid related crimes. The behavioral health practitioner has never been subjected to civil money penalties under the Medicare or Medicaid program or been suspended from participation in	•Application questionnaire •FSMB •NPDB (MD & DO)

	Medicare or Medicaid.	•HIPDB • Cumulative Sanction Internet Sites •Medicare & Medicaid Sanctions and reinstatement reports, distributed by federally contracting organizations •Federal Employees Health Benefits Plan Program department record, published by the Office of Personnel Management, Office of the Inspector General •American Medical Association (AMA) Physician Master File entry •state Medicaid agency or intermediary and the Medicare intermediary
Investigations	The behavioral health practitioner has never been the object of an administrative, civil, or criminal complaint or investigation.	•Application questionnaire
Health Status	The behavioral health practitioner does not have any condition that would impact the ability to perform the essential functions of the position, with or without accommodation, and without exposing the behavioral health practitioner or others to health and safety risks. The behavioral health practitioner not currently abusing medications, other drugs or substances, including alcohol.	•Application questionnaire •Treating provider

Criteria for Participation

Genetic Counselors

LEVEL I CRITERIA
(may not be waived)

In order to be eligible for participation, the behavioral health practitioner or, in the case of a group of behavioral health practitioners i.e., group practice, PHO, IPA, independent network, or any other organized arrangement of genetic counselors, each individual genetic counselor who has a contract to provide professional services through such group, and for whom the group desires to provide Covered Services under Avera, must continuously meet the following requirements:

Element	Criteria for Participation	Verification Source
Licensure	The genetic counselor must hold a current, valid, active license to practice in the states in which the practitioner intends to provide Covered Services, if state has regulation of genetic couselors. A temporary license does not qualify, the license must be the permanent licensure in appropriate state.	•State Board/licensing agency
Professional Education	The genetic counselor must have a master's degree in one of the following disciplines from an accredited college or university. • Human, Medical and clinical genetics • Psychosocial theory and techniques • Social, ethical and legal issues • Healthcare delivery systems and public health principles • Teaching techniques • Research methods • Clinical training, working with individuals and families affected with a broad range of conditions	•Confirmation from accredited college or university
Board Certification	The genetic Counselor must be certified by the American Board of Genetic Counseling as Certified Genetic Counselor (CGC)®	Confirmation by the Certication Board
Liability Insurance	The genetic counselor must have current professional liability coverage of at	•Copy of liability

	least $1 million per claim or occurrence, and $3 million aggregate.	insurance face sheet showing dates and coverage amounts •application attestation on application including dates & amount of current malpractice insurance coverage •Federal Tort Coverage requires a copy of the federal tort letter or an attestation from the practitioner of federal tort coverage
Utilization Review	The genetic counselor must agree to participate in and abide by the utilization review program as established by the Board of Directors.	•Release and attestation on application and/or contract

LEVEL II CRITERIA

The Genetic Counselor must meet the following criteria, unless the Plan, after full disclosure by the genetic counselor waives such requirement.

Element	Criteria for Participation	Verification Source
Professional Liability Claims History	The genetic Counselor has no history of professional liability claim settlements or judgments, and there are no pending cases at the current time.	•Application questionnaire •NPDB
Work History	The genetic counselor has no unexplained gaps in work history.	•Work history on application and/or curriculum vitae
Disciplinary Actions - Licensure	The genetic counselor has not had any action taken by a state licensing board	•Application

	where the practitioner has practiced that would affect the practitioner's license. If a genetic counselor was licensed in more than one state in the most recent five year period, the query must include all states in which the practitioner worked.	questionnaire •State licensing agency •NPDB •HIPDB
Felony Convictions	The genetic counselor has never been convicted of a felony.	•Application questionnaire •State licensing agency •HIPDB
Clinical Staff Membership	The genetic counselor has never been refused membership on a hospital or other health care facility staff for reasons other than closure of that staff to the genetic counselor's specialty.	•Application questionnaire •Hospital •NPDB
Clinical Registration/Privileges	When applicable, the genetic counselor's clinical registration privileges at a Plan Hospital must be in good standing in the appropriate category. Clinical privileges are not required.	•Hospital
Clinical Privileges	The genetic counselor's privileges at any hospital or other health care facility have never been suspended, diminished, revoked, or not renewed.	•Application questionnaire •Hospital/facility •NPDB
Liability Insurance	The genetic counselor's liability insurance has never been denied, suspended, canceled, or not renewed.	•Application questionnaire •Liability insurance carrier •NPDB
Professional Organization	The genetic counselor has never been subjected to disciplinary action in any professional organization.	•Application questionnaire •NPDB
Sanctions	The genetic counselor has never had sanctions imposed or voluntarily accepted any sanctions by any health care institution, professional health care organizations, licensing authority, governmental entity, professional standards review organization (PRO), utilization and quality assurance peer review organization	•Application questionnaire •NPDB •HIPDB

	(PRO).	
Medicare/Medicaid	The genetic counselor has never been convicted of any crimes related to the practice of genetic counseling, including Medicare or Medicaid related crimes. The genetic counselor has never been subjected to civil money penalties under the Medicare or Medicaid program or been suspended from participation in Medicare or Medicaid.	•Application questionnaire •FSMB •NPDB (MD & DO) •HIPDB • Cumulative Sanction Internet Sites •Medicare & Medicaid Sanctions and reinstatement reports, distributed by federally contracting organizations •Federal Employees Health Benefits Plan Program department record, published by the Office of Personnel Management, Office of the Inspector General •American Medical Association (AMA) Physician Master File entry •state Medicaid agency or intermediary and the Medicare intermediary
Investigations	The genetic counselor has never been the object of an administrative, civil, or criminal complaint or investigation.	•Application questionnaire
Health Status	The genetic counselor does not have any condition that would impact the ability to perform the essential functions of the position, with or without accommodation, and without exposing the themselves or others to health and safety risks.	•Application questionnaire •Treating provider

	The genetic counselor not currently abusing medications, other drugs or substances, including alcohol.	

Criteria for Participation

Physical Therapists

LEVEL I CRITERIA
(may not be waived)

In order to be eligible for participation, the physical therapy practitioner or, in the case of a group of such therapy practitioners i.e., group practice, PHO, IPA, independent network, or any other organized arrangement of physical practitioners, each individual practitioners who has a contract to provide professional services through such group, and for whom the group desires to provide Covered Services under Avera, must continuously meet the following requirements:

Element	Criteria for Participation	Verification Source
Licensure	The therapy practitioner must hold a current, valid, active license to practice in the states in which the therapist intends to provide Covered Services.	•State Board/licensing agency
Professional Education	The therapy practitioner must have a doctorate degree in an appropriate discipline from an accredited college or university, a master's degree in an appropriate discipline from an accredited college or university in addition to 5 years clinical experience, or a bachelor's degree in addition to 10 years clinical experience	•Confirmation from accredited college or university
Liability Insurance	The therapy practitioner must have current professional liability coverage of at least $1 million per claim or occurrence, and $3 million aggregate.	•Copy of liability insurance face sheet showing dates and coverage amounts •application attestation on application including dates & amount of current malpractice insurance coverage •Federal Tort Coverage

		requires a copy of the federal tort letter or an attestation from the practitioner of federal tort coverage
Utilization Review	The therapy practitioner must agree to participate in and abide by the utilization review program as established by the Board of Directors.	•Release and attestation on application and/or contract

LEVEL II CRITERIA

PhysicalTherapy practitioners must meet the following criteria, unless AHP after full disclosure by the practitioner waives such requirement.

Element	Criteria for Participation	Verification Source
Professional Liability Claims History	The therapy practitioner has no history of professional liability claim settlements or judgments, and there are no pending cases at the current time.	•Application questionnaire •NPDB
Work History	The therapy practitioner has no unexplained gaps in work history.	•Work history on application and/or curriculum vitae
Disciplinary Actions - Licensure	The therapy practitioner has not had any action taken by a state licensing board where the therapy practitioner has practiced that would affect the therapy practitioner's license to practice. If the therapy practitioner was licensed in more than one state in the most recent five year period, the query must include all states in which the therapy practitioner worked.	•Application questionnaire •State licensing agency •NPDB •HIPDB
Felony Convictions	The therapy practitioner has never been convicted of a felony.	•Application questionnaire •State licensing agency •HIPDB

Clinical Staff Membership	The therapy practitioner has never been refused membership on a hospital or other health care facility staff for reasons other than closure of that staff to the therapy practitioner's specialty.	•Application questionnaire •Hospital •NPDB
Clinical Privileges	The therapy practitioner's privileges at any hospital or other health care facility have never been suspended, diminished, revoked, or not renewed.	•Application questionnaire •Hospital/facility •NPDB
Liability Insurance	The therapy practitioner's liability insurance has never been denied, suspended, canceled, or not renewed.	•Application questionnaire •Liability insurance carrier •NPDB
Professional Organization	The therapy practitioner has never been subjected to disciplinary action in any professional organization.	•Application questionnaire •NPDB
Sanctions	The therapy practitioner has never had sanctions imposed or voluntarily accepted any sanctions by any health care institution, professional health care organizations, licensing authority, governmental entity, professional standards review organization (PRO), utilization and quality assurance peer review organization (PRO).	•Application questionnaire •NPDB •HIPDB
Medicare/Medicaid	The therapy practitioner has never been convicted of any crimes related to the practice of behavioral health, including Medicare or Medicaid related crimes. The therapy practitioner has never been subjected to civil money penalties under the Medicare or Medicaid program or been suspended from participation in Medicare or Medicaid.	•Application questionnaire •FSMB •NPDB (MD & DO) •HIPDB • Cumulative Sanction Internet Sites •Medicare & Medicaid Sanctions and reinstatement reports, distributed by federally

		contracting organizations •Federal Employees Health Benefits Plan Program department record, published by the Office of Personnel Management, Office of the Inspector General •American Medical Association (AMA) Physician Master File entry •state Medicaid agency or intermediary and the Medicare intermediary
Investigations	The therapy practitioner has never been the object of an administrative, civil, or criminal complaint or investigation.	•Application questionnaire
Health Status	The therapy practitioner does not have any condition that would impact the ability to perform the essential functions of the position, with or without accommodation, and without exposing the practitioner or others to health and safety risks. The therapy practitioner is not currently abusing medications, other drugs or substances, including alcohol.	•Application questionnaire •Treating provider

Criteria for Participation

Occupational Therapists and Audiologists

LEVEL I CRITERIA
(may not be waived)

In order to be eligible for participation, the occupational and audiologist practitioner or, in the case of a group of such therapy practitioners i.e., group practice, PHO, IPA, independent network, or any other organized arrangement of occupational, and speech practitioners, each individual practitioners who has a contract to provide professional services through such group, and for whom the group desires to provide Covered Services under Avera, must continuously meet the following requirements:

Element	Criteria for Participation	Verification Source
Licensure	The therapy practitioner must hold a current, valid, active license to practice in the states in which the therapist intends to provide Covered Services.	•State Board/licensing agency
Professional Education	The therapy practitioner must have a master's degree in an appropriate discipline from an accredited college or university, or a bachelor's degree in addition to 5 years clinical experience. .	•Confirmation from accredited college or university
Liability Insurance	The therapy practitioner must have current professional liability coverage of at least $1 million per claim or occurrence, and $3 million aggregate.	•Copy of liability insurance face sheet showing dates and coverage amounts •application attestation on application including dates & amount of current malpractice insurance coverage •Federal Tort Coverage requires a copy of the federal tort letter or an attestation from the practitioner of federal tort

		coverage
Utilization Review	The therapy practitioner must agree to participate in and abide by the utilization review program as established by the Board of Directors.	•Release and attestation on application and/or contract

LEVEL II CRITERIA

Occupational and Speech Therapy practitioners must meet the following criteria, unless AHP after full disclosure by the practitioner waives such requirement.

Element	Criteria for Participation	Verification Source
Professional Liability Claims History	The therapy practitioner has no history of professional liability claim settlements or judgments, and there are no pending cases at the current time.	•Application questionnaire •NPDB
Work History	The therapy practitioner has no unexplained gaps in work history.	•Work history on application and/or curriculum vitae
Disciplinary Actions - Licensure	The therapy practitioner has not had any action taken by a state licensing board where the therapy practitioner has practiced that would affect the therapy practitioner's license to practice. If the therapy practitioner was licensed in more than one state in the most recent five year period, the query must include all states in which the therapy practitioner worked.	•Application questionnaire •State licensing agency •NPDB •HIPDB
Felony Convictions	The therapy practitioner has never been convicted of a felony.	•Application questionnaire •State licensing agency •HIPDB
Clinical Staff Membership	The therapy practitioner has never been refused membership on a hospital or other health care facility staff for reasons other than closure of that staff to the therapy practitioner's specialty.	•Application questionnaire •Hospital

		•NPDB
Clinical Privileges	The therapy practitioner's privileges at any hospital or other health care facility have never been suspended, diminished, revoked, or not renewed.	•Application questionnaire •Hospital/facility •NPDB
Liability Insurance	The therapy practitioner's liability insurance has never been denied, suspended, canceled, or not renewed.	•Application questionnaire •Liability insurance carrier •NPDB
Professional Organization	The therapy practitioner has never been subjected to disciplinary action in any professional organization.	•Application questionnaire •NPDB
Sanctions	The therapy practitioner has never had sanctions imposed or voluntarily accepted any sanctions by any health care institution, professional health care organizations, licensing authority, governmental entity, professional standards review organization (PRO), utilization and quality assurance peer review organization (PRO).	•Application questionnaire •NPDB •HIPDB
Medicare/Medicaid	The therapy practitioner has never been convicted of any crimes related to the practice of behavioral health, including Medicare or Medicaid related crimes. The therapy practitioner has never been subjected to civil money penalties under the Medicare or Medicaid program or been suspended from participation in Medicare or Medicaid.	•Application questionnaire •FSMB •NPDB (MD & DO) •HIPDB • Cumulative Sanction Internet Sites •Medicare & Medicaid Sanctions and reinstatement reports, distributed by federally contracting organizations •Federal Employees Health Benefits Plan

		Program department record, published by the Office of Personnel Management, Office of the Inspector General •American Medical Association (AMA) Physician Master File entry •state Medicaid agency or intermediary and the Medicare intermediary
Investigations	The therapy practitioner has never been the object of an administrative, civil, or criminal complaint or investigation.	•Application questionnaire
Health Status	The therapy practitioner does not have any condition that would impact the ability to perform the essential functions of the position, with or without accommodation, and without exposing the practitioner or others to health and safety risks. The therapy practitioner is not currently abusing medications, other drugs or substances, including alcohol.	•Application questionnaire •Treating provider

Criteria for Participation

Speech Therapists
(Speech Language Pathologists)

LEVEL I CRITERIA
(may not be waived)

In order to be eligible for participation, the speech therapy practitioner or, in the case of a group of such therapy practitioners i.e., group practice, PHO, IPA, independent network, or any other organized arrangement of speech practitioners, each individual practitioners who has a contract to provide professional services through such group, and for whom the group desires to provide Covered Services under Avera, must continuously meet the following requirements:

Element	Criteria for Participation	Verification Source
Licensure, registration and/or certification**	The therapy practitioner must hold a current, valid, active license or registration to practice in the states in which the therapist intends to provide Covered Services, if state has regulation of Speech Pathologists. Note: South Dakota at present does not regulate SLPs	•State Board/licensing agency
Professional Education	1. The therapy practitioner must have a master's degree in an appropriate discipline from an accredited college or university, or a bachelor's degree in addition to 5 years clinical experience. .	•Confirmation from accredited college or university
Certificate of Clinical Competence**	If not licensed, the therapy practitioner must hold ASHA's Certificate of Clinical Competence (CCC). The holder is allowed to provide independent clinical services and to supervise the clinical practice of student trainees, clinicians who do not hold certification and support personnel.	ASHH
Liability Insurance	The therapy practitioner must have current professional liability coverage of at least $1 million per claim or occurrence, and $3 million aggregate.	•Copy of liability insurance face sheet showing dates and coverage amounts •application attestation on

		application including dates & amount of current malpractice insurance coverage •Federal Tort Coverage requires a copy of the federal tort letter or an attestation from the practitioner of federal tort coverage
Utilization Review	The therapy practitioner must agree to participate in and abide by the utilization review program as established by the Board of Directors.	•Release and attestation on application and/or contract

** See Certificate of Clinical Competence

LEVEL II CRITERIA

Speech Therapy practitioners must meet the following criteria, unless AHP after full disclosure by the practitioner waives such requirement.

Element	Criteria for Participation	Verification Source
Professional Liability Claims History	The therapy practitioner has no history of professional liability claim settlements or judgments, and there are no pending cases at the current time.	•Application questionnaire •NPDB
Work History	The therapy practitioner has no unexplained gaps in work history.	•Work history on application and/or curriculum vitae
Disciplinary Actions – Licensure or Regulator	The therapy practitioner has not had any action taken by a state licensing, regulation or certification board where the therapy practitioner has practiced that would affect the therapy practitioner's license to practice. If the therapy practitioner was regulated in more than one state in the most recent five year	•Application questionnaire •State licensing agency •NPDB

	period, the query must include all states in which the therapy practitioner worked.	•HIPDB
Felony Convictions	The behavioral health practitioner has never been convicted of a felony.	•Application questionnaire •State licensing agency •HIPDB
Clinical Staff Membership	The therapy practitioner has never been refused membership on a hospital or other health care facility staff for reasons other than closure of that staff to the therapy practitioner's specialty.	•Application questionnaire •Hospital •NPDB
Clinical Privileges	The therapy practitioner's privileges at any hospital or other health care facility have never been suspended, diminished, revoked, or not renewed.	•Application questionnaire •Hospital/facility •NPDB
Liability Insurance	The therapy practitioner's liability insurance has never been denied, suspended, canceled, or not renewed.	•Application questionnaire •Liability insurance carrier •NPDB
Professional Organization	The therapy practitioner has never been subjected to disciplinary action in any professional organization.	•Application questionnaire •NPDB
Sanctions	The therapy practitioner has never had sanctions imposed or voluntarily accepted any sanctions by any health care institution, professional health care organizations, licensing authority, governmental entity, professional standards review organization (PRO), utilization and quality assurance peer review organization (PRO).	•Application questionnaire •NPDB •HIPDB
Medicare/Medicaid	The therapy practitioner has never been convicted of any crimes related to the practice of speech therapy, including Medicare or Medicaid related crimes. The therapy practitioner has never been subjected to civil money penalties under the Medicare or Medicaid program or been suspended from participation in Medicare or Medicaid.	•Application questionnaire •FSMB •NPDB (MD & DO) •HIPDB • Cumulative Sanction

		Internet Sites •Medicare & Medicaid Sanctions and reinstatement reports, distributed by federally contracting organizations •Federal Employees Health Benefits Plan Program department record, published by the Office of Personnel Management, Office of the Inspector General •American Medical Association (AMA) Physician Master File entry •state Medicaid agency or intermediary and the Medicare intermediary
Investigations	The therapy practitioner has never been the object of an administrative, civil, or criminal complaint or investigation.	•Application questionnaire
Health Status	The therapy practitioner does not have any condition that would impact the ability to perform the essential functions of the position, with or without accommodation, and without exposing the practitioner or others to health and safety risks. The therapy practitioner is not currently abusing medications, other drugs or substances, including alcohol.	•Application questionnaire •Treating provider

Criteria for Participation

Board Certified Behavior Analyst (BCBA)

LEVEL I CRITERIA
(may not be waived)

In order to be eligible for participation, the Board Certified Behavior Analyst or, in the case of a group of Board Certified Behavior Analysts e.g. group practice, PHO, IPA, independent network, or any other organized arrangement of Board Certified Behavior Analyst, each individual therapist who has a contract to provide professional services through such group, and for whom the group desires to provide Covered Services under AHP, must continuously meet the following requirements:
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Element	Criteria for Participation	Verification Source
Licensure, registration and/or certification**	The therapy practitioner must hold a current, valid, active license or registration to practice in the states in which the therapist intends to provide Covered Services, if state has regulation of Behavioral Analysts. Note: South Dakota at present does not regulate BCBAs.	•State Board/licensing agency
Professional Education	The Board Certified Behavior Analyst must have a bachelor's degree in appropriate discipline from an accredited college or university.	•Confirmation from accredited college or university
**Certification	The Board certified Behavior Analyst must have Certfication by the Board Certified Behavior Analyst (BCBA) with active certification from the National Behavior Certification Board and possess a minimum of six months employment of internship in the treatment of autism spectrum disorders under the supervision of a Board Certified Behavior Analyst or a licensed clinician	• Confirmation by certification board
Liability Insurance	The Board Certified Behavior Analyst must have current professional liability coverage of at least $1 million per claim and $3 million annual aggregate.	•Copy of liability insurance face sheet showing dates and coverage amounts

		•application attestation on application including dates & amount of current malpractice insurance coverage •Federal Tort Coverage requires a copy of the federal tort letter or an attestation from the practitioner of federal tort coverage
Utilization Review	The BCBA practitioner must agree to participate in and abide by the utilization review program as established by the Board of Directors.	•Release and attestation on application and/or contract

LEVEL II CRITERIA

Board Certified Behavior Analyst must meet the following criteria, unless AHP, after full disclosure by the Board Certified Behavior Analyst, waives such requirement

Element	Criteria for Participation	Verification Source
Professional Liability Claims History	The Board Certified Behavior Analyst has no history of professional liability claim settlements or judgments, and there are no pending cases at the current time.	•Application questionnaire •NPDB
Work History	The Board Certified Behavior Analyst has no unexplained gaps in work history.	•Work history on application and/or curriculum vitae
Disciplinary Actions – Licensure or Regulator	The Board Certified Behavior Analyst has not had any action taken by a state licensing, regulation or certification board where the Board Certified Behavior Analyst has practiced that would affect the therapy practitioner's license to practice. If the Board Certified Behavior Analyst was regulated in more than one	•Application questionnaire •State licensing agency

	state in the most recent five year period, the query must include all states in which the therapy practitioner worked.	•NPDB •HIPDB
Felony Convictions	The Board Certified Behavior Analyst has never been convicted of a felony.	•Application questionnaire •State licensing agency •HIPDB
Clinical Staff Membership	The Board Certified Behavior Analyst has never been refused membership on a hospital or other health care facility staff for reasons other than closure of that staff to the Board Certified Behavior Analyst specialty.	•Application questionnaire •Hospital •NPDB
Clinical Privileges	The Board Certified Behavior Analyst privileges at any hospital or other health care facility have never been suspended, diminished, revoked, or not renewed.	•Application questionnaire •Hospital/facility •NPDB
Liability Insurance	The Board Certified Behavior Analyst liability insurance has never been denied, suspended, canceled, or not renewed.	•Application questionnaire •Liability insurance carrier •NPDB
Professional Organization	The Board Certified Behavior Analyst has never been subjected to disciplinary action in any professional organization.	•Application questionnaire •NPDB
Sanctions	The Board Certified Behavior Analyst has never had sanctions imposed or voluntarily accepted any sanctions by any health care institution, professional health care organizations, licensing authority, governmental entity, professional standards review organization (PRO), utilization and quality assurance peer review organization (PRO).	•Application questionnaire •NPDB •HIPDB
Medicare/Medicaid	The Board Certified Behavior Analyst has never been convicted of any crimes related to the practice of speech therapy, including Medicare or Medicaid related crimes. The Board Certified Behavior Analyst has never been subjected to civil money penalties under the Medicare or Medicaid program or been suspended from participation in Medicare or Medicaid.	•Application questionnaire •FSMB •NPDB (MD & DO) •HIPDB

		• Cumulative Sanction Internet Sites •Medicare & Medicaid Sanctions and reinstatement reports, distributed by federally contracting organizations •Federal Employees Health Benefits Plan Program department record, published by the Office of Personnel Management, Office of the Inspector General •American Medical Association (AMA) Physician Master File entry •state Medicaid agency or intermediary and the Medicare intermediary
Investigations	The Board Certified Behavior Analyst has never been the object of an administrative, civil, or criminal complaint or investigation.	•Application questionnaire
Health Status	The Board Certified Behavior Analyst does not have any condition that would impact the ability to perform the essential functions of the position, with or without accommodation, and without exposing the practitioner or others to health and safety risks. The Board Certified Behavior Analyst is not currently abusing medications, other drugs or substances, including alcohol.	•Application questionnaire •Treating provider

Criteria for Participation

Institutions

LEVEL I CRITERIA
(May not be waived)

In order to be eligible for participation, the hospital, home health agency, skilled nursing facility, free-standing surgical center and/or behavioral health facilities providing mental and substance abuse services in the following settings in inpatient, residential or ambulatory settings desires to provide Covered Services under Avera, must continuously meet the following requirements:

Element	Criteria for Participation	Verification Source
Licensure	The provider must be in good standing with state and federal regulatory bodies Avera CVS will confirm that the provider continues to be in good standing with state and federal regulatory bodies	• State Board/Licensing Agencies • Copy of current program/facility license, as applicable • Attestation and disclosure • NPDB
Accreditation	The provider has been reviewed and approved by an accredited body. Recognized bodies of accreditation include Joint Commission on Accreditation of Healthcare Organizations (JCAHO), American Osteopathic Association (AOA) or Commission on Accreditation of Rehabilitation Facilities (CARF). If in the cases of non-accredited institutions Avera will substitute a CMS or state review as a site visit. If applicable, Avera will confirm that the provider continues to be reviewed and approved by an accrediting body at least every three years unless the provider is in a rural area, as defined by the US Census Bureau	• Accreditation organization • Copy or Approval Letter • Copy or HCFA or state Review including letter of approval • AHP completion of

	If the provider has not been reviewed by an accrediting body in the last three years, AHP will conduct an onsite quality assessment using the Hospital Site Review Tool, based on the requirements set forth by NCQA. Unless the unaccredited site is a satellite office and is able to provide clear evidence that the satellite offices are held to the same standards as the main facility and the main facility is an accredited facility.	the AHP Hospital Site Review Tool
Liability Insurance	The provider must have current professional liability coverage of at least $1 million per claim or occurrence, and $3 million aggregate or $5 million per claim or occurrence and $5 million per aggregate for facilities with 100 beds or greater.	•Copy of liability insurance face sheet showing dates and coverage amounts •application attestation on application including dates & amount of current malpractice insurance coverage •Federal Tort Coverage requires a copy of the federal tort letter or an attestation from the practitioner of federal tort coverage
Utilization Review/On-Site Quality Assessment	The provider must agree to participate in and abide by the utilization review/on-site quality assessment program as established by the Board of Directors.	•Release and attestation on application and/or contract

LEVEL II CRITERIA

Institutional providers must meet the following criteria, unless AHP, after full disclosure by the provider, waives such requirement.

Element	Criteria for Participation	Verification Source

Professional Liability Claims History	The provider has no history of professional liability claim settlements or judgments, and there are no pending cases at the current time.	•Application questionnaire •NPDB •Malpractice Carrier/Agent
Disciplinary Actions - Licensure	The provider has not had any action taken by a state licensing board that would affect the provider's license.	•Application questionnaire •State licensing agency •NPDB
Liability Insurance	The provider's liability insurance has never been denied, suspended, canceled, or not renewed.	•Application questionnaire •Liability insurance carrier •NPDB
Professional Organization	The provider has never been subjected to disciplinary action.	•Application questionnaire •NPDB
Sanctions	The provider has never had sanctions imposed or voluntarily accepted any sanctions by any health care institution, professional health care organizations, licensing authority, governmental entity, professional standards review organization (PRO), utilization and quality assurance peer review organization (PRO).	•Application questionnaire •NPDB •OIG

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