AVERA HEALTH PLANS
2020 CREDENTIALING PLAN
SECTION ONE
INDIVIDUAL PROVIDERS

I. STATEMENT OF POLICY.

A. The purpose of Avera Credentialing Verification Services ("Avera CVS") is to provide high quality, cost effective credentialing and recredentialing verification services to Avera Health Plans, Inc. ("Avera Health Plans") and other contracted entities who have delegated some or all of their credentialing authority to Avera CVS through a delegated credentialing agreement. These credentialing verification services are carried out according to The Joint Commission and NCQA Standards, for healthcare practitioners, facilities or entities (hereinafter collectively referred to at times as "Providers") for both initial and renewal of clinical privileges or participation status with Avera Health Plans or a contracted entity in accordance with the terms and conditions of a delegated credentialing agreement and in compliance with all applicable federal and 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 ensure that its clients may represent to contracting groups and accreditation bodies that Providers have been credentialed under, and continuously meet such standards.

C. The services provided by Avera CVS shall include: (a) verification from original sources of a Provider's professional licensure, education, training and/or experience, malpractice claims history, professional review actions, and other items relevant to the Provider's credentials and qualifications. For every Provider, Avera CVS agrees to certify that all information was verified with primary sources and to indicate the date of the verification; (b) absent causes beyond the control of Avera CVS, Avera CVS will provide the information in its possession regarding each Provider on or before ninety (90) days following receipt by Avera CVS of a completed request form from the contracted entity; (c) notification to contracted entity by Avera CVS of licensure expiration, revocations, or sanctions imposed on Providers will occur within two (2) weeks of receipt by Avera CVS; (d) Avera 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 Avera CVS shall provide copies to the contracted entity of all other primary source documents obtained by Avera CVS.

D. The Credentialing Plan may be changed upon approval by the Credentialing Committee and the Avera Health Plans Board of Directors (hereinafter "Board

of Directors"). Any change in legal, regulatory or accreditation requirements shall automatically be incorporated into the Credentialing Plan and all applicable policies and procedures as of the requirement's effective date. Changes shall be effective for all new and existing Providers from the effective date of the change unless specific provisions are provided to grandfather Providers who are already credentialed at the time such changes are implemented. Such provisions may extend for the duration that the Provider remains successfully credentialed or specified time frames may be allocated allowing Providers who do not meet the new standards to come into compliance.

II. SCOPE.

A. Avera CVS's scope is to provide timely and accurate credentialing verification services in a cost effective manner and to serve as a centralized database of Provider credentialing information and status to the Avera Health System, Avera Health Plans and to contracted entities that have delegated credentialing authority to Avera CVS consistent with their respective delegated credentialing agreements. The mission of Avera CVS is realized by the following:

1. Centralized Credentialing Verification
    - Provide for a centralized credentialing documentation process.
    - To streamline and manage the essential credentialing elements and eliminate administrative waste and redundancy. The credentialing program involves the initial and ongoing collection, verification, review and monitoring of information necessary for selection and retention of Providers meeting Avera CVS credentialing standards.
2. Centralized Physician Database / Visual Cactus
    - Provide for a centralized Provider database.
3. Credentialing Research and Education
    - Offer credentialing education programs and industry research to meet accreditation standards for the Avera Health System, Avera Health Plans and contracted entities that have delegated credentialing authority to Avera CVS consistent with their respective agreements.
    - Research credentialing issues in response to the needs of MSOs for accreditation standards, legal issues, and national trends in credentialing practices.
4. Credentialing Compliance Monitoring
    - Monitor compliance with accreditation standards, state and federal regulations.
    - Standardize compliance processes with input from corporate compliance, risk management, and legal counsel.

B. Only those Providers meeting Avera Health Plans Criteria for Participation are included. In addition to the credentialing standards, Selection Factors 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 interval thereafter of every thirty-six (36) months.

C. The Avera Health Plans 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 - Certified (PA-C)
3. Advanced Registered Nurse Practitioners (ARNP, CNS, CNM, CNP, CRNA, DNP)
4. Doctor of Chiropractic (DC)
5. Podiatrists (DPM)
6. Licensed Psychologists (PhD, PsyD, EdD)
7. Certified Social Workers-PIP (CSW-PIP) *South Dakota*
8. Licensed and Independent Clinical Social Worker (LICSW)
9. Licensed Master Social Worker (LMSW)
10. Licensed Independent Social Worker (LISW) *Iowa*
11. Licensed Professional Counselors-MH (LPC-MH)
12. Licensed Marriage and Family Therapists (LMFT)
13. Qualified Mental Health Professional (LPC-QMHP or CSW-QMHP) *South Dakota*
14. Optometrists (OD)
15. Doctor of Dental Surgery (DDS) and Doctor of Medical Dentistry (DMD)
16. Physical Therapists (DPT, PT, LPT)
17. Occupational Therapists (OT)
18. Speech Pathologists (SLP)
19. Audiologists (AuD)
20. Board Certified Behavior Analysts (BCBA)
21. Board Certified Behavior Analysts – Doctoral (BCBA-D)
22. Genetic Counselors (CGC) ®

III. OBJECTIVES. The Avera Health System has designed and implemented a comprehensive Credentialing Verification Service ("Avera 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 and participating in networks offered by Avera Health Plans. This information is used by Avera facilities and Avera Health Plans for decisions on initial applications and at least every thirty-six (36) months, 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, Avera CVS has been designed and implemented to assure that requirements of regulatory and licensing agencies are met. Avera CVS strives to meet NCQA and standards and the requirements of the State of South Dakota. Credentialing verification

services are provided for Avera Health Plans and any Avera facility that is interested in participating and other organizations that have established delegated credentialing agreements.

Avera 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 for Participation designed to assess the qualifications and background that impact their ability to deliver care. Criteria for Participation includes, but is 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 Credentialing 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 is not limited to complaints, out of network referrals, and utilization management statistics.

B. Avera Health Plans has developed Criteria for Participation for all Providers as defined in II. Scope. The specific Criteria for Participation and verification requirements for each type of Provider can be found under Section Seven, Criteria for Participation.

V. NON DISCRIMINATION.

Provider credentialing and recredentialing decisions made by Avera Health Plans through Avera CVS 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 Avera Health Plans Participating Provider Agreement per the Avera Health Plans Credentialing Policy.

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 Credentialing 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 Avera Health Plans President or Chief Medical Officer can excuse the employee or Credentialing Committee member from participation if the President or Chief Medical Officer is aware that a conflict of interest may exist.

VII. ACCOUNTABILITY OF CREDENTIALING.

A. Board of Directors. Policies and procedures regarding credentialing are approved by the Board of Directors and reviewed on an annual basis. The Board of Directors has the authority for approval or denial of a Providers' Avera Health Plans participation. The Avera Health System has also delegated their respective credentialing authority to the Board of Directors.

B. Credentialing Committee.

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

2. Committee Membership.

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

   b. The Avera Health Plans Chief Medical Officer is the Chairperson of the Credentialing Committee and is a voting member.

   c. Ex-officio non-voting membership shall include, but not be limited to the Avera Health Plans Director of Provider Contracting.

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

4. Quorum and Voting. The presence of 50% or more of the Credentialing 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 Credentialing Committee. In case of equality of votes, the chair of the Credentialing Committee shall have a second or deciding vote.

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

6. Functions. The Credentialing Committee functions are as follows:

a. Develop and administer the Avera Health Plans 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 Providers who do not fully meet the Avera Health Plans Level II Credentialing Criteria for Participation.

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

f. Review and take action on recommendations from the Avera Health Plans Quality Improvement Committee 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.

i. Report 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 of Directors.

C. Chief Medical Officer. The Avera Health Plans Chief Medical Officer is responsible for the overall program of Provider credentialing to include:

1. Chairperson of the Credentialing Committee.

2. Responsible for all clinical aspects of the credentialing and recredentialing process.

3. Review for approval of Provider applications that meet both Level I and Level II Criteria for Participation. The Avera Health Plans Chief

Medical Officer may also delegate the approval of Providers who meet both Level I and Level II Criteria for Participation to a subordinate Medical Director within Avera Health Plans.

4. Interfacing and communicating with applicants regarding credentialing and recredentialing issues and problems.

5. Select, train, and monitor members of the Credentialing 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 Manager. Responsible for administration of the credentialing program. Ensures that the credentialing procedures are carried out in a consistent, accurate, and complete manner through training, documentation, and quality assurance/improvement activities. Reports any Provider who does not meet the Criteria for Participation to the Avera Health Plans Chief Medical Officer and the Credentialing Committee for their consideration and determination of waiver. Ensures credentialing program compliance to assure that the credentialing activities are complete and effective and report results of monitoring activities to the Credentialing 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 Manager. 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 PLANS Health Services Division. Evaluates quality of care and services provided to Avera Health Plans 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 by the Avera Health Plans Chief Medical Officer or his/her designee. The Appeals Committee shall hear selected appeals from Providers after the Credentialing Committee has recommended denial or termination of Avera Health Plans 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 Credentialing Committee and may exercise other powers given to it by the 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 Provider who is the subject of the hearing, but who are not in direct economic competition. Members of the Appeals Committee may be Avera Health Plans network Providers or members of the Avera Health Plans Pharmacy and Therapeutics Committee, Utilization Management Committee or Quality Improvement Committee for any particular appeal and will be individuals who are not, in the judgment of Avera Health Plans to be in direct economic competition with the Provider who is subject of the hearing. Avera CVS employees, Credentialing Committee members and members of the 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 the Board of Directors and who is not in direct competition with the 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 Health Plans or Avera CVS business needs and requirements. The following process is employed:

A. Review of the Credentialing Plan by the Avera Health Plans Director of Provider Contracting and Chief Medical Officer.

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

C. Presentation of the Credentialing Plan approved by the Credentialing Committee and by the Avera Health Plans Chief Medical Officer to the Board of Directors.

IX. CREDENTIALING PROCESS.

A. Initial Credentialing.

1. Applications.

a. Applicants for credentialing must complete an application on a prescribed application form, either an Avera CVS application form, or an application form that has been approved by Avera CVS. Such forms may be in either paper or electronic formats as governed by Avera CVS's procedures for credentialing.

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

i. Copy of current state professional licenses and/or certificates showing expiration date. Copy of

licenses/certificates are required for each state where the Provider 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 in aggregate through provided 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, must be in mm/yy format.

c. The Provider must complete the 'Disclosure 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 functions 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 'Disclosure 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 accuracy 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 Health Plans 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 Health Plans has met network access needs for the Provider type in accordance to Selection Factors (Sec 3).

f. Incomplete applications are held open for fifteen (15) 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 'Disclosure 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 'Disclosure 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 to provide any other information necessary to process the application.

g. Application processing will not begin until all missing documentation/information is received in the Avera CVS office. If information is not received within fifteen (15) days of the request for missing/additional information, the application is considered withdrawn and the application process is closed.

2. Credentialing Verification. Credentialing 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
x. NPI Number (NPPES)
xi. Social Security Death Master File

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. Other credible information made known to Credentialing Committee Members.

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

d. Time sensitive factors, such as verifications cannot be more than one hundred and eighty (180) days old at the time of approval as specified in the Administrative Work Instructions.

3. Office Site Quality Review.

Avera Health Plans has adopted the NCQA standards and performance thresholds for the offices of all Providers. These standards assure Providers 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 Health Plans 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 are sent to the Provider, Exhibit C of the standards contains an Office Site Quality Review Agreement that must be signed and returned to Avera Health Plans to become part of the Provider's electronic record.

Member Complaints:

For a location that receives a member complaint as outlined in Avera Health Plans policy, an Office Site Quality Review will be conducted accordingly. If a deficiency is identified Avera 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 Credentialing Committee or its designee at the time a decision regarding Avera Health Plans participation is made except as outlined under XX. Provisional Approval of Providers. 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 Credentialing Committee has current information regarding a Provider's credentials; verifications must be completed within the time limits specified in the Administrative Work Instructions .

   b. Streamlined Credentialing.

      i. "Streamlined Credentialing" refers to the process used at Avera CVS's discretion when a Provider subject to the Credentialing Plan has submitted all required application materials to Avera CVS and Avera CVS Credentialing staff has determined that such a practitioner meets all of Avera Health Plans Criteria for Participation set forth in Section Seven for both Level I and Level II Criteria for Participation for the Provider's appropriate specialty, and Avera CVS has the capability to complete the credentialing process for the Provider before the next scheduled Credentialing Committee meeting. Such a Provider's completed application and supporting documentation shall be submitted for review by the Avera Health Plans Chief Medical Officer or his/her subordinate Medical Director on behalf of the Credentialing Committee. An applicant qualifying for streamlined process review must also be in good standing at an existing Avera Health Plans 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 as may be requested by the Avera Health Plans Chief Medical Officer or his/her

subordinate Medical Director. The Avera Health Plans Chief Medical Officer or his/her subordinate Medical Director may approve an applicant for Avera Health Plans participation in the event the Avera Health Plans Chief Medical Officer or his/her subordinate Medical Director determines such applicant meets all of the Criteria for Participation set forth in Section Seven for both Level I and Level II Criteria for Participation. In the event the Avera Health Plans Chief Medical Officer or his/her subordinate Medical Director does not approve a Provider's application for Avera Health Plans participation, such application shall proceed to the Credentialing Committee for review.

c. Credentialing Committee Review.

i. The Credentialing Committee reviews completed applications. In order to be eligible for Avera Health Plans 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 Health Plans, must continuously meet all the Criteria for Participation designated as Level I. The provider must also continuously meet all the Criteria for Participation designated as Level II, unless the Board of Directors, after full disclosure by the Provider and a recommendation from the Credentialing Committee, waives such requirement.

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

(a) The applicant has met both Level I and Level II Criteria for Participation to be approved for Avera Health Plans participation, or

(b) The applicant has met Level I Criteria for Participation but has not met all Level II Criteria for Participation, however a waiver is granted; and the applicant is recommended for approval for Avera Health Plans participation, or

(c) The applicant has met Level I Criteria for Participation but has not met all Level II Criteria for Participation, a waiver is not granted; and

the applicant is recommended for denial for Avera Health Plans participation, or

(d) Additional information is needed before further evaluation can be completed.

d. Granting of Waiver.

i. Waivers may be granted to Providers who do not meet all of the Level II Criteria for Participation if, based on the Credentialing 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 Credentialing Committee believes sufficient monitoring, evaluation, and corrective action is in place by regulatory or other such entity with authority over the Provider.

ii. The Credentialing 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.

e. Approval of Avera Health Plans Participation. Upon approval of the Credentialing Committee or in the case of Streamlined Credentialing, the Chief Medical Officer or his/her subordinate Medical Director, the Provider is given an effective date of Avera Health Plans participation consistent with the Avera Health Plans policies and procedures unless an alternate date of Avera Health Plans participation is mandated by State Law, and the Provider is sent written notification of the approval within ten (10) days of the approval. The recommendation is then presented to the Board of Directors for final ratification. Providers also receive a signed Avera Health Plans Provider Agreement and access to the Provider Manual as applicable.

The decision date for credentialing is used for determining the recredentialing intervals.

f. Denial of Avera Health Plans Participation. Applicants whose Avera Health Plans participation is denied are notified via certified mail of the denial and the basis for the decision within thirty (30) working days of the denial. A description of the reconsideration procedures is included in the letter.

g. 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 Avera Health Plans Chief Medical Officer within 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 sent to the body that determined the Criteria for Participation were not met, that being either the Credentialing Committee or the Board of Directors, as appropriate. The Credentialing 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 Credentialing Committee or the Board of Directors, 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 Credentialing 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.

h. Group Practice of Physicians or Practitioners. When a group practice of physicians or other Providers (whether organized as a partnership, professional corporation, nonprofit corporation, business corporation, or limited liability company) applies to participate as a Participating Provider with Avera Health Plans, an application is completed for each physician or Provider 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 Avera Health Plans Provider Agreement applies only to those individuals who meet the Criteria for Participation.

i. Reapplication after Denial of Avera Health Plans Participation. An applicant whose application has been denied may not reapply for Avera Health Plans 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 Avera Health Plans participation, which shall be processed as an initial application. Such an applicant must furnish evidence that the basis for the prior denial no longer exists and/or satisfactory evidence to the Credentialing Committee that would allow them to grant a Level II waiver and approve the applicant's Avera Health Plans participation.

B. Recredentialing.

1. Automatic Expiration Unless Renewed. Avera Health Plans participation generally extends for a no more than a thirty-six (36) month cycle pursuant to a cycle established for each Provider. Avera Health Plans participation automatically expires at the end of such period unless renewed by Avera Health Plans through recredentialing. Prior to renewal of Avera Health Plans 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 Avera Health Plans Participation.

    a. A renewal application invitation (Recredentialing Application) is emailed to the Provider and/or the Provider's designated Credentialing Contact at least one hundred twenty (120) days before the expiration of the last credentialing date. It is the Provider's responsibility to ensure that accurate email address information is continuously provided to Avera CVS for this purpose.

    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 status, and other disciplinary actions occurring since the last credentialing period.

    c. An attestation by the applicant to the accuracy and completeness the application must be signed and dated. The applicant also signs and dates a release allowing Avera CVS to verify and investigate the 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 'Disclosure Questionnaire', the updated renewal application, supporting documentation, and the release and attestation must be submitted to the offices of Avera CVS within thirty (30) days from the date the renewal application was emailed to the provider.

    e. Supporting documentation required for recredentialing includes:

        i. Copy of current state professional licenses and/or certificates showing expiration date. Copy of licenses/certificates required for each state where the Provider 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 provided 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 emailing date. The Provider is asked to submit the renewal application within fifteen (15) days from the date of the second request.

   b. Third Request. A third and final request is sent five (5) days after the second request. The third and final request is sent with notification that Avera Health Plans participation is subject to termination if the renewal application is not received within five (5) days.

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

4. Incomplete Applications.

   a. Incomplete applications are held open for fifteen (15) 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 'Disclosure 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 the Avera CVS office. If information is not received within fifteen (15) days of the request for missing/additional information, the Provider shall be treated as having withdrawn the request for Renewal of Avera Health Plans Participation and will be terminated according to the terms and conditions of the Avera Health Plans Provider Agreement.

5. Credentialing Verification. Credentialing 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
vii. NPI Number
viii. Social Security Administration's Death Master File

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. Other Credible information made known to the Credentialing Committee Members

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

d. To assure the Credentialing Committee has current information regarding a Provider's credentials; verifications must be completed within the time limits specified in the Administrative Work Instructions.

6. Medical Record Reviews.

a. Medical record reviews are completed for all Provider specialties at the discretion of Avera Health Plans as may be warranted.

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 Avera Health Plans Quality Improvement Committee for tracking purposes and Quality of Care and Case Reviews are managed through the Credentialing Committee, in accordance to Administrative Work Instructions.

7. Recredentialing Decision.

a. Recredentialing Information Time Limits.

i. All recredentialing information must be available to the Credentialing Committee at the time a decision regarding renewal of Avera Health Plans participation is made.

ii. To assure the Credentialing Committee has current information regarding a Provider's credentials; verifications must be completed within the time limits specified in the Administrative Work Instructions.

b. Credentialing Committee Review.

i. The Credentialing Committee receives and must review at a minimum, the credentials of Providers that do not meet the organization's established Criteria for Participation. In order to be eligible for continued Avera Health Plans 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 Health Plans, must continuously meet all the Criteria for Participation designed as Level I. The Provider must also meet all of the Criteria for Participation designated as Level II, unless the Board of Directors, after full disclosure by the Provider and a recommendation from the Credentialing Committee, waives such requirement.

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

(a) The applicant continues to meet both Level I and Level II Criteria for Participation and is approved for continued Avera Health Plans participation, or

(b) The applicant continues to meet Level I Criteria for Participation, but does not meet all Level II Criteria for Participation, however a waiver is granted; and the applicant is approved for continued Avera Health Plans participation, or

(c) The applicant continues to meet Level I Criteria for Participation, but does not meet all Level II Criteria for Participation, a waiver is not granted, and the applicant is denied continued Avera Health Plans 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 Credentialing 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 all of the Level II Criteria for Participation if, based on the Credentialing Committee's 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 Credentialing Committee believes sufficient monitoring, evaluation, and corrective action is in place by regulatory or other such entity with authority over the Provider.

ii. The Credentialing 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 Avera Health Plans Participation. When deemed appropriate by the Credentialing Committee, Providers are notified of any corrective actions necessary, or any 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 ten (10) days of approval, otherwise the Provider's Avera Health Plans participation is documented in the Provider's credentials file.

e. Denial of Continued Avera Health Plans Participation. Providers whose continued Avera Health Plans participation is denied are notified via certified mail of the denial and the basis for the decision within five (5) 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 Avera Health Plans Provider 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 Avera Health Plans Chief Medical Officer within 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 responsibility is up to the body that determined the Criteria for Participation were not met, that being either the Credentialing Committee or the Board of Directors, as appropriate. The Credentialing 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 Credentialing Committee or the Board of Directors, 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 Credentialing 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 Avera Health Plans Participating Physician or Practitioner, it shall complete a Request for Renewal of Avera Health Plans Participation for each individual Physician or Practitioner who has or is under a contract to provide professional services through such group practice and for whom the group practice desires to provide covered services under Avera Health Plans. Avera CVS shall determine whether each individual who has or is under a contract to provide professional services through such group practice and for whom the group practice desires to provide services under Avera Health Plans continues to meet the Criteria for Participation. Any renewal of Avera Health Plans participation of such group practice and its Avera Health Plans Participating Provider shall apply only as to the individual Physicians or Practitioners who continue to meet the Criteria for Participation.

h. Reapplication after Denial of Continued Avera Health Plans Participation. An applicant whose application for continued Avera Health Plans participation has been denied may not reapply for Avera Health Plans 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 Avera Health Plans 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 Credentialing Committee that would allow them to grant a Level II waiver and approve the applicant's Avera Health Plans participation.

X. NOTIFICATION OF CONFLICTING INFORMATION. If information is obtained during credentialing verification that varies substantially from the information submitted by the Provider, Avera CVS contacts the Provider via letter and/or email 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 fifteen (15) days, any corrections of erroneous information obtained from other sources or an explanation of discrepancies. This explanation will be placed in the Provider's electronic file. The foregoing does not require Avera CVS to alter or delete information contained in the file. Avera CVS 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 Avera Health Plans Chief Medical Officer and/or the Credentialing Manager, and must be received within fifteen (15) 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 Credentialing Committee to properly evaluate his or her qualifications and shall have the burden of resolving any doubts about his or her qualifications for Avera Health Plans 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 Avera Health Plans participation has been granted, for immediate termination of such Avera Health Plans 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 by 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, Avera Health Plans 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 clients 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 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 Credentialing Committee members sign confidentiality statements.

D. All information and data collected, developed, or considered by the Credentialing Committee is kept confidential and not disclosed except as required to be disclosed under applicable law. The proceedings of the Credentialing 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 Avera Health Plans participation of an Avera Health Plans Provider, up to and including termination of Avera Health Plans 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 Avera Health Plans Provider Agreements.

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

1. Monitoring the Provider for a specified period of time, followed by a determination as to whether noncompliance with Avera Health Plans or Avera CVS requirements is continuing;

2. Warning the Provider that disciplinary action will be taken in the future if noncompliance with Avera Health Plans or Avera CVS requirements continues or reoccurs;

3. Requiring the Provider to submit and adhere to a corrective action plan;

4. Levying a monetary fine against the Provider;

5. The recoupment of overpayments by Avera Health Plans to a Provider as determined by an internal and external claims audit or reviews;

6. Administrative suspension or termination of the Provider's Avera Health Plans participation status for noncompliance with the Avera Health Plans Criteria for Participation set forth in Section Seven Level I and Level II;

7. Limiting the Provider's scope of practice in treating Avera Health Plans members;

8. Requiring the Provider to obtain training or use peer consultation in specified type(s) of care;

9. Temporarily suspending the Provider as an Avera Health Plans participating provider for noncompliance with the Criteria for Participation;

10. Require the Provider or clinic to execute an amendment to the Avera Health Plans Provider Agreement or a separate agreement related to the disciplinary action; and

11. Terminating the Provider's Avera Health Plans participation status as described in Section Five.

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

D. The Provider 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 Credentialing 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 Credentialing 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 Credentialing 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 South Dakota Board of Medical Examiners or other appropriate licensing authority or agency. Avera CVS shall be entitled to make its determination in its sole discretion, in accordance with such policies and procedures as the Credentialing Committee shall adopt provided, however, that the determination shall be made in good faith. The Credentialing Committee shall notify the affected Provider, in writing, in the event such a report is made.

XIX. SPECIAL RULES FOR PROVIDERS IN HOSPITAL/FACILITY EXCLUSIVE PRACTICE SETTINGS AND LOCUM TENEN PHYSICIANS.

Providers in a Hospital/Facility exclusive practice environment are waived from credentialing requirements when the Criteria for Participation as described below in this section are met. These special rules apply to:

- Providers who practice exclusively in an inpatient setting and provide care for Avera Health Plans members only because members are directed to the Hospital or another inpatient setting.
- Providers who practice exclusively in free-standing Facilities and provide care for Avera Health Plans members only because members are directed to the Facility.
- Providers who do not provide care for members in a treatment setting (e.g., board-certified consultants).
- Providers serving as a Locum Tenen Physician for a period(s) of no greater than 60 consecutive days.

A. Hospital/Facility exclusive practice settings means a Provider who exclusively provides services at an Avera Health Plans Participating Hospital/Facility, when such services are billed for and collected by the Avera Health Plans Participating Hospital/Facility, except for those Providers who have otherwise qualified as an Avera Health Plans Participating Provider, and when the Avera Health Plans Participating Hospital/Facility has entered into an agreement with Avera Health Plans in accordance with this section and which provides that all services of such Providers are billed and collected by the Avera Health Plans Participating Hospital/Facility. As to all such Hospital/Facility exclusive practice locations, the Criteria for Participation shall be modified and the applicable process for application and approval waived, and the following (B) substituted in its place.

B. The Avera Health Plans Participating Hospital/Facility shall, under oath, represent and warrant that: (a) the Provider has a current, valid, active license to practice in the state in which the service of the Provider is provided, and is a member of the medical staff of the Avera Health Plans Participating Hospital/Facility; with appropriate privileges to provide services consistent with their licensure and scope of practice. In granting such membership and privileges or applying such credentialing standards, the Avera Health Plans Participating Hospital/Facility 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 Provider is eligible to provide covered services under the Medicare and Medicaid programs; (c) the Provider maintains malpractice insurance as required by Avera Health Plans; (d) the Avera Health Plans Participating Hospital/Facility will immediately notify Avera Health Plans whenever the representations and warranties about the Provider are no longer accurate and complete; and (e) the terms and conditions of the Avera Health Plans Participating Provider Agreement apply to all Providers at the Avera Health Plans Participating Hospital/Facility location who are not otherwise Avera Health Plans Participating Providers. The representations and warranties by the Avera Health Plans Hospital/Facility or Avera Health Plans Provider office may be included in the Avera Health Plans Hospital/Facility Agreement or the Avera Health Plans Provider Agreement as applicable, and therefore, apply to all Providers at the Avera Health Plans Hospital/Facility or Avera Health Plans Provider office who are not otherwise Avera Health Plans Participating Providers, or may be an individual representation and warranty by the Avera Health Plans Hospital/Facility of Avera Health Plans Provider office as an individual Provider.

C. Examples of Providers that may be considered as practicing exclusively in a Hospital/Facility practice location may include, but are not limited to, the following Provider types. Avera Health Plans reserves the sole discretion to determine if these special rules described herein apply.
    - Pathologists
    - Radiologists
    - Anesthesiologists

- Neonatologists
- Emergency Room Physicians
- Hospitalists
- Board Certified Consultants
- Hospital Based CRNA's

D. Avera Health Plans participation by such Providers shall be subject to the following:

1. Avera Health Plans reserves the right to immediately terminate, at its sole discretion, such Avera Health Plans participation by any Provider at any time.

XX. Provisional Approval of Providers.

It is Avera CVS policy that all credentialing information is available to the Credentialing Committee or to the Avera Health Plans Chief Medical Officer at the time a decision regarding Avera Health Plans participation is made. However, for Providers completing residency or fellowship training, or those Providers who apply to 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 Avera Health Plans members to approve Avera Health Plans participation before the entire credentialing process is completed. For this purpose a provisional credentialing process is followed for Providers who have completed their residency or fellowship requirements for their particular specialty area within twelve (12) months or whom are applying to Avera CVS for the first time, prior to review by the Credentialing Committee or the Avera Health Plans Chief Medical Officer. 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 (5) 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.

To assure the Credentialing Committee has current information regarding a Provider's credentials; verifications must be completed within the time limits specified in the Administrative Work Instructions.

Provisional approval is effective for not more than sixty (60) days.

XXI. REAPPLICATION AFTER TERMINATION/REINSTATEMENT.

If Avera Health Plans terminates a Provider that it later wishes to reinstate, and the break is (thirty) 30 days or more, the Provider will be credentialed as an initial applicant. 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 Credentialing Committee or the Avera Health Plans Chief

Medical Officer will review all credentials and make a final determination prior to the Provider'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 provided to our clients 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 #
- Provider NPI
- Practice Address, City, State, Zip Code
- Practice Telephone Number
- Billing Address, City, State, Zip Code
- Billing Address Telephone Number
- License designation
- Languages spoken
- Gender
- Board certification status and type
- Hospital affiliations
- Provider Education, including post graduate when applicable
- Accepting new patients

In order to provide Avera CVS clients with consistent and timely data information, Avera CVS will:

A. Maintain database integrity through a series of 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. Compile a monthly Quality Assurance Report ("Board Report") to provide a quality analysis for initial and recredentialed Providers, and terminations, which is created by the Credentialing Manager.

To provide Avera 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 Avera Health Plans Call Center Representatives. The shared Policies and Procedures establish a guidance system for filtering Provider data to Avera CVS and/or Avera Health Plans Provider Relations Department to research and complete

updates to the Provider database. The tracking of communication will be maintained through a workflow database or internal email and electronic files, which includes the following Avera Health Plans departments:

- Call Center
- Claims/Operations
- Provider File Maintenance
- 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 Credentialing Committee for consideration. Prior to forwarding the Provider information, each file is initially reviewed by the processor / credentialing department staff who did the initial credentialing. The processor completes the Credentialing Checklist in the Credentialing Database (CACTUS). Once the required verifications have been received, the file is electronically marked for another member of the credentialing staff other than the person that did the initial credentialing work, to audit the file for accuracy. The reviewer checks each file to ensure that all necessary information is present. If deficiencies are noted, the Provider's file is returned to the processor for correction. Once the file has been reviewed and approved, documentation to that effect is placed in the Provider's CACTUS file and the Provider information is submitted to the Avera Health Plans Chief Medical Officer or the Credentialing 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 CVS recognizes the American Board of Medical Specialties and the American Osteopathic Association as the standard guidelines for specialty listings. Board certification is not required for all Provider types as part of the Criteria for Participation, but may be used as a factor in the determination of a Provider's specialty listing in the member materials or Provider database.

Avera Credentialing Verification Services

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 Health Plans members and Avera CVS clients. The credentialing program involves the initial and ongoing collection, verification, and review of information necessary for selection and retention of Providers meeting Avera Health Plans credentialing standards.

B. Only those Providers meeting the credentialing standards developed by Avera Health Plans and Avera CVS and approved by the Board of Directors are included in the network. In addition to the credentialing standards, Selection Factors may be considered in contracting with Providers. Providers are credentialed prior to acceptance into the Avera Health Plans network(s) 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. Hospices
4. Dialysis Centers
5. Skilled Nursing Facilities
6. Free-Standing Ambulatory Surgical Centers
7. Behavioral Health Facilities providing inpatient, residential and ambulatory mental health and substance abuse services.
8. Independent Diagnostic Testing Facilities (IDTFs)
9. Public Health Agencies

II. CRITERIA FOR PARTICIPATION.

A. Only those Providers meeting the Avera Health Plans Criteria for Participation are credentialed. In addition to the credentialing standards, Selection Factors may also be considered in contracting with Providers. Providers are credentialed prior to acceptance into the Avera Health Plans network(s) and at least every thirty-six (36) months thereafter.

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

- Hospitals
- Home Health Agencies
- Hospices
- Dialysis Centers
- Skilled Nursing Facilities
- Free-standing surgical centers
- Behavioral Health Facilities providing inpatient, residential and ambulatory mental health and substance abuse services.
- Independent Diagnostic Testing Facilities (IDTFs)
- Public Health Agencies

1) Hospitals. In order to be eligible to be an Avera Health Plans Participating Hospital, the Hospital must continuously meet the following requirements:

   a. The Hospital must hold a current, valid, active license from the state in which it is located.

   b. The Hospital must be certified for participation in the Medicare and Medicaid programs.

   c. The Hospital must present a copy of their current professional liability insurance certificate.

   d. A Hospital with greater than 50 beds must provide documentation to satisfy that it has an active Patient Safety Evaluation Program (PSO) and a Comprehensive Person Centered Hospital Discharge Program in place that satisfies requirements established in 45 CFR § 156.1110

   e. The Hospital must be approved by a recognized accrediting body no more than every three (3) years, i.e. The Joint Commission, American Osteopathic Association (AOA), Accreditation Association for Ambulatory Health Care, Inc. (AAAHC), 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 (3) years, Avera Health Plans will conduct an onsite quality assessment using the Hospital Site Review Tool, based on the requirements set forth by NCQA.

f. The Hospital must have negative responses to each of the following questions, unless the Credentialing Committee and/or the Avera Health Plans Chief Medical Officer, after full disclosure by the Hospital waives the requirement.

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

    ii. Has the Hospital's federal or state pharmacy permits been limited, suspended, revoked, or placed on probation, within the last ten (10) years?

    iii. 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 (10) years?

    iv. Has the Hospital been convicted of any crime, whether felony or misdemeanor, in the last ten (10) years?

    v. Has the Hospital's participation in Medicare or Medicaid been limited, suspended, revoked, or placed on probation, within the last ten (10) years?

    vi. Have civil monetary penalties under the Medicare or Medicaid program been assessed against the Hospital, within the last ten (10) years?

    vii. Has the Hospital's accreditation by any accrediting organization (including The Joint Commission) been limited, suspended, revoked, or placed on probation, within the last ten (10) years?

    viii. Have sanctions of any kind been imposed on the Hospital by any other health care licensure or accreditation organization, within the last ten (10) years?

    ix. 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 (10) years?

    x. 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 (10) years?

Are there any pending malpractice suits against the Hospital?

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

a. The Facility must hold a current, valid active license by the state in which it is located.

b. The Facility must be certified for participation in the Medicare and Medicaid programs, and maintains an agreement to participate as such.

c. Be approved by a recognized accrediting body no more than every three (3) years, i.e. The Joint Commission, American Osteopathic Association (AOA), Accreditation Association for Ambulatory Health Care, Inc. (AAAHC), 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 (3) years, Avera Health Plans will conduct an onsite quality assessment using the Hospital Site Review Tool, based on the requirements set forth by NCQA.

d. The Facility must have in effect appropriate agreements with an Avera Health Plans Participating Hospital for handling emergencies and transfers.

e. The Facility must have negative responses to each of the following questions, unless the Board of Directors, after full disclosure by the Facility and a recommendation from the Credentialing Committee, waives the requirement:

i. Has the Facility's license to operate been limited, suspended, revoked, or placed on probation, within the last ten (10) years?

ii. 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 (10) years?

iii. Has the Facility's participation in Medicare or Medicaid been limited, suspended, revoked, or placed on probation, within the last ten (10) years?

iv. Have civil monetary penalties under the Medicare or Medicaid program been assessed against the Facility, within the last ten (10) years?

v. 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 (10) years?

vi. Have sanctions of any kind been imposed on the Facility by any other health care licensure or accreditation organization, within the last ten (10) years?

vii. 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 (10) years?

viii. Have any medical malpractice judgments been entered against the Facility or settled with payment made by the Facility, or on its behalf, within the last ten (10) years? Are there any pending malpractice suits against the Facility?

3.) Independent Diagnostic Testing Facilities. In order to be eligible to be an Avera Health Plans 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 the 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 thirty (30) days of the change. All other changes to the enrollment application must be reported within ninety (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.

d. 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.

e. 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.

f. 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 CVS upon request and notification of any changes in equipment within ninety (90) days.

g. 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 directory or directory assistance.

h. 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 CVS. The IDTF must ensure that the insurance policy must remain in effect at all times and provide coverage of at least $300,000 per incident, and notify Avera CVS of any policy changes or cancellations.

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

j. Answer, document and maintain documentation of a client's clinical complaints at the physical site of the IDTF (for mobile IDTFs, this documentation would be stored at their home office).

k. Post Medicare standards for review by patients and public.

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

m. Have the equipment calibrated and maintained per equipment instructions and its compliance with applicable manufacturers suggested maintenance and calibration standards.

n. 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.

o. Have proper medical record storage and be able to retrieve medical records upon request within two (2) business days.

p. Allow Avera CVS 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.

q. With the exception of a Hospital based and mobile IDTF, a fixed base IDTF does not include the following:

    i. Sharing a practice location with another Medicare-enrolled individual or organization.

    ii. Leasing or subleasing its operations or its practice location to another Medicare enrolled individual or organization.

    iii. Sharing diagnostic testing equipment used in the initial diagnostic test with another Medicare-enrolled individual or organization.

4.) Public Health Agencies are agencies recognized by Avera Health Plans to administer immunizations. Other services billed by these locations may not be covered.

a. Must have a Medical Director and supply his or her name. The Medical Director must have an active license in the same state as the Public Health Agency that is in good standing.

b. Designation as a Public Health Agency by the County Board of Supervisors **or** Board of Health.

III. Credentialing Process.

A. Initial Credentialing.

1. Applications.

a. Applicants for Avera Health Plans 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 'Disclosure Questionnaire' section of the application and must furnish a detailed written description of 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. Finally, a release must be signed and dated along with the attestation by the applicant of the accuracy and completeness of the application.

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

i. The 'Disclosure 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 Avera Health Plans network(s).

iv. The applicant does not meet the minimum liability insurance requirements.

c. Incomplete applications are held open for fifteen (15) 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 'Disclosure 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 Provider application by Avera CVS.

d. Application processing will not begin until all missing documentation/information is received in the Avera CVS office. If information is not received within fifteen (15) days of the request for missing/additional information, the application is closed and returned to the Provider.

2. Review of Criteria for Participation. The Credentialing Committee shall review the application and any additional information in accordance with the Criteria for Participation. In the event the Credentialing Committee finds the application meets both Level I and Level II Criteria for Participation and does not require a waiver, the Credentialing Committee shall recommend for approval under the Criteria for Participation. In the event that the Credentialing 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 Credentialing Committee shall make a recommendation to the Board of Directors, and the Credentialing 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 Chief Medical Officer, or the Board of Directors or one or more of the Board members.

3. Notification of Credentialing Decision. The recommendation date of the Chief Medical Officer or Credentialing Committee is used as the effective date of the Provider's Avera Health Plans credentialed status and the Provider is sent written notification of the approval within ten (10) days of the approval. The recommendation then is presented to the Board of Directors for final ratification. Providers also receive a signed Avera Health Plans Provider Agreement and a Provider Manual when applicable.

4. Denial of Avera Health Plans Participation. New applicants whose Avera Health Plans participation is denied are notified via certified mail of the denial and the basis for the decision within thirty (30) days of the denial. A description of the reconsideration procedures is included in the letter.

5. Reconsideration. A Provider whose application is denied based on the Criteria for Participation may request reconsideration upon sending a

notice to the Avera Health Plans Chief Medical Officer 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 sent to the body that determined the Criteria for Participation were not met, that being either the Credentialing Committee or the Board of Directors, as appropriate. The Credentialing 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 Credentialing Committee or the Board of Directors, 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 Credentialing 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 Avera Health Plans Participation. An applicant whose application for Avera Health Plans participation has been denied may not reapply for Avera Health Plans 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 Avera Health Plans 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 Level II Criteria for Participation waiver.

B. Recredentialing.

1. Automatic Expiration Unless Renewed. Avera Health Plans participation generally extends for a thirty-six (36) month period pursuant to a cycle established for each Provider. Avera Health Plans participation expires at the end of such period unless renewed. Prior to renewal of Avera Health Plans 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 Avera Health Plans Participation

    a. A renewal application (Recredentialing Application) is mailed or emailed to the Provider at least one hundred twenty (120) days before the expiration of Avera Health Plans participation. It is the Provider's responsibility to ensure that accurate email

address information is continuously provided to Avera CVS for this purpose.

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

c. 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 Avera Health Plans participation, the Provider's Avera Health Plans participation will be terminated.

d. Applications are immediately returned if the 'Disclosure 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.

e. Incomplete applications are held open for fifteen (15) 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 the Avera CVS office. If information is not received within fifteen (15) days of the request for missing/additional information, the Provider will be contacted to request submission of the information. If there is no response by the expiration of Avera Health Plans participation, the Provider shall be treated as having withdrawn the request for renewal of Avera Health Plans participation and will be terminated for lack of response.

3. Review of Criteria for Participation. The Avera Health Plans Chief Medical Officer shall review the renewal application and any additional information in accordance with the Criteria for Participation. In the event the Avera Health Plans Chief Medical Officer finds the application continues to meet the Criteria for Participation and does not require a waiver, the Avera Health Plans Chief Medical Officer shall approve the application under the Criteria for Participation. In the event that the Avera Health Plans Chief Medical Officer 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 Avera Health Plans Chief Medical Officer shall make a recommendation to the Board of Directors, and the Avera Health Plans Chief Medical Officer or 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 Avera Health Plans Chief Medical Officer, or the Board of Directors or one or more of the Board's members.

4. Notification of Recredentialing Decision. Providers whose Avera Health Plans participation is not renewed receive written notification. Providers whose renewal of Avera Health Plans participation is denied are notified via certified mail of the denial and the basis for the decision within thirty (30) 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 Avera Health Plans Chief Medical Officer 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 Credentialing Committee or the Board of Directors, as appropriate. The Credentialing 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 Credentialing Committee or the

Board of Directors, 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 Credentialing 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 Avera Health Plans Participation. An applicant whose application for continued Avera Health Plans participation has been denied may not reapply for Avera Health Plans 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 Avera Health Plans 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 that would allow granting of a waiver.

SECTION THREE
PROVIDER SELECTION FACTORS

I. SELECTION FACTORS. In determining whether to contract with a Provider, Avera Health Plans may consider the following factors:

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

B. The extent to which Avera Health Plans 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 Avera Health Plans participating providers to provide similar services as the applicant, without undue inconvenience to the Avera Health Plans members.

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

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

G. The existing referral relationships of the applicant with Avera Health Plans participating providers, and the continuity of care, which exists between the applicant and existing Avera Health Plans 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 Health Plans, including the utilization review plan.

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 Health Plans.

L. The judgment of the Board of Directors as to what is in the best interests of Avera Health Plans.

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

N. Any applicable "Any Willing Provider" laws.

II. SELECTION FACTOR PROCESS. All Provider applications are evaluated using the Selection Factors. Other Provider applications may be evaluated under the Selection Factors at the discretion of the Director of Provider Contracting or the Board of Directors. The Director of Provider Contracting reviews the Providers' applications and any additional information in accordance with the Selection Factors and makes a recommendation to the President of Avera Health Plans as to the appropriateness of contracting with each applicant. If the Director of Provider Contracting 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 or recommends denial to the President or determines that the President should consider the application. If the Director of Provider Contracting 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 of Directors. If the Director of Provider Contracting recommends denial of the application, the Director of Provider Contracting may defer review of the Criteria for Participation pending a determination by the Board of Directors 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 for Participation, that approval of the application is consistent with the Selection Factors; and, that the applicant, upon signing the Agreement, shall be an Avera Health Plans 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 therefore denied.

4. The application is incomplete and directs the Director of Provider Contracting 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 Provider Contracting, to initial contracting decisions as well as determination of continued contracting at the time of

renewal.

SECTION FOUR
ONGOING PERFORMANCE MONITORING

Avera Health Plans includes, as part of the formal evaluation process, a reappraisal of professional performance, judgment, and clinical competence, and objective evidence considering the assessment of the Provider's performance while working with Avera Health Plans. Ongoing monitoring of a Provider's performance is conducted by the Avera Health Plans Utilization Management and Quality Improvement Committees in collaboration with the Avera Health Plans Chief Medical Officer and Director of Provider Contracting. 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 Provider has relocated or opened a new site that has not previously been approved.

B. Review of Provider 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 Credentialing Committee for review and consideration at time of the credentialing decision.

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SECTION FIVE
TERMINATION OF PROVIDERS

I. PROCESS FOR TERMINATION. Avera Health Plans may terminate a provider's Avera Health Plans participation at any time when the Board of Directors, the Credentialing Committee, or the Avera Health Plans Chief Medical Officer 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 Credentialing Committee 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 Credentialing 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 Avera Health Plans Chief Medical Officer 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 sent to the body that determined the Provider's Avera Health Plans participation should be terminated, that being either the Credentialing Committee or the Board of Directors, as appropriate. The Credentialing 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 Credentialing Committee or the Board of Directors, 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 Credentialing 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 Avera Health Plans participation has been terminated may not reapply for Avera Health Plans 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 Avera Health Plans 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 Credentialing Committee that would allow them to grant a waiver and approve the applicant's Avera Health Plans participation.

IV. DUTY OF PROVIDER TO NOTIFY WHEN CRITERIA FOR PARTICIPATION IS NO LONGER MET. Each Provider is responsible to notify the Avera Health Plans Chief Medical Officer if the Provider no longer meets the Criteria for Participation or would do so only if granted a waiver. Each Avera Health Plans Participating Provider shall notify Avera Health Plans 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 Avera Health Plans:

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 Avera Health Plans Physician or Practitioner, Avera Health Plans may terminate the Physician or Practitioner Agreement as to any individual Provider 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 Avera Health Plans Provider Agreement shall apply only to those individual Providers who continue to meet the Criteria for Participation.

VI. IMMEDIATE THREAT OR LICENSE REVOCATION, OR SUSPENSION. In the case of a Provider whose license to practice 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 the Avera Health Plans Chief Medical Officer or the Credentialing Committee to approve immediate Avera Health Plans termination.

VII. REAPPLICATION AFTER TERMINATION/REINSTATEMENT.
If Avera Health Plans terminates a Provider that it later wishes to reinstate, and the break is thirty (30) days or more, the Provider will be credentialed as an initial applicant. 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 Credentialing Committee or the Avera Health Plans Chief Medical Officer will review all credentials and make a final determination prior to the Provider's reentry into the organization.

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SECTION SIX
DELEGATED CREDENTIALING

I. STATEMENT OF POLICY. In certain circumstances Avera Health Plans 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 Health Plans evaluates the capability of the delegated entity to perform the credentialing functions according to the Avera Health Plans 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 Health Plans applicable state standards and those established by the National Committee for Quality Assurance (NCQA).

2. Minutes of the delegate's Credentialing Committee meetings to verify critical review of the Providers' credentials.

3. Five percent (5%) or twenty-five (25) Providers' credentialing files, whichever is less. A minimum of ten (10) initial credentialing files and (10) ten recredentialing files are audited.

B. The Avera Health Plans Credentialing Committee reviews the audit results. The recommendation of the Credentialing 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 Health Plans will use to evaluate the delegate's performance and the consequences of the delegate's failure to meet the terms of the delegated credentialing agreement. As part of the agreement, the delegate is required to notify Avera Health Plans 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 Health Plans annually evaluates the delegated entity's credentialing process to assure it continues to meet or exceed the Avera Health Plans standards, applicable state standards and those established by the National Committee for Quality Assurance (NCQA), Avera Health Plans 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 Health Plans applicable state standards and those established by the National Committee for Quality Assurance (NCQA).

2. Minutes of the delegate's Credentialing 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 Health Plans Chief Medical Officer and the Credentialing Committee review results of the annual audit. If deficiencies are found during the evaluation, Avera Health Plans works with the delegated entity to develop a plan for improvement with specified time frames and actions to achieve the Avera Health Plans standards. If the improvement process is unsuccessful, Avera Health Plans reserves the right to terminate the delegation arrangement.

III. Sub delegation. Should Avera Health Plans 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 Health Plans retains the right to approve new Providers and to terminate, place on probation, or take any other action related to the Provider's Avera Health Plans 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 semiannually.

VI. Contract for Delegation. Avera Health Plans will maintain signed, written agreements with all delegated credentialing entities that describe the scope of the

business arrangement. The delegated credentialing agreement (contract) will specifically address the following:

1. The contract will list those responsibilities delegated to the delegated entity and those retained by Avera Health Plans.

2. The contract will require that services of the delegated entity be performed in accordance with Avera Health Plans requirements and national credentialing standards.

3. The contract will require notification to Avera Health Plans of any material change in the delegated entity performance of the delegated functions.

4. The contract will specify that Avera Health Plans may conduct surveys of the delegated entity, as needed.

5. The contract will require that the delegated entity submit periodic reports to Avera Health Plans regarding the performance of its delegated responsibilities.

6. 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 Health Plans in accordance with national credentialing standards.

7. The contract will specify recourse and/or sanctions if the delegated entity does not make corrections to identified problems within a specified period.

8. The contract will specify the circumstances under which the delegated entity may further delegate activities.

9. The contract will specify allowed use of PHI.

10. The contract will include a description of delegate safeguards to protect the information from inappropriate use or further disclosure.

11. The contract will include a stipulation that the delegate will ensure the sub-delegates have similar safeguards.

12. The contract will include a stipulation that the delegate will provide individuals with access to their PHI.

13. The contract will include a stipulation that the delegate will inform the organization if inappropriate uses of the information occur.

14. The contract will include a stipulation that the delegate will ensure that all PHI is returned, destroyed, or protected if the delegation agreement ends.

Avera Credentialing Verification Services

SECTION SEVEN
CRITERIA FOR PARTICIPATION

Criteria for Participation

Physician (MD, DO)

In order to be eligible for Avera Health Plans participation, the Physician must continuously meet the following requirements:

LEVEL I CRITERIA
(Cannot be waived)

Element	Criteria for Participation	Verification Source / Options
Licensure	The MD or DO must hold a current, valid, active license to practice medicine in the state(s) in which the MD or DO intends to provide Covered Services.	• State licensing agency
DEA Registration	The MD or DO must hold a current and active DEA Registration. MD's or DO's who do not, as part of their practice, prescribe medications are exempt from this requirement. This may include but is not limited to such specialties as radiology and pathology.	• 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 • Waiver / Statement of intentions to not prescribe
Professional Education	The MD or DO 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). The MD or DO must have also completed a residency program recognized by the Accreditation Council for Graduate Medical Education (ACGME), the American Board of Medical Specialties (ABMS), the Federation of the Royal College of Physicians and Surgeons of the UK, or a one (1) year fellowship recognized by the ACGME, the Royal College of Physicians and Surgeons of Glasgow (UK), the College of Family Physicians of Canada, or the Royal College of Physicians and Surgeons of Canada. Equivalent experience shall be considered for those General Practice practitioners graduating from medical school before 1980. In addition, Foreign Medical School Graduates must also be certified by the Educational Commission for Foreign Medical Graduates (ECFMG). However, if a resident is moonlighting outside of his/her residency training program and has a full medical license, or residency license, the resident may be credentialed for the moonlighting practice location.	• Highest level of education **OR** • Board Certification ABMS AOA **OR** • ECFMG
Utilization Review	The MD or DO must agree to participate in and abide by the utilization review program as established by Avera Health Plans.	• Release and attestation on application and/or contract
Office Site/Medical Records Evaluation	The MD or DO 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 MD or DO 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
NPI Number	The MD or DO must have a current active NPI number.	• NPPES NPI Registry
Social Security Number	The MD or DO must have a valid, authentic social security number.	Social Security Administration's Death Master File (NTIS)

LEVEL II CRITERIA

The Physician must also continuously meet the following requirements, unless Avera Health Plans, after full disclosure by the Physician, waives such requirement:

Element	Criteria for Participation	Verification Source / Options
Professional Liability Claims History	In the five (5) years prior to making application, the MD or DO 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 MD or DO 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 MD or DO has not had any action taken by a state medical board where the MD or DO has practiced medicine that would affect the MD's or DO's license to	• Application questionnaire

	practice. If an MD or DO was licensed in more than one state in the most recent five year period, the query must include all states in which the MD or DO practiced.	• State licensing agency • FSMB • NPDB
Felony Convictions	The MD or DO has never been convicted of a felony.	• Application questionnaire • State licensing agency • FSMB • NPDB
Clinical Staff Membership	The MD or DO has never been refused membership on a Hospital or healthcare facility medical staff for reasons other than closure of that staff to the MD's or DO's specialty.	• Application questionnaire • Hospital/Healthcare facility • NPDB
Clinical Privileges	The MD or DO must have clinical privileges in good standing, as defined by that institution, at an Avera Health Plans Participating Hospital in a category and with privileges appropriate for such MD or DO. The MD or DO'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 MD or DO does not, as a part of their practice, have a need to admit patients to a Hospital, clinical privileges are not required, but if as part of their practice the potential for privileges is required, a letter of agreement with an Avera Health Plans Participating Provider must be maintained and documentation presented to Avera Health Plans of such agreement.	• Application questionnaire • Hospital/Healthcare facility • NPDB • Hospital • Letter of agreement, if applicable
DEA Registrations	The MD or DO'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 • DEA Office of Diversion Control
Liability Insurance	The MD or DO's liability insurance has never been denied, suspended, canceled, or not renewed.	• Application questionnaire

		• Liability insurance carrier • NPDB
Medical Organization	The MD or DO has never been subjected to disciplinary action in any medical organization.	• Application questionnaire • NPDB
Sanctions	The MD or DO 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
Medicare/Medicaid	The MD or DO has never been convicted of any crimes related to the practice of medicine, including Medicare or Medicaid related crimes. The MD or DO 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 • 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 MD or DO has never been the object of an administrative, civil, or criminal complaint or investigation.	• Application questionnaire
Health Status	The MD or DO 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 MD, DO or others to health and safety risks. The MD or DO is not currently abusing medications, other drugs or substances, including alcohol.	• Application questionnaire • Treating provider
Office Site Review	The MD or DO must meet the threshold for the office site visit, when applicable.	• Site audit results
Medical Record Review	The MD or DO must meet the threshold for the medical record review, when applicable.	• Medical record audit results

Criteria for Participation

Doctor of Dental Medicine (DMD) and Doctor of Dental Surgery (DDS)

In order to be eligible for Avera Health Plans participation, the Doctor of Dental Medicine or Doctor of Dental Surgery must continuously meet the following requirements:

LEVEL I CRITERIA
(Cannot not be waived)

Element	Criteria for Participation	Verification Source / Options
Licensure	The DMD or DDS must hold a current, valid, active license to practice medicine in the state(s) in which the DMD or DDS intends to provide Covered Services.	• State licensing agency
DEA Registration	The DMD or DDS must hold a current and active DEA Registration. DMD's or DDS's 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 DMD or DDS 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 • Board Certification ABMS, AOA • ECFMG
Utilization Review	The DMD or DDS must agree to participate in and abide by the utilization review program as established by Avera Health Plans.	• Release and attestation on application and/or contract

Office Site/Medical Records Evaluation	The DMD or DDS 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 DMD or DDS 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
NPI Number	The DMD or DDS must have a current active NPI number.	• NPPES NPI Registry
Social Security Number	The DMD or DDS must have a valid, authentic social security number.	Social Security Death Master File (NTIS)

LEVEL II CRITERIA

The Doctor of Dental Medicine or Doctor of Dental Surgery must also continuously meet the following requirements, unless the HEALTH PLANS, after full disclosure, waives such requirement:

Element	Criteria for Participation	Verification Source / Options
Professional Liability Claims History	In the five (5) years prior to making application, the DMD or DDS 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 DMD or DDS 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 DMD or DDS has not had any action taken by a state medical/dentistry board where the DMD or DDS has practiced that would affect the DMD or DDS's license to practice. If a DMD or DDS was licensed in more than one state in the most recent five year period, the query must include all states in which the DMD or DDS worked.	• Application questionnaire • State licensing agency • FSMB • NPDB
Felony Convictions	The DMD or DDS has never been convicted of a felony.	• Application questionnaire • State licensing agency • FSMB • NPDB
Clinical Staff Membership	The DMD or DDS has never been refused membership on a Hospital or healthcare facility medical staff for reasons other than closure of that staff to the DMD's or DDS's specialty.	• Application questionnaire • Hospital/Healthcare facility • NPDB
Clinical Privileges	The DMD or DDS must have clinical privileges in good standing, as defined by that institution, at an Avera Health Plans Participating Hospital in a category and with privileges appropriate for such DMD or DDS. The DMD or DDS's privileges at any Hospital or healthcare facility have never been suspended, diminished, revoked, or not renewed. If the DMD or DDS does not, as a part of their 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 an Avera Health Plans Participating Provider must be maintained and documentation presented to Avera Health Plans of such agreement.	• Application questionnaire • Hospital/Healthcare facility • NPDB • Hospital • Letter of agreement, if applicable
DEA Registrations	The DMD or DDS's DEA registration has never been suspended, restricted, or revoked.	• Application questionnaire • State licensing agency • NPDB

		• FSMB • DEA Office of Diversion Control
Liability Insurance	The DMD or DDS's liability insurance has never been denied, suspended, canceled, or not renewed.	• Application questionnaire • Liability insurance carrier • NPDB
Medical Organization	The DMD or DDS has never been subjected to disciplinary action in any medical organization.	• Application questionnaire • NPDB
Sanctions	The DMD or DDS 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
Medicare/Medicaid	The DMD or DDS has never been convicted of any crimes related to the practice of medicine or dentistry, including Medicare or Medicaid related crimes. The DMD or DDS 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 • 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 DMD or DDS has never been the object of an administrative, civil, or criminal complaint or investigation.	• Application questionnaire
Health Status	The DMD or DDS does not have any condition that would impact their ability to perform the essential functions of the position, with or without accommodation, and without exposing the DMD, DDS or others to health and safety risks. The DMD or DDS is not currently abusing medications, other drugs or substances, including alcohol.	• Application questionnaire • Treating provider
Medical Record Review	The DMD or DDS 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 Avera Health Plans participation, the Podiatrist must continuously meet the following requirements:

LEVEL I CRITERIA
(Cannot be waived)

Element	Criteria for Participation	Verification Source / Options
Licensure	The DPM must hold a current, valid, active license to practice podiatry in the state(s) in which the DPM intends to provide Covered Services.	• State licensing agency
DEA Registration	The DPM must hold a current and active DEA Registration. DPM's 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 DPM must be a graduate of an accredited school of podiatry.	• Highest level of education • Board Certification -American Board of Podiatric Medicine -American Board of Podiatry Surgery -American Board of Foot and Ankle Surgery

		-American Board of Multiple Specialties in Podiatry
Utilization Review	The DPM must agree to participate in and abide by the utilization review program as established by Avera Health Plans.	• Release and attestation on application and/or contract
Liability Insurance	The DPM 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
NPI Number	The DPM must have a current active NPI number.	• NPPES NPI Registry
Social Security Number	The DPM must have a valid, authentic social security number.	Social Security Death Master File (NTIS)

LEVEL II CRITERIA

Podiatrists must also continuously meet the following requirements, unless Avera Health Plans, after full disclosure by the Podiatrist, waives such requirement:

Element	Criteria for Participation	Verification Source / Options
Professional Liability Claims History	The DPM 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 DPM 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 DPM has no not had any action taken by a state podiatry board where the DPM has practiced that would affect the DPM's license to practice. If a DPM was licensed in more than one state in the most recent five year period, the query must include all states in which the DPM worked.	• Application questionnaire • State licensing agency • NPDB • Federation of Podiatric Medical Boards
Felony Convictions	The DPM has never been convicted of a felony.	• Application questionnaire • State licensing agency • Federation of Podiatric Medical Boards • NPDB
Clinical Staff Membership	The DPM has never been refused membership on a Hospital or healthcare facility medical staff for reasons other than closure of that staff to the DPM's specialty.	• Application questionnaire • Hospital/Healthcare Facility • NPDB
Clinical Privileges	The DPM must have clinical privileges in good standing, as determined by that institution, at an Avera Health Plans Participating Hospital in a category and with privileges appropriate for such DPM. The DPM'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 DPM does not, as a part of the practice, have a need to admit patients to a Hospital, clinical privileges are not required.	• Application questionnaire • Hospital/Healthcare Facility • NPDB
DEA Registrations	The DPM'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 • DEA Office of Diversion Control
Liability Insurance	The DPM's liability insurance has never been denied, suspended, canceled, or not renewed.	• Application questionnaire • Liability insurance carrier •NPDB
Podiatric Organization	The DPM has never been subjected to disciplinary action in any podiatric organization.	• Application questionnaire • NPDB
Sanctions	The DPM 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
Medicare/Medicaid	The DPM has never been convicted of any crimes related to the practice of podiatry, including Medicare or Medicaid related crimes. The DPM 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 • 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 DPM has never been the object of an administrative, civil, or criminal complaint or investigation.	• Application questionnaire
Health Status	The DPM 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 DPM or others to health and safety risks. The DPM 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 Avera Health Plans participation, the Chiropractor must continuously meet the following requirements:

LEVEL I CRITERIA
(Cannot be waived)

Element	Criteria for Participation	Verification Source / Options
Licensure	The DC must hold a current, valid, active license to practice medicine in the state(s) in which the DC intends to provide Covered Services.	• State licensing agency
Professional Education	The DC must be a graduate of an accredited chiropractic college.	• Confirmation from chiropractic college
Utilization Review	The DC must agree to participate in and abide by the utilization review program as established by Avera Health Plans.	• Release and attestation on application
Liability Insurance	The DC 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
NPI Number	The DC must have a current active NPI number.	• NPPES NPI Registry

Social Security Number	The DC must have a valid, authentic social security number.	Social Security Death Master File (NTIS)

LEVEL II CRITERIA

Chiropractors must also continuously meet the following requirements, unless the HEALTH PLANS, after full disclosure by the Chiropractor, waives such requirement:

Element	Criteria for Participation	Verification Source / Options
Professional Liability Claims History	The DC has no history of professional liability claim settlements, judgments, or pending cases.	• Application questionnaire • NPDB
Work History	The DC 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 DC has not had any action taken by a state chiropractic board where the DC has practiced that would affect the DC's license to practice. If a DC was licensed in more than one state in the most recent five year period, the query must include all states in which the DC worked.	• Application questionnaire • State licensing agency • CIN-BAD • NPDB
Felony Convictions	The DC has never been convicted of a felony.	• Application questionnaire • State licensing agency • CIN-BAD • NPDB
Clinical Staff Membership	The DC has never been refused membership on a Hospital or healthcare facility medical staff for reasons other than closure of that staff to the DC's specialty.	• Application questionnaire • Hospital/Healthcare facility • NPDB
Clinical Privileges	The DC's privileges at any Hospital or healthcare facility have never been suspended, diminished, revoked, or not renewed.	• Application questionnaire

	When applicable, the DC's clinical registration/privileges at an Avera Health Plans Participating Hospital must be in good standing, as determined by that institution, in the appropriate category.	• Hospital/Healthcare facility • NPDB
Liability Insurance	The DC's liability insurance has never been denied, suspended, canceled, or not renewed.	• Application questionnaire • Liability insurance carrier • NPDB
Medical Organization	The DC has never been subjected to disciplinary action in any chiropractic organization.	• Application questionnaire • NPDB
Sanctions	The DC 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 • Cumulative Sanction Internet Sites
Medicare/Medicaid	The DC has never been convicted of any crimes related to his or her practice, including Medicare or Medicaid related crimes. The DC 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 • 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 DC has never been the object of an administrative, civil, or criminal complaint or investigation.	• Application questionnaire
Health Status	The DC 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 DC or others to health and safety risks. The DC 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 Avera Health Plans participation, the Optometrist must continuously meet the following requirements:

LEVEL I CRITERIA
(Cannot be waived)

Element	Criteria for Participation	Verification Source / Options
Licensure	The OD must hold a current, valid, active license to practice optometry in the state(s) in which the OD intends to provide Covered Services.	• State licensing agency
DEA Registration	The OD must hold a current and active DEA Registration. OD's 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 OD's clinical privileges at an Avera Health Plans Participating Hospital must be in good standing in the appropriate category. Clinical privileges are not required.	• Hospital
Professional Education	The OD must be a graduate of an accredited school of optometry.	• Confirmation from school of optometry
Utilization Review	The OD must agree to participate in and abide by the utilization review program as established by Avera Health Plans.	• Release and attestation on application and/or contract

Liability Insurance	The OD 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
NPI Number	The OD must have a current active NPI number	• NPPES NPI Registry
Social Security Number	The OD must have a valid, authentic social security number	Social Security Death Master File (NTIS)

LEVEL II CRITERIA

Optometrists must also continuously meet the following requirements, unless Avera Health Plans, after full disclosure by the Optometrist, waives such requirement:

Element	Criteria for Participation	Verification Source / Options
Professional Liability Claims History	The OD 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 OD has no unexplained gaps of six months or greater in the OD's work history.	• Work history on application and/or curriculum vitae

Disciplinary Actions - Licensure	The OD has not had any action taken by a state optometry board where the OD has practiced optometry that would affect the OD's license to practice. If an OD was licensed in more than one state in the most recent five year period, the query must include all states in which the OD worked.	• Application questionnaire • State licensing agency • NPDB
Felony Convictions	The OD has never been convicted of a felony.	• Application questionnaire • State licensing agency • NPDB
Clinical Staff Membership	The OD has never been refused membership on a Hospital or healthcare facility medical staff for reasons other than closure of that staff to the OD's specialty.	• Application questionnaire • Hospital/Healthcare facility • NPDB
Clinical Privileges	The OD'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 OD's DEA registration has never been suspended, restricted, or revoked or acted upon in any way whatsoever.	• Application questionnaire • State licensing agency • NPDB • DEA Office of Diversion Control
Liability Insurance	The OD's liability insurance has never been denied, suspended, canceled, or not renewed.	• Application questionnaire • Liability insurance carrier • NPDB
Professional Organization	The OD has never been subjected to disciplinary action in any professional organization.	• Application questionnaire •NPDB

Sanctions	The OD 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
Medicare/Medicaid	The OD has never been convicted of any crimes related to the practice of optometry, including Medicare or Medicaid related crimes. The OD 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 • 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 OD has never been the object of an administrative, civil, or criminal complaint or investigation.	• Application questionnaire
Health Status	The OD 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 OD or others to health and safety risks.	• Application questionnaire • Treating provider

	The OD is not currently abusing medications, other drugs or substances, including alcohol.	

Criteria for Participation

Nurse Practitioner (NP)
(Including, but not limited to ARNP, DNP, CNS, CNM, CNP, CRNA)

LEVEL I CRITERIA
(Cannot be waived)

In order to be eligible for Avera Health Plans participation, the Nurse Practitioner must continuously meet the following requirements:

Element	Criteria for Participation	Verification Source / Options
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. NP's 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 (ANCC), American Academy of Nurse Practitioners Certification Program (AANPCP), The National Certification Corporation (NCC), American Midwifery Certification Board (AMCB), Pediatric Nursing Certification Board (PNCB), American Association of Critical-Care Nurses (AACN) or the National Board of Certification & Recertification for Nurse Anesthetists (NBCRNA).	• 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 Avera Health Plans.	• 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
NPI Number	The NP must have a current active NPI number	• NPPES NPI Registry
Social Security Number	The NP must have a valid, authentic social security number	Social Security Death Master File (NTIS)

LEVEL II CRITERIA

NP's must also continuously meet the following requirements, unless Avera Health Plans, after full disclosure by the NP waives such requirement:

Element	Criteria for Participation	Verification Source / Options
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 an Avera Health Plans Participating Hospital must be in good standing in the appropriate category.	• Hospital

	Clinical privileges are not required.	
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 • FSMB
Felony Convictions	The NP has never been convicted of a felony.	• Application questionnaire • State licensing agency • NPDB • FSMB
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 • FSMB
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 acted upon in any way whatsoever.	• Application questionnaire • State licensing agency • NPDB • DEA Office of Diversion Control

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 • FSMB
Medicare/Medicaid	The NP has never been convicted of any crimes related to their 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 • 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 – Certified (PA-C)

LEVEL I CRITERIA
(Cannot be waived)

In order to be eligible for Avera Health Plans participation, the PA-C must continuously meet the following requirements:

Element	Criteria for Participation	Verification Source / Options
Licensure	The PA-C must hold a current, valid, active license to practice in the state(s) in which the PA-C intends to provide Covered Services.	• State licensing agency
DEA Registration	The PA-C must hold a current and active DEA Registration. PA-C's 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-C must be a graduate of an accredited PA program.	• Confirmation from accredited PA program
Board Certification	The PA-C 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-C must agree to participate in and abide by the utilization review program as established by Avera Health Plans.	• Release and attestation on application and/or contract

Liability Insurance	The PA-C 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
Supervising or Collaborating Physician	Supervising or collaborating physician who is an Avera Health Plans Participating Physician.	• Name of supervising or collaborating physician
NPI Number	The PA-C must have a current active NPI number.	• NPPES NPI Registry
Social Security Number	The PA-C must have a valid, authentic social security number.	• Social Security Death Master File (NTIS)

LEVEL II CRITERIA

PA-C's must also continuously meet the following requirements, unless Avera Health Plans, after full disclosure by the PA-C, waives such requirement:

Element	Criteria for Participation	Verification Source / Options
Professional Liability Claims History	The PA-C 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-C's clinical registration/privileges at an Avera Health Plans Participating Hospital must be in good standing in the appropriate category.	• Hospital

	Clinical privileges are not required.	
Work History	The PA-C 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-C has not had any action taken by a state medical board where the PA-C has practiced medicine that would affect the PA-C's license to practice. If a PA-C was licensed in more than one state in the most recent five year period, the query must include all states in which the PA-C worked.	• Application questionnaire • State licensing agency • NPDB • FSMB
Felony Convictions	The PA-C has never been convicted of a felony.	• Application questionnaire • State licensing agency • NPDB • FSMB
Clinical Staff Membership	The PA-C has never been refused membership on a Hospital or healthcare facility staff for reasons other than closure of that staff to the PA-C's specialty.	• Application questionnaire • Hospital/Healthcare facility • NPDB • FSMB
Clinical Privileges	The PA-C'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-C's DEA registration has never been suspended, restricted, or revoked or acted upon in any way whatsoever.	• Application questionnaire • State licensing agency • NPDB • FSMB • DEA Office of Diversion Control

Liability Insurance	The PA-C's liability insurance has never been denied, suspended, canceled, or not renewed.	• Application questionnaire • Liability insurance carrier • NPDB
Professional Organization	The PA-C has never been subjected to disciplinary action in any professional organization.	• Application questionnaire •NPDB
Sanctions	The PA-C 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
Medicare/Medicaid	The PA-C has never been convicted of any crimes related to their practice, including Medicare or Medicaid related crimes. The PA-C 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) • 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-C has never been the object of an administrative, civil, or criminal complaint or investigation.	• Application questionnaire
Health Status	The PA-C 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-C is not currently abusing medications, other drugs or substances, including alcohol.	• Application questionnaire • Treating provider

Criteria for Participation

Psychologist (PhD, PsyD, EdD)

LEVEL I CRITERIA
(Cannot be waived)

In order to be eligible for Avera Health Plans participation, the Psychologist must continuously meet the following requirements:

Element	Criteria for Participation	Verification Source / Options
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 Avera Health Plans.	• Release and attestation on application and/or contract

NPI Number	The Psychologist must have a current active NPI number.	• NPPES NPI Registry
Social Security Number	The Psychologist must have a valid, authentic social security number.	• Social Security Death Master File (NTIS)

LEVEL II CRITERIA

Psychologists must also continuously meet the following requirements, unless Avera Health Plans, after full disclosure by the Psychologist, waives such requirement:

Element	Criteria for Participation	Verification Source / Options
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
Felony Convictions	The Psychologist has never been convicted of a felony.	• Application questionnaire • State licensing agency • NPDB
Clinical Registration/Privileges	When applicable, the Psychologist's clinical registration privileges at an Avera Health Plans Participating 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 Psychologist's specialty.	• Application questionnaire • 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
Medicare/Medicaid	The Psychologist has never been convicted of any crimes related to their 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 • 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 their 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 Practitioners (MLBHP)

Including, but not limited to (CSW-PIP, LISW, LICSW, LMSW, LPC-MH, LMHC, LMFT, LPC-QMHP, LAC, LADC, LPCC, LMHP, CSW-QMHP)

LEVEL I CRITERIA

(Cannot be waived)

In order to be eligible for Avera Health Plans participation, the Masters Level Behavioral Health Practitioner must continuously meet the following requirements:

Element	Criteria for Participation	Verification Source / Options
Licensure	The MLBHP 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
Licensure, LPC-MH or LPC-QMHP (South Dakota)	Licensed Professional Counselors in SD must hold the Mental Health (LPC-MH) or Qualified Mental Health Practitioner (LPC-QMHP) licensure level.	• SD Board of Counselors and Marriage and Family Therapists Examiners.
Licensure, CSW-PIP or CSW-QMHP (South Dakota)	Licensed Certified Social Workers in SD must hold the Private Independent Practice (CSW-PIP) or Qualified Mental Health Practitioner (CSW-QMHP) licensure level.	• SD Board of Social Work Examiners.
Professional Education	The MLBHP 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 MLBHP 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 MLBHP must agree to participate in and abide by the utilization review program as established by Avera Health Plans.	• Release and attestation on application and/or contract
NPI Number	The MLBHP must have a current active NPI number.	• NPPES NPI Registry
Social Security Number	The MLBHP must have a valid, authentic social security number.	Social Security Death Master File (NTIS)

LEVEL II CRITERIA

Masters Level Behavioral Health Practitioners must also continuously meet the following requirements, unless Avera Health Plans, after full disclosure by the Masters Level Behavioral Health Practitioner, waives such requirement:

Element	Criteria for Participation	Verification Source / Options
Professional Liability Claims History	The MLBHP 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 MLBHP has no unexplained gaps in work history.	• Work history on application and/or curriculum vitae
Disciplinary Actions - Licensure	The MLBHP has not had any action taken by a state licensing board where the MLBHP has practiced that would affect the MLBHP's license. If a MLBHP 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
Felony Convictions	The MLBHP has never been convicted of a felony.	• Application questionnaire

		• State licensing agency • NPDB
Clinical Staff Membership	The MLBHP has never been refused membership on a Hospital or other health care facility staff for reasons other than closure of that staff to the MLBHP's specialty.	• Application questionnaire • Hospital • NPDB
Clinical Registration/Privileges	When applicable, the MLBHP's clinical registration privileges at an Avera Health Plans Participating Hospital must be in good standing in the appropriate category. Clinical privileges are not required.	• Hospital
Clinical Privileges	The MLBHP'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 MLBHP's liability insurance has never been denied, suspended, canceled, or not renewed.	• Application questionnaire • Liability insurance carrier • NPDB
Professional Organization	The MLBHP has never been subjected to disciplinary action in any professional organization.	• Application questionnaire • NPDB
Sanctions	The MLBHP 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
Medicare/Medicaid	The MLBHP has never been convicted of any crimes related to their practice of behavioral health, including Medicare or Medicaid related crimes. The MLBHP 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 • 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 MLBHP has never been the object of an administrative, civil, or criminal complaint or investigation.	• Application questionnaire
Health Status	The MLBHP 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 MLBHP or others to health and safety risks. The MLBHP not currently abusing medications, other drugs or substances, including alcohol.	• Application questionnaire • Treating provider

Criteria for Participation

Certified Genetic Counselors (CGC) ®

LEVEL I CRITERIA
(Cannot be waived)

In order to be eligible for Avera Health Plans participation, the CHC ® must continuously meet the following requirements:

Element	Criteria for Participation	Verification Source / Options
Licensure	The CGC ® 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 counselors. A temporary license does not qualify; the license must be the permanent licensure in appropriate state.	• State Board/licensing agency
Professional Education	The CGC ® 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 CGC ® must be certified by the American Board of Genetic Counseling (ABGC) as Certified Genetic Counselor (CGC) ®.	• Confirmation with the ABGC of CGC ® status
Liability Insurance	The CGC ® 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 CGC ® must agree to participate in and abide by the utilization review program as established by Avera Health Plans.	• Release and attestation on application and/or contract
NPI Number	The CGC ® must have a current active NPI number.	• NPPES NPI Registry
Social Security Number	The CGC ® must have a valid, authentic social security number.	Social Security Death Master File (NTIS)

LEVEL II CRITERIA

The Certified Genetic Counselor must also continuously meet the following requirements, unless Avera Health Plans, after full disclosure by the Certified Genetic Counselor, waives such requirement:

Element	Criteria for Participation	Verification Source / Options
Professional Liability Claims History	The CGC ® 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 CGC ® has no unexplained gaps in work history.	• Work history on application and/or curriculum vitae
Disciplinary Actions - Licensure	The CGC ® 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 genetic	• Application questionnaire • State licensing agency

	counselor was licensed in more than one state in the most recent five year period, the query must include all states in which the CGC ® worked.	• NPDB
Felony Convictions	The CGC ® has never been convicted of a felony.	• Application questionnaire • State licensing agency • NPDB
Clinical Staff Membership	The CGC ® has never been refused membership on a hospital or other health care facility staff for reasons other than closure of that staff to the CGC's ® specialty.	• Application questionnaire • Hospital • NPDB
Clinical Registration/Privileges	When applicable, the CGC's ® clinical registration privileges at an Avera Health Plans Participating Hospital must be in good standing in the appropriate category. Clinical privileges are not required.	• Hospital
Clinical Privileges	The CGC'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 CGC's ® liability insurance has never been denied, suspended, canceled, or not renewed.	• Application questionnaire • Liability insurance carrier • NPDB
Professional Organization	The CGC ® has never been subjected to disciplinary action in any professional organization.	• Application questionnaire • NPDB
Sanctions	The CGC ® 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
Medicare/Medicaid	The CGC ® has never been convicted of any crimes related to their practice of genetic counseling, including Medicare or Medicaid related crimes. The CGC ® has	• Application questionnaire • FSMB

	never been subjected to civil money penalties under the Medicare or Medicaid program or been suspended from participation in Medicare or Medicaid.	• NPDB • 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 CGC ® has never been the object of an administrative, civil, or criminal complaint or investigation.	• Application questionnaire
Health Status	The CGC ® 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 themselves or others to health and safety risks. The CGC ® is not currently abusing medications, other drugs or substances, including alcohol.	• Application questionnaire • Treating provider

Criteria for Participation

Physical Therapists (DPT, PT, LPT)

LEVEL I CRITERIA
(Cannot be waived)

In order to be eligible for Avera Health Plans participation, the Physical Therapist must continuously meet the following requirements:

Element	Criteria for Participation	Verification Source / Options
Licensure	The DPT, PT or LPT 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 DPT, PT or LPT must have either 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 DPT, PT or LPT 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 DPT, PT or LPT 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
NPI Number	The DPT, PT or LPT must have a current active NPI number.	• NPPES NPI Registry
Social Security Number	The DPT, PT or LPT must have a valid, authentic social security number.	Social Security Death Master File (NTIS)

LEVEL II CRITERIA

The Physical Therapist must also continuously meet the following requirements, unless Avera Health Plans, after full disclosure by the Physical Therapist, waives such requirement:

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

Clinical Privileges	The DPT, PT or LPT'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 DPT, PT or LPT's liability insurance has never been denied, suspended, canceled, or not renewed.	• Application questionnaire • Liability insurance carrier • NPDB
Professional Organization	The DPT, PT or LPT has never been subjected to disciplinary action in any professional organization.	• Application questionnaire • NPDB
Sanctions	The DPT, PT or LPT 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
Medicare/Medicaid	The DPT, PT or LPT has never been convicted of any crimes related to the practice of physical medicine, including Medicare or Medicaid related crimes. The DPT, PT or LPT 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 • 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 DPT, PT or LPT has never been the object of an administrative, civil, or criminal complaint or investigation.	• Application questionnaire
Health Status	The DPT, PT or LPT 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 DPT, PT or LPT or others to health and safety risks. The DPT, PT or LPT is not currently abusing medications, other drugs or substances, including alcohol.	• Application questionnaire • Treating provider

Criteria for Participation

Occupational Therapists (OT) and Audiologists (AuD)

LEVEL I CRITERIA
(Cannot be waived)

In order to be eligible for Avera Health Plans participation, the Occupational Therapist or Audiologist must continuously meet the following requirements:

Element	Criteria for Participation	Verification Source / Options
Licensure	The OT or AuD must hold a current, valid, active license to practice in the states in which the OT or AuD intends to provide Covered Services.	• State Board/licensing agency
Professional Education	The OT or AuD 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 OT or AuD 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 OT or AuD must agree to participate in and abide by the utilization review program as established by Avera Health Plans.	• Release and attestation on application and/or contract
NPI Number	The OT or AuD must have a current active NPI number.	• NPPES NPI Registry
Social Security Number	The OT or AuD must have a valid, authentic social security number.	Social Security Death Master File (NTIS)

LEVEL II CRITERIA

The Occupational Therapist or Audiologist must also continuously meet the following requirements, unless Avera Health Plans, after full disclosure by the Occupational Therapist or Audiologist, waives such requirement:

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

Clinical Privileges	The OT or AuD'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 OT or AuD's liability insurance has never been denied, suspended, canceled, or not renewed.	• Application questionnaire • Liability insurance carrier • NPDB
Professional Organization	The OT or AuD has never been subjected to disciplinary action in any professional organization.	• Application questionnaire • NPDB
Sanctions	The OT or AuD 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
Medicare/Medicaid	The OT or AuD has never been convicted of any crimes related to their respective health care practice, including Medicare or Medicaid related crimes. The OT or AuD 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 • 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 OT or AuD has never been the object of an administrative, civil, or criminal complaint or investigation.	• Application questionnaire
Health Status	The OT or AuD does not have any condition that would impact the ability to perform the essential functions of their position, with or without accommodation, and without exposing the OT, the AuD or others to health and safety risks. The OT or AuD is not currently abusing medications, other drugs or substances, including alcohol.	• Application questionnaire • Treating provider

Criteria for Participation

Speech Language Pathologists (SLP)

LEVEL I CRITERIA
(Cannot be waived)

In order to be eligible for Avera Health Plans participation, the Speech Language Pathologist must continuously meet the following requirements:

Element	Criteria for Participation	Verification Source / Options
Licensure, registration and/or certification**	The SLP 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 SLP's.	• State Board/licensing agency
Professional Education	The SLP 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 SLP 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.	ASHA
Liability Insurance	The SLP 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 SLP must agree to participate in and abide by the utilization review program as established by Avera Health Plans.	• Release and attestation on application and/or contract
NPI Number	The SLP must have a current active NPI number.	• NPPES NPI Registry
Social Security Number	The SLP must have a valid, authentic social security number.	Social Security Death Master File (NTIS)

** See Certificate of Clinical Competence

LEVEL II CRITERIA

Speech Language Pathologists must meet the following requirements, unless Avera Health Plans, after full disclosure by the Speech Language Pathologist, waives such requirement.

Element	Criteria for Participation	Verification Source / Options
Professional Liability Claims History	The SLP 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 SLP has no unexplained gaps in work history.	• Work history on application and/or curriculum vitae
Disciplinary Actions – Licensure or Regulator	The SLP has not had any action taken by a state licensing; regulation or certification board where the SLP has practiced that would affect the SLP's license to practice. If the SLP was regulated in more than one state in the most recent five year period, the query must include all states in which the SLP worked.	• Application questionnaire • State licensing agency • NPDB
Felony Convictions	The SLP has never been convicted of a felony.	• Application questionnaire • State licensing agency • NPDB

Clinical Staff Membership	The SLP has never been refused membership on a hospital or other health care facility staff for reasons other than closure of that staff to the SLP's specialty.	• Application questionnaire • Hospital • NPDB
Clinical Privileges	The SLP'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 SLP's liability insurance has never been denied, suspended, canceled, or not renewed.	• Application questionnaire • Liability insurance carrier • NPDB
Professional Organization	The SLP has never been subjected to disciplinary action in any professional organization.	• Application questionnaire • NPDB
Sanctions	The SLP 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
Medicare/Medicaid	The SLP has never been convicted of any crimes related to the practice of speech therapy, including Medicare or Medicaid related crimes. The SLP 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 • 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 SLP has never been the object of an administrative, civil, or criminal complaint or investigation.	• Application questionnaire
Health Status	The SLP 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 SLP or others to health and safety risks. The SLP is not currently abusing medications, other drugs or substances, including alcohol.	• Application questionnaire • Treating provider

Criteria for Participation

Board Certified Behavior Analyst (BCBA), Board Certified Behavior Analyst – Doctoral (BCBA-D)

LEVEL I CRITERIA
(Cannot be waived)

In order to be eligible for Avera Health Plans participation, the Board Certified Behavior Analyst or Board Certified Behavior Analyst – Doctoral must continuously meet the following requirements:

Element	Criteria for Participation	Verification Source / Options
Licensure, registration and/or certification**	The BCBA or BCBA-D must hold a current, valid, active license or registration to practice in the states in which the analyst intends to provide Covered Services, if state has regulation. Note: South Dakota at present does not regulate BCBA's or BCBA-D's.	• State Board/licensing agency
Professional Education	The BCBA must have a bachelor's degree in appropriate discipline from an accredited college or university. The BCBA-D must have a doctoral degree consistent with the requirements of the Behavior Analyst Certification Board (BACB).	• Confirmation from accredited college or university • Confirmation from BACB
**Certification	The BCBA must have an active certification from BACB and possess a minimum of six months employment or internship in the treatment of autism spectrum disorders under the supervision of an experienced BCBA or a licensed clinician. The BCBA-D must have an active certification from BACB.	• Confirmation from BACB • Work or internship experience
Liability Insurance	The BCBA or BCBA-D 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 or BCBA-D must agree to participate in and abide by the utilization review program as established by Avera Health Plans.	• Release and attestation on application and/or contract
NPI Number	The BCBA or BCBA-D must have a current active NPI number.	• NPPES NPI Registry
Social Security Number	The BCBA or BCBA-D must have a valid, authentic social security number.	Social Security Death Master File (NTIS)

LEVEL II CRITERIA

The Board Certified Behavior Analyst or Board Certified Behavior Analyst – Doctoral must also continuously meet the following requirements, unless the Avera Health Plans, after full disclosure, waives such requirement:

Element	Criteria for Participation	Verification Source / Options
Professional Liability Claims History	The BCBA 0r BCBA-D 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 BCBA or BCBA-D has no unexplained gaps in work history.	• Work history on application and/or curriculum vitae
Disciplinary Actions – Licensure or Regulator	The BCBA or BCBA-D has not had any action taken by a state licensing; regulation or certification board where the BCBA or BCBA-D has practiced that would affect the BCBA or BCBA-D's license to practice. If the BCBA or BCBA-D was regulated in more than one state in the most recent five year period, the query must include all states in which the BCBA or BCBA-D worked.	• Application questionnaire • State licensing agency • NPDB

Felony Convictions	The BCBA or BCBA-D has never been convicted of a felony.	• Application questionnaire • State licensing agency • NPDB
Clinical Staff Membership	The BCBA or BCBA-D has never been refused membership on a Hospital or other health care facility staff for reasons other than closure of that staff to the BCBA or BCBA-D's specialty.	• Application questionnaire • Hospital • NPDB
Clinical Privileges	The BCBA or BCBA-D'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 BCBA or BCBA-D's liability insurance has never been denied, suspended, canceled, or not renewed.	• Application questionnaire • Liability insurance carrier • NPDB
Professional Organization	The BCBA or BCBA-D has never been subjected to disciplinary action in any professional organization.	• Application questionnaire • NPDB
Sanctions	The BCBA or BCBA-D 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
Medicare/Medicaid	The BCBA or BCBA-D has never been convicted of any crimes related to their practice discipline, including Medicare or Medicaid related crimes. The BCBA or BCBA-D 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 • 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 BCBA or BCBA-D has never been the object of an administrative, civil, or criminal complaint or investigation.	• Application questionnaire
Health Status	The BCBA or BCBA-D 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 BCBA or BCBA-D is not currently abusing medications, other drugs or substances, including alcohol.	• Application questionnaire • Treating provider

Criteria for Participation

Institutions

LEVEL I CRITERIA
(Cannot be waived)

In order to be eligible for Avera Health Plans participation, the Hospital, Home Health Agency, Hospice, Dialysis Center, 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 Health Plans, must continuously meet the following requirements:

Element	Criteria for Participation	Verification Source / Options
Licensure	The Provider must be in good standing with state and federal regulatory bodies. Avera Health Plans 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 The Joint Commission, American Osteopathic Association (AOA) or Commission on Accreditation of Rehabilitation Facilities (CARF). If, in the cases of non-accredited institutions Avera Health Plans will substitute a CMS or state review as a site visit.	• Accreditation organization • Copy or Approval Letter • Copy or HCFA or state Review including letter of approval • HEALTH PLANS completion of the HEALTH PLANS

	If applicable, Avera Health Plans 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. If the Provider has not been reviewed by an accrediting body in the last three years, Avera Health Plans will conduct an onsite quality assessment using the Hospital Site Review Tool, based on the requirements set forth by NCQA, unless the Provider is located in a rural area, as defined by the US Census Bureau. If 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.	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 Avera Health Plans.	• Release and attestation on application and/or contract
NPI Number	The Provider must have a current active NPI number.	• NPPES NPI Registry
Patient Safety Standards	For Hospitals with greater than 50 beds, the facility must provide documentation to satisfy that it has an active Patient Safety Evaluation Program (PSO) and a	• Accredited by an accreditation organization, i.e. The

	Comprehensive Person Centered Hospital Discharge Program in place that satisfies requirements as established in 45 CFR § 156.1110.	Joint Commission, or contracted contracted with a Patient Safety Organization (PSO), Health Engagement Network (HEN), Hospital Improvement Innovation Network (HIIN), or a Quality Improvement Organization (QIO); or • Provides documentation deemed suitable to Avera Health Plans to demonstrate material compliance with 45 CFR § 156.1110

All facilities/entities must have at least one of the following licenses/certifications/accreditations to meet credentialing requirements:

Facility/Entity	**Licensure/Accreditation/Certification Requirement***
Ambulatory Surgery Center	State License, Medicare certified, **and** *either* AAAHC or The Joint Commission or AAAASF *Note:* License for Iowa is not applicable
Chemical Dependency Treatment Center	State accreditation **and** accredited by one of the following: The Joint Commission, CARF, or COA
Dialysis Center	Medicare certified
Freestanding Substance Abuse Facility	State license/certification **and one of the following:** The Joint Commission or CARF or COA
Home Health Agency	Medicare certified or The Joint Commission or CHAP OR ACHC
Hospice	State license or Medicare certified or CHAP or ACHC or The Joint Commission
Hospital	State license **and** *either* Medicare certified or The Joint Commission or AOA/HFAP or DNVHC

Public Health Agency	Designation as a Public Health Agency by the County Board of Supervisors **or** Board of Health
Skilled Nursing Facility	State license **and one of the following:** Medicare certified or The Joint Commission or AAAHC or CARF
Specialty Hospital	State license **and one of the following:** Medicare certified or The Joint Commission or AOA/HFAP

LEVEL II CRITERIA

Institutional Providers must also continuously meet the following requirements, unless Avera Health Plans, after full disclosure by the Provider, waives such requirement.

Element	Criteria for Participation	Verification Source / Options
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

Redrafted: 11/15/05, 03/07/08, 11/01/09, 03/24/2010, 12/22/2010, 10,10/2013, 11/14/2013, 4/10/2014, 1/1/2015/ 5/1/2015, 7/1/2015, 10/1/2016, 2/1/2017, 3/1/2017, 3/1/2018, 12/13/2018)

Credentialing Committee Review (12/05, 04/10/08, 11/12/09, 04/08/2010, 01/13/2011, 10/10/2013, 11/14/2013, 4/10/2014, 1/8/2015, 5/14/2015, 7/9/2015, 10/13/2016, 4/13/2017, 3/8/2018, 12/13/2018, 12/10/2019

Avera Health Plans Board of Directors Approved (12/05, 05/22/08, 12/10/2009, 04/12/2010, 02/2011, 10/10/2013, 5/2015, 10/2016, 4/2017, 4/2018, 6/2019, 12/2020)