Network Access Plan for West Virginia

Optimum Choice, Inc. (OCI)

Overview: Optimum Choice, Inc. (OCI) is a subsidiary of UnitedHealthcare (UHC). Within this document, reference to Optimum Choice is used interchangeably with UHC/UnitedHealthcare. The Optimum Choice network requires PCP selection. The PCP is responsible for coordinating care and issuing referrals when appropriate.

Preventive Care Services

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force.*
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.*
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

Finding a network health care provider

Sign in to myuhc.com to find information on network doctors and other health care professionals who can meet your need for primary care, specialty care or behavioral health care, if applicable. You can search and filter by name, specialty, location and other options. Information on network hospitals and other health care facilities can also be found here. Always confirm the network participation of both the health care professional and the facility before receiving health care services.

If you are not able to view our online directory, or for more information on the professional qualifications of a network provider, call the member phone number on your health plan ID card. A customer service representative will help you or have a printed copy of the network directory sent to you.

Choosing a doctor is one of the most important health care decisions you'll make. The UnitedHealth

Premium® designation makes it easier for you to find doctors who meet national standards for quality and local market benchmarks for cost efficiency. Visit myuhc.com to find the doctor that is right for you.

Telehealth

Additionally, participating providers may offer telemedicine to their members in addition to office-based services, in accordance with UHC's Telemedicine Policy. We offer telehealth resources, best practices and education to our provider network on our portal at https://uhcprovider.com/en/resource-library/telehealth.html. UnitedHealthcare's network includes four national telehealth providers with 24-hour access to services for all our members. The behavioral health network has additional virtual-only national groups.

Reasons providers may use Telehealth:

- Can help improve access to services from providers and increase convenience for members
- Visits have the potential to decrease providers' risk of exposure to infectious agents that are potentially introduced during a visit in a public health setting
- Creates appointment scheduling flexibility
- May attract patients who prefer access to providers outside traditional business hours
- Can help establish and build better relationships between providers and members, making it easier to coordinate care

We have increased coverage when telemedicine is added to the existing in-person network. A substantial increase in telehealth utilization has been seen since the onset of the COVID-19 pandemic. We expect telehealth services to continue to be accessed at levels greater than pre-pandemic. Telemedicine was not applied to the network access standards submitted.

Referrals

The Optimum Choice (OCI) network requires PCP selection. The PCP is responsible for coordinating care and issuing referrals when appropriate.

UnitedHealthcare's notification and prior authorization requirements for select procedures and hospitalization are outlined in the *UnitedHealthcare Provider Administrative Guide*. Participating providers are strongly encouraged to use in network physicians and facilities, but we do have protocols in place to allow for authorization of out of network providers at an in network benefit level when specific network gaps (e.g. a provider who does a specialized service or for continuity of care purposes) are identified.

Referral submission requirements:

Referrals must be submitted by the member's PCP or by a PCP within the same provider group and tax ID number.

Specialists can't enter referrals in our system. They must ask the member's PCP to enter a referral. Referrals are accepted to network physicians only.

The member's assigned PCP must:

- Submit referrals electronically, prior to the service being rendered, using:
- Enter a start date within 5 calendar days of submission date.

Referrals are effective immediately, but may take up to 2 business days to be viewable in the portal system. They may be backdated up to 5 calendar days before the date of entry.

Specialist referrals

The member's assigned PCP manages their care. The member's PCP needs to submit electronic referrals to us before the member sees another network provider (a network provider that is not within the same provider group and tax ID number as the member's PCP). Referrals are valid for any health care provider within the same provider group and tax ID number as the specialist listed. It is best practice to communicate clinical findings to the referring PCP.

Standards of Accessibility

UnitedHealthcare completes an assessment of Network Adequacy in order to identify areas for improved member access to services. Included in the Network Adequacy assessment are evaluations of Availability (geographic, numeric, cultural and linguistic availability of practitioners), Accessibility (access to appointments based on Consumer Assessment of Healthcare Providers and Systems (CAHPS) and analysis of requests for out of network (OON) specialty care services. An assessment of complaints and appeals related to access to care is integrated into the analysis.

UnitedHealthcare has policies and procedures in place to ensure accessibility standards are met, and Quality Improvement Programs to provide effective monitoring and evaluation of patient care and services provided by practitioners and providers for compatibility with evidence-based medicine guidelines.
In addition, if a member needs services from a unique hospital-based health system that is not part of the network, UHC will work with those providers to ensure the member may see that out of network provider at in-network and be held harmless from billed charges above their cost share.

UnitedHealthcare monitors networks for network adequacy weekly. UnitedHealthcare leverages Quest Analytics to determine if the minimum number of providers/facilities and meeting maximum time/distance requirements are met. If the network is found to be inadequate for any service area (county) and specialty, network teams identify providers available to close the inadequacy. Once the provider is contracted and loaded to the source systems, the updated network adequacy assessment will be reflected. This process is cyclical and dynamic as provider term and contract.

Monitoring access to specialist providers of emergency room care, anesthesiology, radiology, hospitalist care, and pathology/laboratory services at their participating hospitals is as follows:

A. Performance against appointment access standards are measured by analysis of:
- CAHPS® questions/supplemental questions
- Key Member Indicators Survey questions
- Qualified Health Plan Survey (QHP) questions
- Primary Care Practitioner and Specialty care Practitioner Accessibility Surveys
- PCP After-hours Access Survey
- Member access complaints
- OON service requests and claim utilization
- Behavioral Health member experience survey questions, complaints, treatment record reviews, appointment tracking and claims data

B. Member service telephone access performance is measured with results from reports generated by Customer Care (service) department. Telephone access is evaluated on an annual basis against standards at the corporate level for UnitedHealthcare Employer and Individual (E&I).

Provider Network Factors

UnitedHealthcare networks consist of a variety of primary care and behavioral professionals, specialists, hospitals and other facilities. To help provide members with reasonable access to providers who meet their needs, we look at the number of providers and the types of services offered within a geographic area. Additionally, we conduct an assessment of how well the network meets members' cultural needs and preferences, as well as, any special healthcare needs. We make outreach to providers, as needed, in order to recruit them to our network. We accept requests from employers, members, and providers to accommodate needs and preferences.

In accordance with UnitedHealthcare's Practitioner Availability policy regarding availability and accessibility of providers, we conduct a thorough assessment annually to ensure that the network is sufficient in numbers and types of providers, geographic distribution and cultural/linguistic features to meet the documented needs of our membership.
Access to specialty services such as emergency, anesthesiology, radiology, hospitalist, pathology and laboratory care services at participating hospitals are evaluated same as other participating provider types. Additionally, facility contracts include terms indicating facilities will make reasonable efforts to ensure all facility-based providers participate in UnitedHealthcare's network.

Network providers may be found throughout the state of West Virginia. A list of Network providers within your Service Area can be obtained by visiting the UnitedHealthcare provider lookup website at www.uhc.com/find-a-physician. If you would like a printed copy of providers, we will send it free of charge upon request.

Standards for Network Composition

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The UnitedHealthcare Credentialing Plan is publicly available at 2021-2023 UnitedHealthcare Credentialing and Recredentialing Plan (uhcprovider.com) and describes the credentialing process used to select providers.

Needs of Special Populations

In 2010, the Health Equity Services (HES) program was established to help address health disparities. The HES program helps reduce health disparities by improving our culturally sensitive initiatives that promote health and prevent avoidable health care cost. To accomplish this, the HES program operates with four key focus areas:

- Collecting data to better understand our membership and their cultural characteristics
- Identifying gaps in health and health care to develop interventions
- Refining the patient-centered approach based on member demographics, including race, ethnicity and language
- Growing multicultural capabilities to enhance the member experience

In 2019 and 2020, we are significantly enhancing our HES programs and offerings through:

- Employee training for more insight about providing services to our members from diverse cultural backgrounds
- Customized member outreach and communication
- Enhanced data analytics to address identified health disparities

The Health Equity Services program completed an enterprise compliance assessment of the 2013 enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care and is at industry standard or better for all 15
standards. Despite being at industry standard or better for all CLAS standards, we continue to plan and implement improvements that will further our efforts to reduce identified member health outcome disparities.

Evaluation of members' cultural, ethnic, racial and linguistic needs may be measured using the following data sources:

- CAHPS® data
- Member Satisfaction Survey Data
- U.S. Census Data
- Network Database (NDB)
- Enrollment Data
- Medicare/Medicaid eligibility files
- Focus Groups
- American Community survey
- Other Sources As Required Or Needed

To enable services to be provided in a culturally competent manner and accessible to all members, an assessment of the cultural/linguistic needs of the members is conducted at least biennially. Based on the analysis of this assessment, adjustments may be made to the health plan networks to improve cultural availability. In addition, literacy needs may be measured for Marketplace.

As a company that serves more than 75 million people across our lines of business, UnitedHealth Group has a distinct incentive to ensure that our products and services are accessible to everyone. We believe that health disparities exist in large part because individuals are seen merely as part of a population and not people with unique needs. We have adopted a philosophy that better information leads to better results and, ultimately, better health. That value also extends to our multicultural initiatives. We address health disparities on several fronts: education, accessibility, usability, data collection and health or wellness programming. We also participate in the health care disparities discussion/agenda at both the national and community levels.

To address the needs of members with literacy issues, UnitedHealthcare Customer Care can provide assistance in how to access care by providing benefit information and information on in network providers. To further aid members with special needs, our provider directories (available online or via phone) provide information on providers including gender and language capabilities.

In collaboration with our sister company Optum Health, each year we conduct a comprehensive assessment to evaluate

the characteristics and needs of our member populations and subpopulations relevant to complex case management programs. The results of this assessment are utilized in developing or revising complex case management programs and services, and in identifying and evaluating measures of effectiveness. The characteristics included in this assessment include:

- Age
- Gender
- Clinical diagnosis (medical and/or behavioral
- Special needs: hearing impaired and/or vision impaired
- Translation services
- Member satisfaction data

UnitedHealthcare contracts with Essential Community Providers (ECP) in an effort to have a network with adequate coverage for enrollees in the service area. We have several ECPs in our network throughout West Virginia. We will continue to monitor the adequacy and availability of current complement of network providers and will undertake any supplemental contracting with ECPs or other provider types that is necessary to ensure continued appropriate access.

Communication with Members

It is the policy of UnitedHealthcare to ensure that members have access to information regarding key topics about their benefits and plan design including but not limited to:

- Member rights and responsibilities,
- Accessing Customer Care,
- Voicing complaints and grievances,
- Choosing and changing primary care physicians,
- Accessing routine, specialty and emergency care, and
- Understanding benefit coverage exclusions, restrictions and notifications.

Methods of communication include, but are not limited to, distribution of the Certificate of Coverage, Welcome Guide and the annual Rights and Resource Disclosure Booklet. Members also have access to myuhc.com, a website with resources for accessing personal health records, searching the provider directory, and encouraging healthy behaviors.

Procedures are in place to ensure that members are notified when any of their active providers terminate participation agreements and that when clinically appropriate, members are allowed continued access to terminated providers at an in-network benefit level. Member notifications include continuity of care information and we direct members to contact us or utilize the online directory for assistance in locating other in-network providers. Additionally, provider contracts include hold harmless provisions that prohibit balance billing in the event of insolvency or inability to continue operations.

Supporting Customer Needs

UnitedHealthcare's *Assessing Member Experience* policy is to assess member experience with its services and programs, at least annually, and identify areas for potential improvement. When opportunities for improvement are identified, actions are taken to improve member experience.

Primary data collection sources include member complaints and appeals, UM consumer concerns, and member experience surveys. Member experience surveys may include, but are not limited to:

- Consumer Assessment of Healthcare Provider and Systems (CAHPS®)
- Key Member Indicators (KMI) Survey
- Member Focus Groups
- Complex Case Management Surveys
- Disease Management Surveys
- State, Federal and Regulatory Surveys

Appeals and Complaint Procedures

- Covered persons are provided with a Certificate of Coverage when coverage is initially purchased, which

includes a description of the coverage and grievance procedure. In addition, the appeals procedure is included with any adverse determination. Please see sample adverse determination letter in appendix.

Process for choosing and changing providers

- Covered persons are directed in the Certificate of Coverage to choose their provider. The language of the COC states:
- It is your responsibility to select the health care professionals who will deliver care to you. We arrange for Physicians and other health care professionals and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.
- Further, language in the schedule of benefits informs members of how they might select a network provider:
- A provider's status may change. You can verify the provider's status by calling the telephone number on your ID card. A directory of providers is available by contacting us at [www.myuhc.com] or the telephone number on your ID card to request a copy.

Providing and approving emergency and specialty care

Covered persons are provided with a Certificate of Coverage and Schedule of Benefits when coverage is initially purchased. These documents include a description of the coverage for emergency and other provider services including information regarding services requiring prior authorization.

Prior authorization requests: UnitedHealthcare maintains prior authorization processes that members must follow for certain services. As part of the UnitedHealthcare Clinical Services Medical Management Program, non- clinical staff members who perform intake or initial screening are not responsible for clinical interpretation, evaluation or review. Non-clinical staff members may provide non-clinical, administrative benefit coverage approvals or adverse determinations for explicit benefit exclusions or based on the provider contract. Non-clinical staff will only provide approval/certification using structured data and will not provide clinical adverse determinations. Licensed health professionals will oversee non-clinical staff members who perform initial screening and will be available at all times throughout the screening process.

- In general, Network providers are responsible for obtaining prior authorization before they provide these services to the member. There are some benefits, however, for which the member is responsible for obtaining prior authorization. Services for which the member is required to obtain prior authorization are in the member's Schedule of Benefits table within each Covered Health Service category. To obtain prior authorization, the member may call the telephone number on their ID card. This call starts the utilization review process.

Prior Authorization Request Timelines

All requests for in-network coverage for services rendered by out-of-network providers are processed in accordance with regulatory requirements and the consumer's benefit plan. The Prior Authorization and Notification process is outlined in the Provider Administrative Manual and online at uhcprovider.com. The Utilization Review policy is outlined in the member plan schedule of benefits.

- Our utilization review process timeframes are conducted in a timely manner appropriate to the severity of the member's condition and the urgency of the need for treatment. We will make clinical review criteria available upon request to network providers.
- Providers may submit a prior authorization request online or by phone:
- Online: By using the Prior Authorization and Notification tool on the UHC provider Link dashboard on uhcprovider.com
- Phone: 877-842-3210

Upon the receipt of all necessary information from the provider, or the expiration of the deadline for providing information, we will review the request within seven days. However, the request will be reviewed within two days if the request is for a condition that could seriously jeopardize the life, health or safety of the patient or others due to the patient's psychological state or in the opinion of the provider would subject the patient to adverse health consequences.

Notice of approval/certification determinations will be made to the provider who is requesting and/or providing the service and to the enrollee. Where written notice is not the standard operating procedure or is not required by the state or government program, it will be granted upon request to the provider or consumer. Notices will include information pertinent to the review as well as tracking identifiers.

Written notice of an adverse determination will be given to the provider who is requesting coverage and/or providing the service as well as the consumer. To ensure timeliness, verbal and other acceptable electronic means of notice will be used in addition to written notices. Written notice of all adverse determinations will provide principle reasons for the determination, information about availability and how to contact a peer clinical reviewer, and a description of appeal rights.

Gap Exceptions

The following is the process for a member to seek a GAP exception:

1. A member can request a Network GAP Exception, both Clinical and Geographic, with UHC when there are no physicians or specialists within 30 minutes or 25 miles of their home zip code. The member must have their selected specialist or physician, who will be performing the services requested, contact Care Coordination at 1-800-638-7204 and:
    a. Request a GAP exception to allow the services to be processed as in-network.
    b. Request a pre-determination of benefits to see what services will be covered under the benefit. All diagnosis codes/procedure codes for services the provider is planning on rendering should be listed by the provider.
    c. The requests should also specify the estimated time frame it will take to complete the treatment.
2. Once the GAP exception and pre-determination have been approved both the member and the provider should receive a letter approving the GAP exception and stating that the pre-determination has been completed and what CPT codes/services have been approved.
3. The letter should also indicate the time frame approved (Ex. June 1st – Sept 30th). If members require additional time to complete the treatment the provider should call back in to request an extension of dates (and wait to receive approval) prior to continuing any treatment outside the approved time frames.

The member, of course, would still be responsible for any in-network member responsibility amounts (copay/deductible/coinsurance) and these would apply normally to their in-network accumulator. Lastly, as these services will be provided either through a single case agreement with the provider or by paying billed charges, there would be no opportunity for the provider to balance bill the member.

Filing an appeal

To resolve a question, complaint/grievance, or appeal, the member may call or write us at the telephone number or address on their ID card. Representatives are available to take calls during regular business hours, Monday through Friday. We will acknowledge receipt of the appeal in writing. Members may find complete information on the appeal process in the Questions, Complaints and Appeals section in their Certificate of Coverage.

Out-of-Network Requests and Continuing Care

UnitedHealthcare also has a documented process for providing services, when necessary, outside of the network. Upon receipt of a provider or member's coverage request to begin or continue treatment with an out-of-network provider, the procedures under the utilization management program provide for administrative and/or clinical reviews in accordance with the consumer's benefit plan and in compliance with state, federal, government program and accreditation requirements. If the individual's benefit plan coverage of services is exhausted while the individual still needs care, the organization will offer services, as required, to educate the consumer about alternatives for continuing care and how to obtain care.

The purpose of this process is to provide timely and consistent determinations and notices for all out of network coverage requests and to ensure members have needed information regarding alternatives for continuing care. Examples of Out of Network Coverage Requests include the following:

- Network Gaps: A network gap request for services to be rendered by an out-of-network provider and covered at the in- network level of benefits when the network lacks an appropriate provider to perform the specific service being requested. An appropriate provider is one either within the required mileage range or one who possesses the necessary clinical expertise.
- Transition of Care (TOC): A request for TOC is based on a benefit which allows a newly covered consumer who is

receiving ongoing care a transition period before they are required to transfer from an out-of-network provider to an in-network provider and to receive network benefits under the terms of the employer health benefits or government program contract for the transition period.

- Continuity of Care (CoC): A request for CoC is based on a benefit which allows a covered consumer to continue to receive in-network benefits for services rendered by a provider who has terminated from the provider network. The consumer is given a defined period of time in which to transition to an in-network provider while continuing to receive in-network
  benefits for services from the terminated provider under the terms of the employer health benefits or government program contract.

The Annual Member Notice states that if you need covered health care services that are not available from a network provider—or access to a network provider would require unreasonable delay or travel—you, your doctor or a representative acting on your behalf can ask for an exception or referral to an out-of-network provider. To request a referral to an out of-network provider, call the toll-free member phone number on your health plan ID card. For mental health and substance use disorder services, call the Mental Health phone number on your ID card. If we confirm that care is not available from a network provider due to the reasons above, we will work with you and/or your network provider to coordinate care through an out-of-network provider.

Medical Continuity and Coordination of Care

Per UCSMM 06.21 - Out-of-Network Requests and Continuing Care, section A(3) - Continuity of Care (CoC): A request for CoC is based on a benefit which allows a covered consumer to continue to receive in-network benefits for services rendered by a provider who has terminated from the provider network. The consumer is given a defined period of time in which to transition to an in-network provider while continuing to receive in-network benefits for services from the terminated provider under the terms of the employer health benefits or government program contract.

Case Management

UCS UM staff evaluates, identifies, and refers members to the appropriate case management services. Case Managers collaborate with the members to facilitate health care access and to assist them with decisions that can have an impact on the quality and affordability of their health care. The core of the Case Management program focuses on identifying high-cost, complex, at- risk individuals who meet criteria for and can benefit from case management services. The purpose of Case Management is to identify and facilitate appropriate health care services across the continuum of care and across co-morbid conditions (physical and behavioral) as well as to monitor and evaluate options and services, to include community services or local support groups, to promote quality cost effective outcomes in the outpatient setting.

The Case Management program structure and functionality support the commitment to ensure compliance with case management standards as set forth by state and federal regulatory agencies and accreditation organizations. High-level program outcomes of case management focus on the following value domains:

- Increased overall medical cost savings,
- Improved care seeking behaviors/utilization,
- Improved functional health status,
- Improved workplace productivity, and
- Improved overall enrollee satisfaction.

Alternate Sources for Care

Per UCSMM 06.21 - Out-of-Network Requests and Continuing Care, section B

1. Utilization management staff will identify cases where benefits are exhausted but the consumer still needs care, and will provide information to the consumer if necessary about alternatives for continuing care that is not covered by the benefit plan.
2. Alternate sources for continuation of care not covered by the consumer's benefit plan may include, but are not limited to:
   i. Resources funded through local, state or federal programs
   ii. On-line resources, such as health plan websites

Inpatient Management/Concurrent Review/Discharge Planning

The Inpatient Care Management (ICM) and Skilled Nursing Facility (SNF) Specialist activities focus on promoting delivery of care for facility-based patients at the appropriate time. These activities are performed both telephonically and in the facilities. The primary focus is to:

*Promote efficient execution of the physician's treatment plan by reviewing against the appropriate guidelines
*Identify and prevent potential delays in care, tests and procedures
*Identify and ensure members' comprehensive health care needs and preferences are addressed
*Facilitate prompt access to specialists and consultants
*Coordinate discharge-planning services with Transitional Care Managers, Case Managers or disability management programs
*Facilitate alignment of the level of care according to the patient's physical condition
*Identify and refer appropriate patients to the various case management programs for post-discharge follow-up.

The ICM and SNF Specialist nurses perform onsite or telephonic review using MCG Care Guidelines and Inter-Qual Guidelines where a contract dictates, both are nationally recognized sets of guidelines. Medical necessity determinations may be made for specific entities that require the process within their contract, Certificate of Coverage or Summary Plan Description. The ICM consults with the hospital/SNF UR team and/or attending physician to have a dialog surrounding any potential issues according to appropriate guidelines. They consult with the ICM Medical Director to review cases and discuss treatment plans. If a case requires escalation, a peer-to- peer dialogue between the ICM Medical Director and treating physician occurs as needed to collaboratively discuss treatment options and plans, and to facilitate access to care or alternate care settings.

Changing primary care professionals

OCI provides HMO plans. For HMO plans, a member elects a primary care professional during their open enrollment period with their employer.

Members can call the number on the back of their ID card during the first 30 days of their plan to elect or change their PCP for an immediate effective date. Changes requested after the initial 30 days will be effective on the 1st day of the month following when the request is made.

Members to Obtain Printed Copies of Provider Directories

A searchable provider directory for the UHC web-based online directory can be accessed via these links via a non-authenticated access:
Https://connect.werally.com/plans/uhc/1 or myuhc.com.
Members may obtain a print copy of the directory by selecting the "Print/Email Provider Directory" Quick Links function at the bottom of the search landing page. Directory results can either be emailed or printed in pdf format. Members may also call customer service at the telephone number listed on the back of their ID card, and request a copy be mailed. A walkthrough of this process can be found in the appendix.

Auditing Provider Directories

UnitedHealthcare (UHC) requests providers attest to the accuracy of their data every 90 days, providing multiple avenues by which to do so. In addition to the monthly quality review performed by UHC, which includes a source of truth (SOT) review, outbound provider call campaigns and attestations occurring every 90 days positions the West Virginia UHC network to be validated every year. As a result of these processes, updates are made within 30 days when demographic deficiencies are identified. Process and attestation documentation is archived for a minimum of 36-months, and reporting is available to the Commissioner upon request.

United HealthCare Services, Inc. on behalf of
(Insert Legal Entity)
[INSERT: Reviewer's return address]

UnitedHealthcare®

Patient:
Service Ref #:

Member:
Member ID:
Group Name:
Group #:

Letter ID:

[INSERT: Date]

[INSERT: Name
Street Address
City, State ZIP]

Dear [Insert member full name]:

We received a request to cover health care services. After review of the information submitted and your plan documents, it was determined this service is not medically necessary, so it is not covered by your plan.

Medically necessary means the service meets accepted standards of medicine and is needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms.

Requested service or care:

- Physician/health care professional: [INSERT full name of health care provider]
- Facility name: [INSERT: Name OR Not Applicable (N/A)]
- Place of service: [CHOOSE: Home OR Office OR Outpatient OR Facility]
- Diagnosis: [INSERT code and description]

If Inpatient, add the following highlighted items:

- Type of treatment: [No code available OR enter specific code]
- Admission date (if applicable):
- Date(s) of service: [INSERT]
- Date(s) determined not to be medically necessary: [INSERT]
- The reason for our determination is: [INSERT: medical director's rationale]
- Denial code (if applicable):
- Claim amount (if applicable):

Description of services	
Procedure code	**Procedure description**

If ancillary letter, add the following table:

Description of services

Procedure code	Procedure description	Total requested	Start date	End date
[Insert code]	[Insert description]	[Insert amt]	[Insert date]	[Insert date]

This decision is based on the following information: [INSERT: Medical policies, guidelines used for the review]

Remember:

- You're still responsible for your copayment, coinsurance, and deductible (when applicable).
- Your plan may have limits on how many visits or services the plan covers. Please check your plan documents.

Before getting service, it's a good idea to check your provider's network status and cost of service.

- A network provider is a doctor, health care professional, or facility (like a hospital) that has a contract with us to provide services or supplies at an agreed upon rate, so you usually pay less when you get services in network.
- Some plans have a designated or a tiered network of providers. These doctors, health care professionals, facilities, and suppliers provide health care services at the highest benefit level. If you have this type of plan, you may pay less depending on which provider you see.

If required by your plan, your primary care provider must send an electronic referral before you see a specialist. If you see a specialist without a referral, you might have to pay the full cost for services.

This is a benefit determination, not a medical decision. Only you and your doctor can decide what medical care you need.

Your **provider** can discuss this case by calling the UnitedHealthcare Peer-to-Peer Support Team at **1-800-955-7615**.

- If your provider asks for a peer-to-peer review, and the request for coverage is still denied, you can ask for an appeal.
- If you have already *started* an appeal, your provider cannot ask for a peer-to-peer review.

Add the following:
ASO Appeal Right Document **OR** Fully Insured Appeal Rights Document
Non-Discrimination Notice
Any state-specific attachments

Can I get copies of information used to make the decision?
You, your doctor, health care professional, or a person you trust to represent you, such as a family member (authorized representative) may ask to see any information we used to make this decision. This information is free of charge and includes:

- Documents
- Records
- Health benefit plan provisions
- Internal rules
- Guidelines and protocols
- Any other relevant information

Mail your request for this information and a copy of this letter to:

UnitedHealthcare Central Escalation Unit
Appeal Document Request
P.O. Box 30573
Salt Lake City, UT 84130-0573

What if I don't agree with this decision?

1. You or your authorized representative may accept our decision as it stands.
2. You or your authorized representative may request an appeal.

What is an appeal?
An appeal is a formal way of asking us to review a coverage decision.

Who can file an appeal?
You, your doctor, health care professional, or authorized representative can file an appeal.

- This person must have your written approval to make appeals for you.
- To have someone else represent you, call the toll-free member number on your health plan ID card, and we'll send you a form.

How long do I have to file an appeal?
You have 180 days from the time you receive this letter to send an appeal request. If you don't send the appeal on time, you may lose your right to appeal the decision. Inquiring about the appeals process does not change the time frame to submit an appeal.

We'll review your appeal and give you a decision within 30 days for services you haven't received yet and within 60 days for services you have received. This is known as a standard appeal.

What if my situation is urgent?
If your situation is urgent, you can request an urgent appeal. If your request is approved, we'll review your appeal within 72 hours. You may ask for an urgent external review to be completed at the same time as an internal urgent appeal.

Generally, an urgent situation means your health may be in serious jeopardy or, in your doctor's opinion, you may have pain that cannot be adequately controlled while you wait for a decision on your appeal.

How do I file an appeal?
The following information is what we need to review an appeal:

- A written appeal request asking us to reconsider our decision
- The specific coverage decision you want us to review
- An explanation of why the requested service should be considered for coverage
- Any additional information that supports your position
- A copy of this letter

Mail or fax this information to:

UnitedHealthcare Appeals Unit
P.O. Box 30575
Salt Lake City, UT 84130-0575

Standard appeal fax: 1-801-938-2100

Urgent appeal fax: 1-801-994-1083
Or call the toll-free member number listed on your health plan ID card.
Please tell us why your request is urgent.

We'll send you a letter that explains our decision about your appeal and what you can do if you don't agree.

The person who reviews your appeal will not be the same person, or work for the person, who made the original decision.

Are there other resources that can help me understand the appeal process?
[Enter the CCIIO Ombudsman information]

Contact us if you:

- Have questions about our decision
- Need help filing an appeal
- Need an interpreter to help you to understand the information in your language
- Need this letter in another format like large print

We're here to help
Please call the toll-free member number on your health plan ID card Monday through Friday, 8 a.m. to 8 p.m. local time. TTY users dial 711.

You can also visit **justplainclear.com** for help with definitions and medical terms.

Sincerely,
[INSERT CLINICAL REVIEWER FULL NAME]
[INSERT TITLE (e.g., MD, DO, DC, etc.]

Copy to: [Provider(s), facility, vendor, as applicable]

Enclosure: *Non-Discrimination Notice*
United HealthCare Services, Inc. (UHS) Appeal Rights Process for West Virginia

Select the appropriate letter and delete the others.
If a mixed determination, add "Mixed" before the letter name
WV Ancillary
WV Clinical Contract
WV Clinical Gap
WV Cosmetic
WV Genetic Testing
WV Inpatient
WV Inpatient Bed Day – LOC
WV Inpatient Bed Day – LOI
WV Outpatient
WV Transition/Continuity of Care Denial
Clinical
WV Unproven
Revised: 08-2020

Visit myuhc.com® to access the cost estimator tool, view your claims, Health Statements and Explanation of Benefits, look up benefits, update account information, find a doctor or facility, or to learn more about healthy living. Registration is easy and gives you access to useful tools and information to help you take charge of your health and health care.

United HealthCare Services, Inc. (UHS)Appeal Rights Process for West Virginia OR
OptumHealth Care Solutions, LLC (OHCS)
on behalf of UnitedHealthcare

Your Rights to an Appeal Review

You, your treating provider, or someone acting on your behalf have the right to request an appeal review of the decision made by United HealthCare Services, Inc. (UHS). You may request an appeal either verbally or in writing by following the steps below.

You have the right to file an urgent or non-urgent appeal. An urgent appeal can be requested if a delay in treatment places your health or the health of others in serious jeopardy, significantly increases the risk to your health, results in severe pain, or impacts your ability to regain maximum functioning.

If you have questions after reviewing the following information, please contact the UnitedHealthcare Appeals Unit by calling the Customer Care Professionals at the toll-free number referenced on the back of the member's insurance identification (ID) card.

How to Initiate an Internal Appeal Review

You must request an appeal within one hundred eighty (180) calendar days of the date you received your initial adverse determination letter. Please submit the request for an appeal in writing to the appeal address or fax number provided on the enclosed letter.

Appeal requests should include:

- The employee's name;
- The group name and group policy number (if available);
- The patient's name;
- Our case ID or reference number (if available) provided in the initial adverse determination letter;
- The actual service which is the subject of the adverse determination;
- The reasons why you feel coverage should be provided; and
- Any additional information to support your reasons for reconsideration of the adverse determination.

For clinical cases, a board-certified physician in the same or similar specialty area as your treating physician will review and make the decision about your appeal request. The physician reviewer will not have had any previous involvement in decisions about your case.

The Internal Appeal Review Process

Non-Urgent/Standard Process

The UnitedHealthcare Appeals Unit will notify you or your authorized representative and your health care provider of the appeal resolution in writing within sixty (60) calendar days of the receipt of your request. If this is an appeal of services you have not yet received, the UnitedHealthcare Appeals Unit will complete the review and notify you of the outcome within thirty (30) calendar days of the receipt of your request.

Urgent/Expedited Process

If a delay in treatment places your health or the health of others in serious jeopardy, significantly increases the risk to your health, results in severe pain, or impacts your ability to regain maximum function you can request an urgent/expedited appeal. An expedited appeal will be reviewed, a decision made, and you and your provider notified within seventy-two (72) hours following receipt of your request.

Please request an urgent/expedited internal appeal to the UnitedHealthcare Appeals Unit by calling the Customer Care Professionals at the toll-free number referenced on the back of the member's insurance identification (ID) card or fax your appeal request to the UnitedHealthcare Appeals Unit at 1-801-994-1083.

You may also request an expedited external review as described below.

How to Initiate an External Review

Standard External Review

If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

Within four months of receipt of a notice of an adverse determination or final adverse determination, you may file a request for an external review with the West Virginia Offices of the Insurance Commissioner.

Expedited External Review

An expedited external review may be available to you if the medical condition:

1. Is such that the time needed to complete an expedited internal appeal or standard external review could seriously jeopardize the patient's life, health, or ability to regain maximum function; or
2. Concerns an admission, availability of care, continued stay, or health care item or service for which the patient received emergency services, but have not been discharged from a facility.

You may request an expedited external review to the Commissioner at the same time you request an expedited internal review if the above conditions apply and/or it was determined that the treatment or service is experimental or investigational and your physician certifies in writing that the recommended or requested service or treatment would be significantly less effective if not promptly initiated.

The Commissioner shall immediately send a copy of a request for an expedited external review to UnitedHealthcare, who shall immediately make an initial determination whether the request meets the requirements and immediately notify the Commissioner and you of its initial determination. Within one business day after the Commissioner receives a notice that a request is eligible for external review the review will immediately be assigned an Independent Review Organization (IRO). Within seventy-two hours after receipt of the request for an expedited external review the assigned IRO shall notify you, UnitedHealthcare, and the Commissioner of the determination.

Department of Insurance

The mission of the Consumer Services Division (CSD) is to provide assistance to West Virginia citizens who have questions or problems involving insurance. The CSD is the consumer assistance and investigative arm of the West Virginia Insurance Commission and is available to answer your questions and work to resolve your insurance problems.

If a dispute arises between you and UnitedHealthcare the consumer service representative investigates the particular issue, contacts UnitedHealthcare on your behalf and attempts to resolve the issue. There is no charge for any of the services provided.

Contact Information:

Telephone:	**Toll Free 1-888-TRY WVIC (1-888-879-9842)** **TTY 1-800-435-7381**
Fax:	**1-304-558-4965**
Correspondence:	**West Virginia Offices of the Insurance Commissioner** **Attn: Consumer Service Division** **P.O. Box 50540** **Charleston, WV 25305-0540**
Physical Address:	**West Virginia Lottery Building** **900 Pennsylvania Avenue** **Charleston, WV 25302**

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

What if You Have a Question?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

What if You Have a Complaint?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the representative can provide you with the address.

If the representative cannot resolve the issue over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 60 days of receiving it.

If you prefer, you can also contact the West Virginia Offices of the Insurance Commissioner Consumer Services Division by mailing your request to:

West Virginia Offices of the Insurance Commissioner Consumer Services Division

Post Office Box 50540

Charleston, WV 25305-0540

How Do You Appeal a Claim Decision?

Post-service Claims

Post-service claims are claims filed for payment of Benefits after medical care has been received.

Pre-service Requests for Benefits

Pre-service requests for Benefits are requests that require prior authorization or benefit confirmation prior to receiving medical care.

How to Request an Appeal

If you disagree with a pre-service request for Benefits determination, post-service claim determination or a rescission of coverage determination, you can contact us in writing to request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with expertise in the field, who was not involved in the prior determination. We may consult with, or ask medical experts to take part in the appeal process. You consent to this referral and the sharing of needed medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information related to your claim for Benefits. If any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures related to urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as defined above, the appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied request for Benefits.
- For appeals of post-service claims as defined above, the appeal will take place and you will be notified of the decision within 60 days from receipt of a request for appeal of a denied claim.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in our decision letter to you.

Urgent Appeals that Require Immediate Action

Your appeal may require urgent action if a delay in treatment could increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

State External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by us, or if we fail to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of our determination.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons.

- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the **West Virginia Offices of the Insurance Commissioner Consumer Services Division**, which will be noted in the determination letter.

You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the **West Virginia Offices of the Insurance Commissioner Consumer Services Division**, which the address will be noted in the determination letter. A request must be made within **six** months **(180 days)** after the date you received our decision.

An external review request should include all of the following:

- A specific request for an external review.
- The Covered Person's name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an *Independent Review Organization (IRO)*. The West Virginia OIC Contracts have entered into agreements with three or more *IRO*s that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Please mail your request to:

West Virginia Offices of the Insurance Commissioner Consumer Services Division

Post Office Box 50540

Charleston, WV 25305-0540

Standard External Review

A standard external review is comprised of all of the following:

- A preliminary review by us of the request.
- A referral of the request by us to the *IRO*.
- A decision by the *IRO*.

Within the applicable timeframe after receipt of the request, The West Virginia OIC Contracts will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Policy at the time the health care service or procedure that is at issue in the request was provided.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that The West Virginia OIC Contracts may process the request.

After The West Virginia OIC Contracts complete the preliminary review, The West Virginia OIC Contracts will issue a notification in writing to you. If the request is eligible for external review, The West Virginia OIC Contracts will assign an *IRO* to conduct such review. The West Virginia OIC Contracts will assign requests by either rotating claims assignments among the *IRO*s or by using a random selection process.

The *IRO* will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the *IRO* within ten business days following the date of receipt of the notice additional information that the *IRO* will consider when conducting the external review. The *IRO* is not required to, but may, accept and consider additional information submitted by you after ten business days.

The West Virginia OIC Contracts will provide to the assigned *IRO* the documents and information considered in making our determination. The documents include:

- All relevant medical records.
- All other documents relied upon by us.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and The West Virginia OIC Contracts will include it with the documents forwarded to the *IRO.*

In reaching a decision, the *IRO* will review the claim anew and not be bound by any decisions or conclusions reached by us. The *IRO* will provide written notice of its determination (the *"Final External Review Decision"*) within 45 days after it receives the request for the external review (unless they request additional time and you agree). The *IRO* will deliver the notice of *Final External Review Decision* to you and us, and it will include the clinical basis for the determination.

Upon receipt of a *Final External Review Decision* reversing our determination, The West Virginia OIC Contracts will immediately provide coverage or payment for the Benefit claim at issue in accordance with the terms and conditions of the Policy, and any applicable law regarding plan remedies. If the *Final External Review Decision* is that payment or referral will not be made, The West Virginia OIC Contracts will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal.
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, The West Virginia OIC Contracts will determine whether the individual meets both of the following:

- Is or was covered under the Policy at the time the health care service or procedure that is at issue in the request was provided.

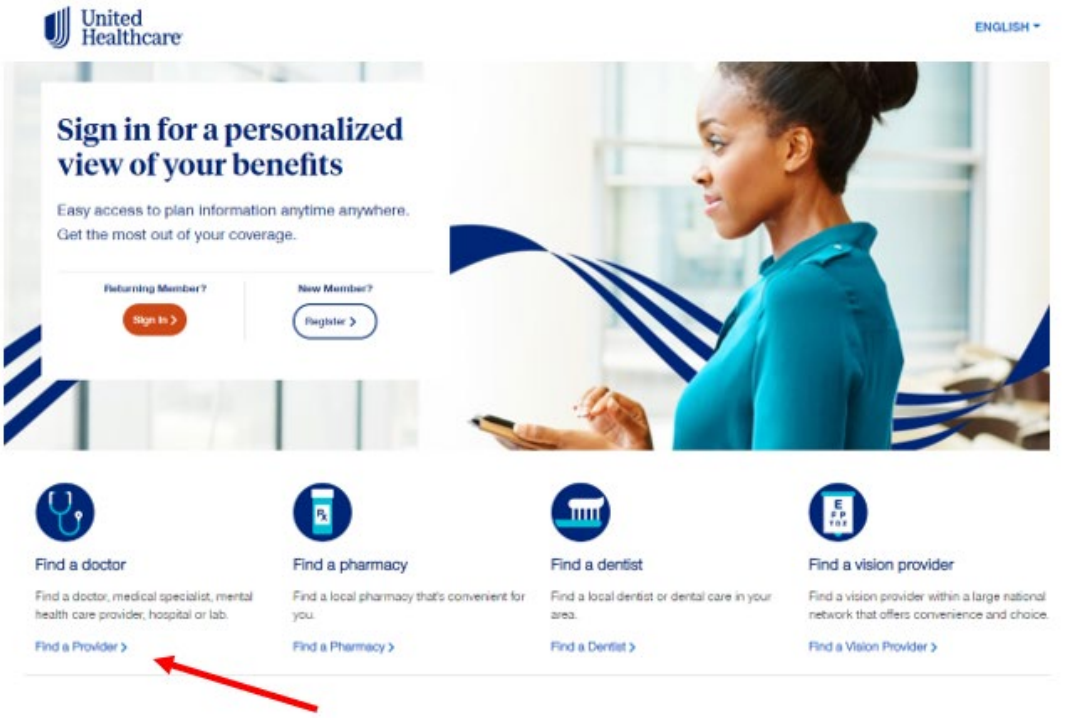
- Has provided all the information and forms required so that The West Virginia OIC Contracts may process the request.

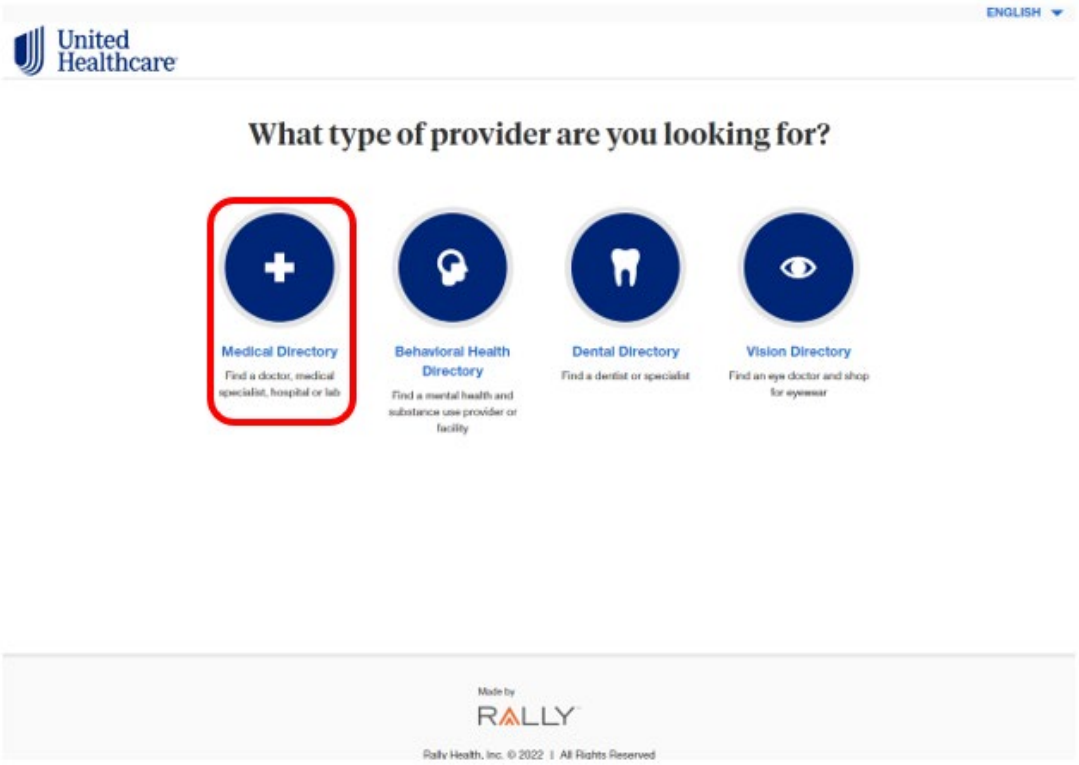
After The West Virginia OIC Contracts complete the review, The West Virginia OIC Contracts will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, The West Virginia OIC Contracts will assign an *IRO* in the same manner The West Virginia OIC Contracts utilize to assign standard external reviews to *IRO*s. The West Virginia OIC Contracts will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned *IRO* electronically or by telephone or facsimile or any other available expeditious method. The *IRO*, to the extent the information or documents are available and the *IRO* considers them appropriate, must consider the same type of information and documents considered in a standard external review.

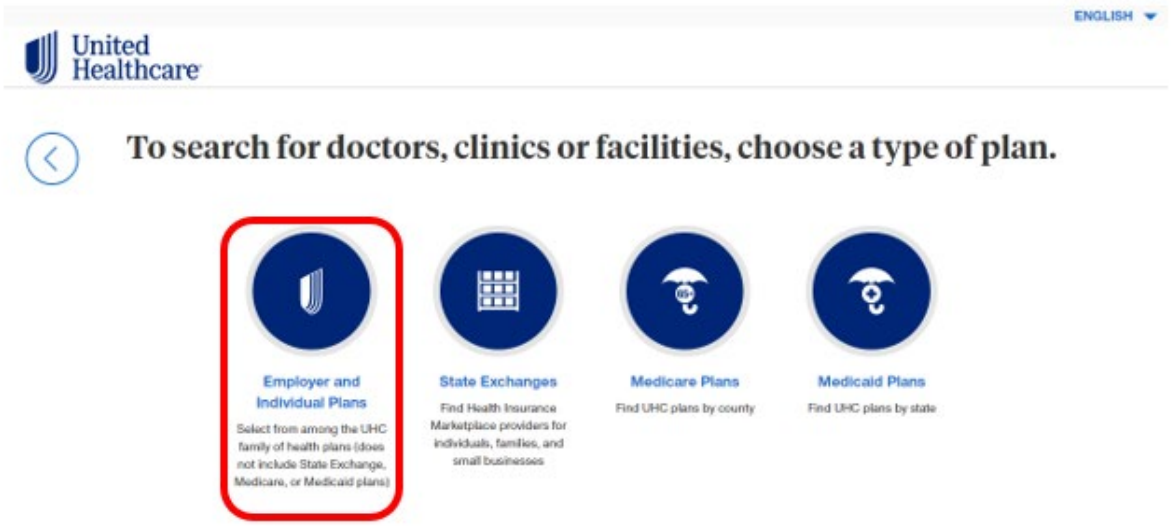
In reaching a decision, the *IRO* will review the claim anew and not be bound by any decisions or conclusions reached by us. The *IRO* will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the *IRO* receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned *IRO* will provide written confirmation of the decision to you and to us.

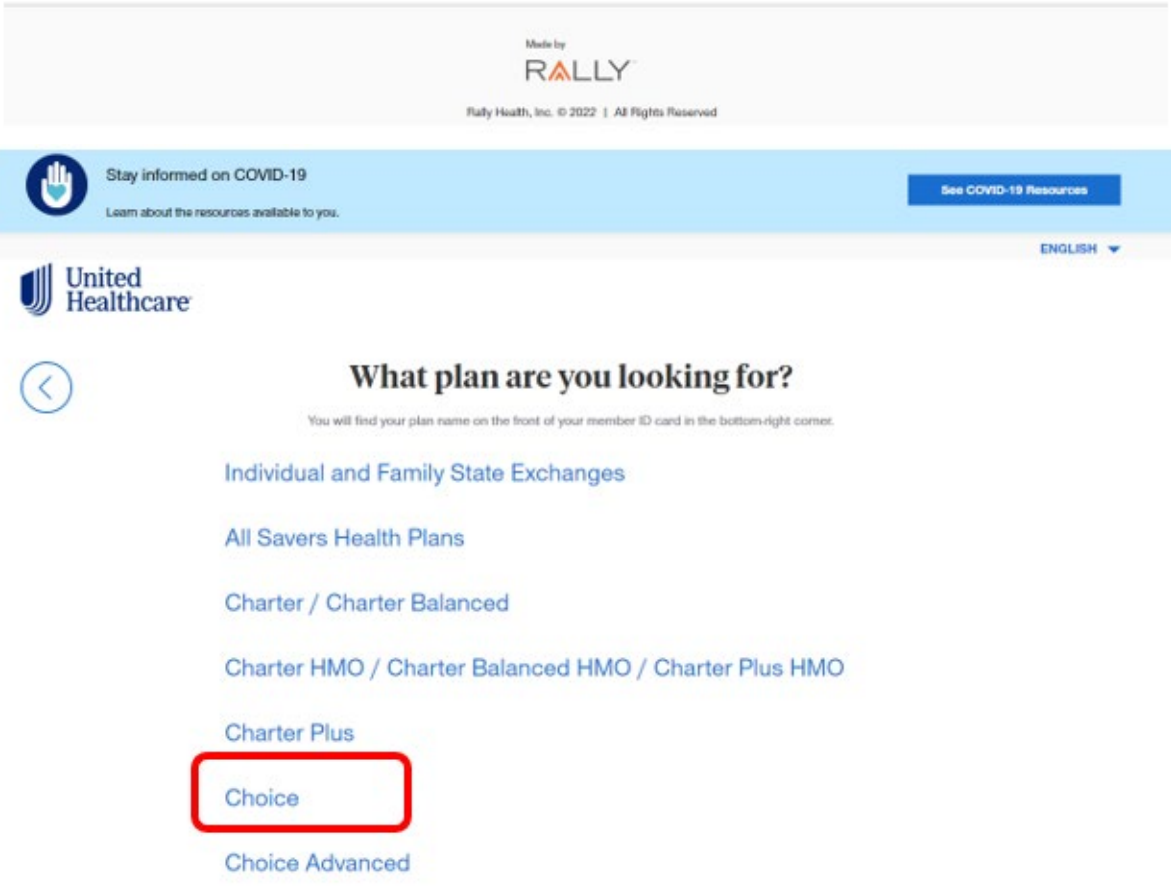
You may contact us at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

How to Obtain Printed Copies of Provider Directories






ENGLISH
United Healthcare
To search for doctors, clinics or facilities, choose a type of plan.
Employer and Individual Plans
Select from among the UHC family of health plans (does not include State Exchange, Medicare, or Medicaid plans)
State Exchanges
Find Health Insurance Marketplace providers for individuals, families, and small businesses
Medicare Plans
Find UHC plans by county
Medicaid Plans
Find UHC plans by state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RALLY
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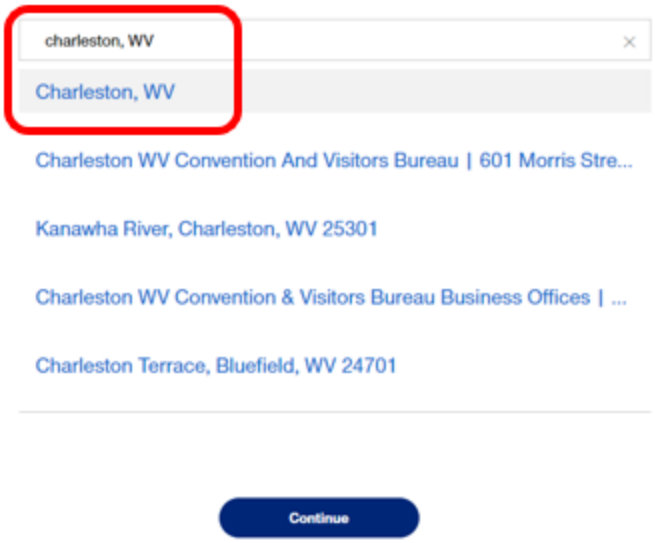
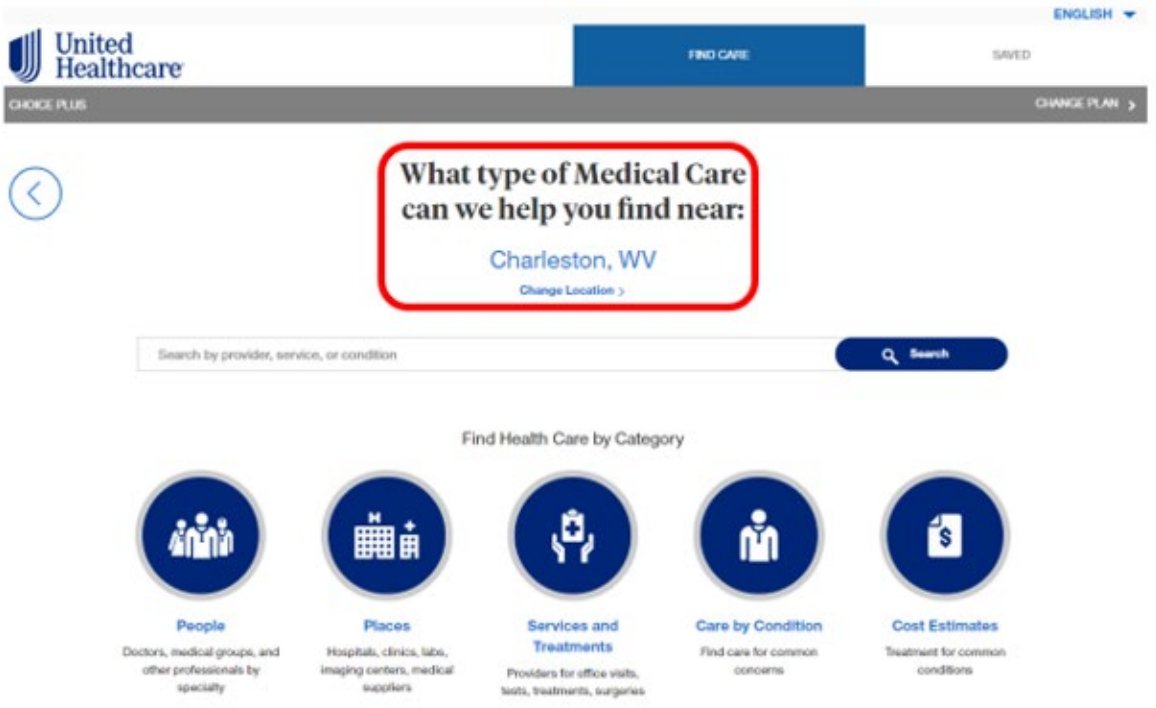
Stay informed on COVID-19
Learn about the resources available to you.
See COVID-19 Resources
ENGLISH
United Healthcare
What plan are you looking for?
You will find your plan name on the front of your member ID card in the bottom-right corner.
Individual and Family State Exchanges
All Savers Health Plans
Charter / Charter Balanced
Charter HMO / Charter Balanced HMO / Charter Plus HMO
Charter Plus
Choice
Choice Advanced

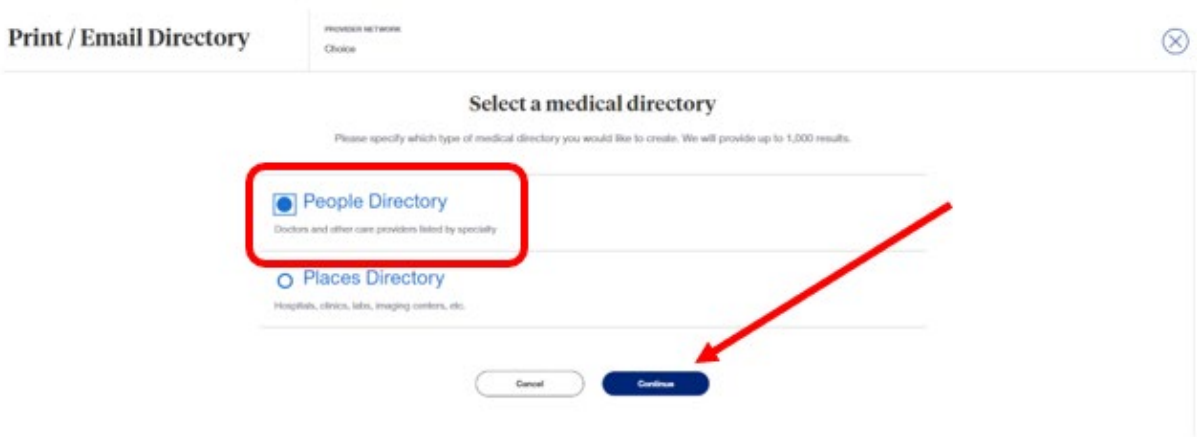
What location do you want to find a provider in?

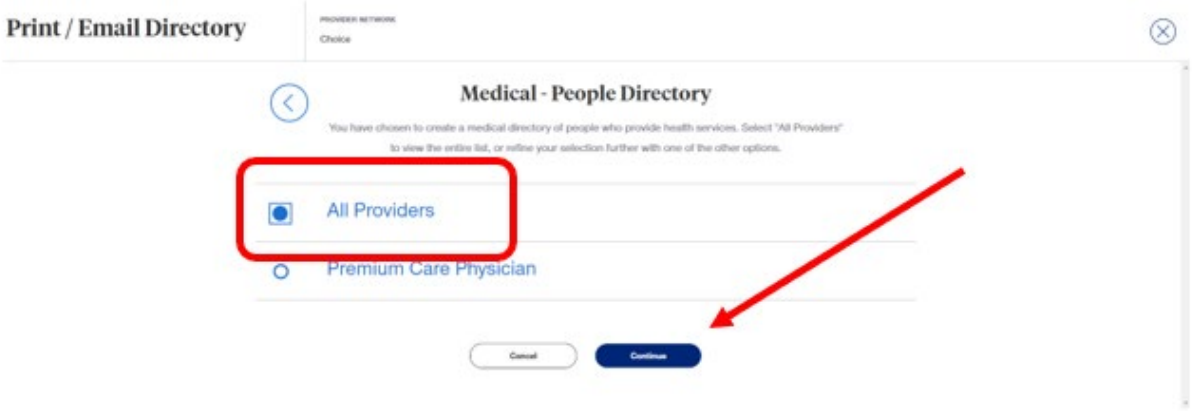
Enter a street address, city & state or 5 digit zip code.



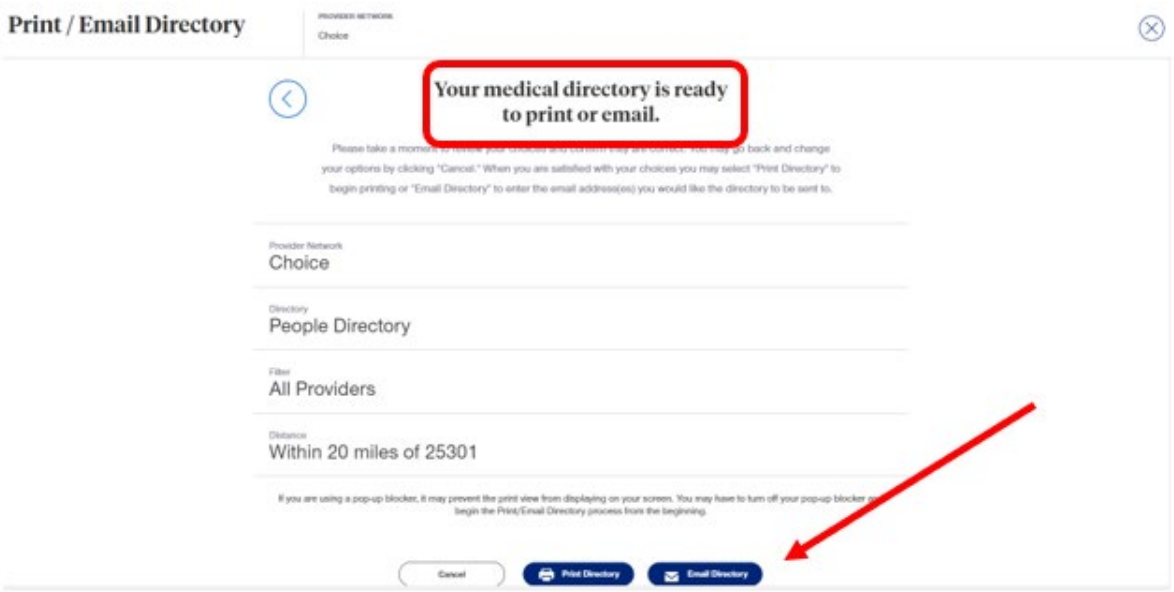

ENGLISH
United Healthcare
FIND CARE
SAVED
CHOICE PLUS
CHANGE PLAN
What type of Medical Care can we help you find near:
Charleston, WV
Change Location
Search by provider, service, or condition
Search
Find Health Care by Category
People
Doctors, medical groups, and other professionals by specialty
Places
Hospitals, clinics, labs, imaging centers, medical suppliers
Services and Treatments
Providers for office visits, tests, treatments, surgeries
Care by Condition
Find care for common concerns
Cost Estimates
Treatment for common conditions

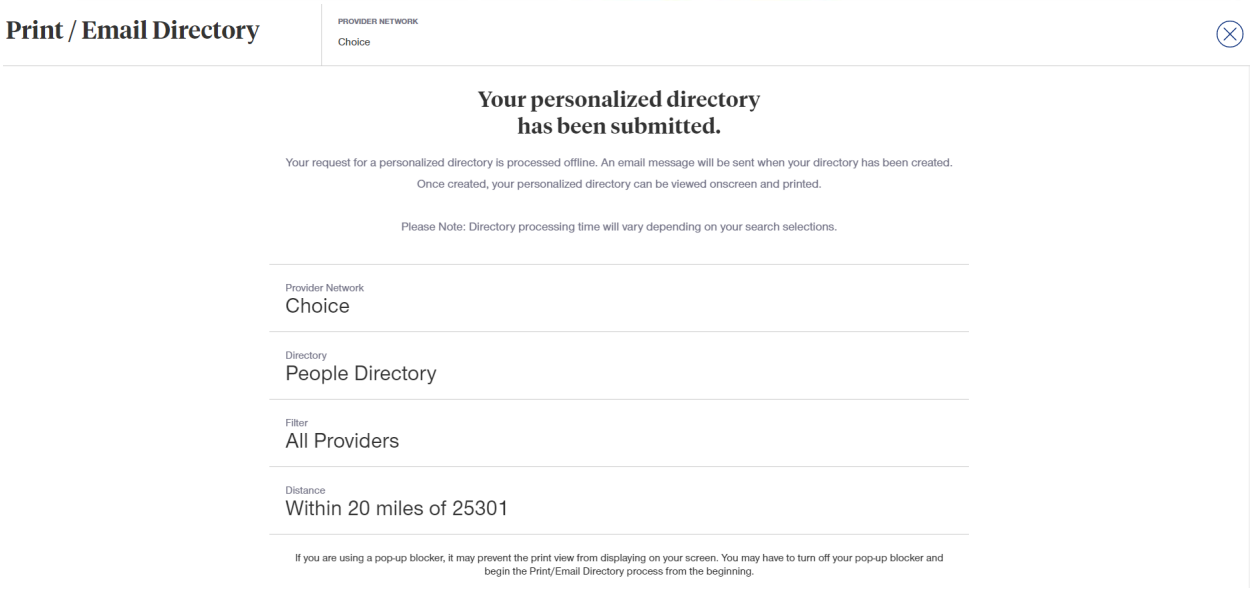

Member Support
Contact Us
Common Questions
Member Information
Legal Entities
Provider Data Information
Quick Links
Find Care
Saved
Print / Email Provider Directory
Rally Health, Inc. © 2021 | All Rights Reserved
About Rally | Terms of Service | Privacy Policy | HIPAA
Medical information last updated: 9/30/21
Made by
RALLY


Print / Email Directory
PROVIDER NETWORK
Choice
Select a medical directory
Please specify which type of medical directory you would like to create. We will provide up to 1,000 results.
People Directory
Doctors and other care providers listed by specialty
Places Directory
Hospitals, clinics, labs, imaging centers, etc.
Cancel
Continue


Print / Email Directory
PROVIDER NETWORK
Choice
Medical - People Directory
You have chosen to create a medical directory of people who provide health services. Select "All Providers"
to view the entire list, or refine your selection further with one of the other options.
All Providers
Premium Care Physician
Cancel
Continue


Print / Email Directory
PROVIDER NETWORK
Choice
Medical - People Directory
You have chosen to create a medical directory of people who provide health services.
Charleston, WV
Within 20 miles
Cancel
Continue


Print / Email Directory
Choice
Your medical directory is ready to print or email.
Provider Network
Choice
Directory
People Directory
Filter
All Providers
Distance
Within 20 miles of 25301
Cancel
Print Directory
Email Directory


Print / Email Directory
PROVIDER NETWORK
Choice
Your personalized directory has been submitted.
Your request for a personalized directory is processed offline. An email message will be sent when your directory has been created.
Once created, your personalized directory can be viewed onscreen and printed.
Please Note: Directory processing time will vary depending on your search selections.
Provider Network
Choice
Directory
People Directory
Filter
All Providers
Distance
Within 20 miles of 25301
If you are using a pop-up blocker, it may prevent the print view from displaying on your screen. You may have to turn off your pop-up blocker and begin the Print/Email Directory process from the beginning.

Optimum Choice, Inc. Optimum Choice Network Provider and Facility Types

County	Specialty Type	Specialty External Desc
Barbour	Facility	Acute Inpatient Hospitals
Barbour	Physician	Allergists
Barbour	Physician	Anesthesiology
Barbour	Physician	Audiologists
Barbour	Physician	Cardiologists
Barbour	Physician	Chiropractic
Barbour	Physician	Dentist for Pediatric only
Barbour	Physician	Dermatologists
Barbour	Facility	Dialysis
Barbour	Facility	Durable Medical Equipment (DME)
Barbour	Facility	Emergency
Barbour	Physician	Endocrinology
Barbour	Physician	Gastroenterologists
Barbour	Physician	General Surgeon
Barbour	Physician	Hematology
Barbour	Facility	Home Health Services
Barbour	Facility	Laboratory
Barbour	Physician	Licensed Independent Clinical Social Worker
Barbour	Physician	Nephrology
Barbour	Physician	Neurologists
Barbour	Physician	Neurosurgery
Barbour	Physician	OB/GYNs and/or Nurse Midwives
Barbour	Physician	Occupational Therapy
Barbour	Physician	Oncologists
Barbour	Physician	Ophthalmologists
Barbour	Physician	Oral Surgeon
Barbour	Physician	Orthodontist
Barbour	Physician	Orthopedic
Barbour	Physician	Orthopedic Surgeons
Barbour	Facility	Orthotics/Prosthetics
Barbour	Physician	Otolaryngologist/Otorhinolaryngologic
Barbour	Facility	Outpatient SUD Provider
Barbour	Physician	Pathology
Barbour	Physician	Pediatric or Age appropriate Primary: Care Physicians (PCPs)
Barbour	Facility	Physical Therapy
Barbour	Physician	Plastic Surgery
Barbour	Physician	Podiatry
Barbour	Physician	Primary Care Physicians (PCPs)
Barbour	Physician	Psychiatrists
Barbour	Physician	Psychologists
Barbour	Physician	Pulmonologists
Barbour	Facility	Radiology Services
Barbour	Physician	Thoracic Surgery
Barbour	Facility	Urgent Care Facilities
Barbour	Physician	Urology
Berkeley	Facility	Acute Inpatient Hospitals
Berkeley	Physician	Allergists
Berkeley	Physician	Anesthesiology
Berkeley	Physician	Audiologists
Berkeley	Physician	Cardiologists

Berkeley	Physician	Chiropractic
Berkeley	Physician	Dentist for Pediatric only
Berkeley	Physician	Dermatologists
Berkeley	Facility	Dialysis
Berkeley	Facility	Durable Medical Equipment (DME)
Berkeley	Facility	Emergency
Berkeley	Physician	Endocrinology
Berkeley	Physician	Gastroenterologists
Berkeley	Physician	General Surgeon
Berkeley	Physician	Hematology
Berkeley	Facility	Home Health Services
Berkeley	Facility	Laboratory
Berkeley	Physician	Licensed Independent Clinical Social Worker
Berkeley	Physician	Nephrology
Berkeley	Physician	Neurologists
Berkeley	Physician	Neurosurgery
Berkeley	Physician	OB/GYNs and/or Nurse Midwives
Berkeley	Physician	Occupational Therapy
Berkeley	Physician	Oncologists
Berkeley	Physician	Ophthalmologists
Berkeley	Physician	Oral Surgeon
Berkeley	Physician	Orthodontist
Berkeley	Physician	Orthopedic
Berkeley	Physician	Orthopedic Surgeons
Berkeley	Facility	Orthotics/Prosthetics
Berkeley	Physician	Otolaryngologist/Otorhinolaryngologic
Berkeley	Facility	Outpatient SUD Provider
Berkeley	Physician	Pathology
Berkeley	Physician	Pediatric or Age appropriate Primary: Care Physicians (PCPs)
Berkeley	Facility	Physical Therapy
Berkeley	Physician	Plastic Surgery
Berkeley	Physician	Podiatry
Berkeley	Physician	Primary Care Physicians (PCPs)
Berkeley	Physician	Psychiatrists
Berkeley	Physician	Psychologists
Berkeley	Physician	Pulmonologists
Berkeley	Facility	Radiology Services
Berkeley	Physician	Thoracic Surgery
Berkeley	Facility	Urgent Care Facilities
Berkeley	Physician	Urology
Cabell	Facility	Acute Inpatient Hospitals
Cabell	Physician	Allergists
Cabell	Physician	Anesthesiology
Cabell	Physician	Audiologists
Cabell	Physician	Cardiologists
Cabell	Physician	Chiropractic
Cabell	Physician	Dentist for Pediatric only
Cabell	Physician	Dermatologists
Cabell	Facility	Dialysis
Cabell	Facility	Durable Medical Equipment (DME)
Cabell	Facility	Emergency
Cabell	Physician	Endocrinology
Cabell	Physician	Gastroenterologists
Cabell	Physician	General Surgeon
Cabell	Physician	Hematology

Cabell	Facility	Home Health Services
Cabell	Facility	Laboratory
Cabell	Physician	Licensed Independent Clinical Social Worker
Cabell	Physician	Nephrology
Cabell	Physician	Neurologists
Cabell	Physician	Neurosurgery
Cabell	Physician	OB/GYNs and/or Nurse Midwives
Cabell	Physician	Occupational Therapy
Cabell	Physician	Oncologists
Cabell	Physician	Ophthalmologists
Cabell	Physician	Oral Surgeon
Cabell	Physician	Orthodontist
Cabell	Physician	Orthopedic
Cabell	Physician	Orthopedic Surgeons
Cabell	Facility	Orthotics/Prosthetics
Cabell	Physician	Otolaryngologist/Otorhinolaryngologic
Cabell	Facility	Outpatient SUD Provider
Cabell	Physician	Pathology
Cabell	Physician	Pediatric or Age appropriate Primary: Care Physicians (PCPs)
Cabell	Facility	Physical Therapy
Cabell	Physician	Plastic Surgery
Cabell	Physician	Podiatry
Cabell	Physician	Primary Care Physicians (PCPs)
Cabell	Physician	Psychiatrists
Cabell	Physician	Psychologists
Cabell	Physician	Pulmonologists
Cabell	Facility	Radiology Services
Cabell	Physician	Thoracic Surgery
Cabell	Facility	Urgent Care Facilities
Cabell	Physician	Urology
Calhoun	Facility	Acute Inpatient Hospitals
Calhoun	Physician	Allergists
Calhoun	Physician	Anesthesiology
Calhoun	Physician	Audiologists
Calhoun	Physician	Cardiologists
Calhoun	Physician	Chiropractic
Calhoun	Physician	Dentist for Pediatric only
Calhoun	Physician	Dermatologists
Calhoun	Facility	Dialysis
Calhoun	Facility	Durable Medical Equipment (DME)
Calhoun	Facility	Emergency
Calhoun	Physician	Endocrinology
Calhoun	Physician	Gastroenterologists
Calhoun	Physician	General Surgeon
Calhoun	Physician	Hematology
Calhoun	Facility	Home Health Services
Calhoun	Facility	Laboratory
Calhoun	Physician	Licensed Independent Clinical Social Worker
Calhoun	Physician	Nephrology
Calhoun	Physician	Neurologists
Calhoun	Physician	Neurosurgery
Calhoun	Physician	OB/GYNs and/or Nurse Midwives
Calhoun	Physician	Occupational Therapy
Calhoun	Physician	Oncologists
Calhoun	Physician	Ophthalmologists

Calhoun	Physician	Oral Surgeon
Calhoun	Physician	Orthodontist
Calhoun	Physician	Orthopedic
Calhoun	Physician	Orthopedic Surgeons
Calhoun	Facility	Orthotics/Prosthetics
Calhoun	Physician	Otolaryngologist/Otorhinolaryngologic
Calhoun	Facility	Outpatient SUD Provider
Calhoun	Physician	Pathology
Calhoun	Physician	Pediatric or Age appropriate Primary: Care Physicians (PCPs)
Calhoun	Facility	Physical Therapy
Calhoun	Physician	Plastic Surgery
Calhoun	Physician	Podiatry
Calhoun	Physician	Primary Care Physicians (PCPs)
Calhoun	Physician	Psychiatrists
Calhoun	Physician	Psychologists
Calhoun	Physician	Pulmonologists
Calhoun	Facility	Radiology Services
Calhoun	Physician	Thoracic Surgery
Calhoun	Facility	Urgent Care Facilities
Calhoun	Physician	Urology
Fayette	Facility	Acute Inpatient Hospitals
Fayette	Physician	Allergists
Fayette	Physician	Anesthesiology
Fayette	Physician	Audiologists
Fayette	Physician	Cardiologists
Fayette	Physician	Chiropractic
Fayette	Physician	Dentist for Pediatric only
Fayette	Physician	Dermatologists
Fayette	Facility	Dialysis
Fayette	Facility	Durable Medical Equipment (DME)
Fayette	Facility	Emergency
Fayette	Physician	Endocrinology
Fayette	Physician	Gastroenterologists
Fayette	Physician	General Surgeon
Fayette	Physician	Hematology
Fayette	Facility	Home Health Services
Fayette	Facility	Laboratory
Fayette	Physician	Licensed Independent Clinical Social Worker
Fayette	Physician	Nephrology
Fayette	Physician	Neurologists
Fayette	Physician	Neurosurgery
Fayette	Physician	OB/GYNs and/or Nurse Midwives
Fayette	Physician	Occupational Therapy
Fayette	Physician	Oncologists
Fayette	Physician	Ophthalmologists
Fayette	Physician	Oral Surgeon
Fayette	Physician	Orthodontist
Fayette	Physician	Orthopedic
Fayette	Physician	Orthopedic Surgeons
Fayette	Facility	Orthotics/Prosthetics
Fayette	Physician	Otolaryngologist/Otorhinolaryngologic
Fayette	Facility	Outpatient SUD Provider
Fayette	Physician	Pathology
Fayette	Physician	Pediatric or Age appropriate Primary: Care Physicians (PCPs)
Fayette	Facility	Physical Therapy

Fayette	Physician	Plastic Surgery
Fayette	Physician	Podiatry
Fayette	Physician	Primary Care Physicians (PCPs)
Fayette	Physician	Psychiatrists
Fayette	Physician	Psychologists
Fayette	Physician	Pulmonologists
Fayette	Facility	Radiology Services
Fayette	Physician	Thoracic Surgery
Fayette	Facility	Urgent Care Facilities
Fayette	Physician	Urology
Grant	Facility	Acute Inpatient Hospitals
Grant	Physician	Allergists
Grant	Physician	Anesthesiology
Grant	Physician	Audiologists
Grant	Physician	Cardiologists
Grant	Physician	Chiropractic
Grant	Physician	Dentist for Pediatric only
Grant	Physician	Dermatologists
Grant	Facility	Dialysis
Grant	Facility	Durable Medical Equipment (DME)
Grant	Facility	Emergency
Grant	Physician	Endocrinology
Grant	Physician	Gastroenterologists
Grant	Physician	General Surgeon
Grant	Physician	Hematology
Grant	Facility	Home Health Services
Grant	Facility	Laboratory
Grant	Physician	Licensed Independent Clinical Social Worker
Grant	Physician	Nephrology
Grant	Physician	Neurologists
Grant	Physician	Neurosurgery
Grant	Physician	OB/GYNs and/or Nurse Midwives
Grant	Physician	Occupational Therapy
Grant	Physician	Oncologists
Grant	Physician	Ophthalmologists
Grant	Physician	Oral Surgeon
Grant	Physician	Orthodontist
Grant	Physician	Orthopedic
Grant	Physician	Orthopedic Surgeons
Grant	Facility	Orthotics/Prosthetics
Grant	Physician	Otolaryngologist/Otorhinolaryngologic
Grant	Facility	Outpatient SUD Provider
Grant	Physician	Pathology
Grant	Physician	Pediatric or Age appropriate Primary: Care Physicians (PCPs)
Grant	Facility	Physical Therapy
Grant	Physician	Plastic Surgery
Grant	Physician	Podiatry
Grant	Physician	Primary Care Physicians (PCPs)
Grant	Physician	Psychiatrists
Grant	Physician	Psychologists
Grant	Physician	Pulmonologists
Grant	Facility	Radiology Services
Grant	Physician	Thoracic Surgery
Grant	Facility	Urgent Care Facilities
Grant	Physician	Urology

Hampshire	Facility	Acute Inpatient Hospitals
Hampshire	Physician	Allergists
Hampshire	Physician	Anesthesiology
Hampshire	Physician	Audiologists
Hampshire	Physician	Cardiologists
Hampshire	Physician	Chiropractic
Hampshire	Physician	Dentist for Pediatric only
Hampshire	Physician	Dermatologists
Hampshire	Facility	Dialysis
Hampshire	Facility	Durable Medical Equipment (DME)
Hampshire	Facility	Emergency
Hampshire	Physician	Endocrinology
Hampshire	Physician	Gastroenterologists
Hampshire	Physician	General Surgeon
Hampshire	Physician	Hematology
Hampshire	Facility	Home Health Services
Hampshire	Facility	Laboratory
Hampshire	Physician	Licensed Independent Clinical Social Worker
Hampshire	Physician	Nephrology
Hampshire	Physician	Neurologists
Hampshire	Physician	Neurosurgery
Hampshire	Physician	OB/GYNs and/or Nurse Midwives
Hampshire	Physician	Occupational Therapy
Hampshire	Physician	Oncologists
Hampshire	Physician	Ophthalmologists
Hampshire	Physician	Oral Surgeon
Hampshire	Physician	Orthodontist
Hampshire	Physician	Orthopedic
Hampshire	Physician	Orthopedic Surgeons
Hampshire	Facility	Orthotics/Prosthetics
Hampshire	Physician	Otolaryngologist/Otorhinolaryngologic
Hampshire	Facility	Outpatient SUD Provider
Hampshire	Physician	Pathology
Hampshire	Physician	Pediatric or Age appropriate Primary: Care Physicians (PCPs)
Hampshire	Facility	Physical Therapy
Hampshire	Physician	Plastic Surgery
Hampshire	Physician	Podiatry
Hampshire	Physician	Primary Care Physicians (PCPs)
Hampshire	Physician	Psychiatrists
Hampshire	Physician	Psychologists
Hampshire	Physician	Pulmonologists
Hampshire	Facility	Radiology Services
Hampshire	Physician	Thoracic Surgery
Hampshire	Facility	Urgent Care Facilities
Hampshire	Physician	Urology
Hancock	Facility	Acute Inpatient Hospitals
Hancock	Physician	Allergists
Hancock	Physician	Anesthesiology
Hancock	Physician	Audiologists
Hancock	Physician	Cardiologists
Hancock	Physician	Chiropractic
Hancock	Physician	Dentist for Pediatric only
Hancock	Physician	Dermatologists
Hancock	Facility	Dialysis
Hancock	Facility	Durable Medical Equipment (DME)

Hancock	Facility	Emergency
Hancock	Physician	Endocrinology
Hancock	Physician	Gastroenterologists
Hancock	Physician	General Surgeon
Hancock	Physician	Hematology
Hancock	Facility	Home Health Services
Hancock	Facility	Laboratory
Hancock	Physician	Licensed Independent Clinical Social Worker
Hancock	Physician	Nephrology
Hancock	Physician	Neurologists
Hancock	Physician	Neurosurgery
Hancock	Physician	OB/GYNs and/or Nurse Midwives
Hancock	Physician	Occupational Therapy
Hancock	Physician	Oncologists
Hancock	Physician	Ophthalmologists
Hancock	Physician	Oral Surgeon
Hancock	Physician	Orthodontist
Hancock	Physician	Orthopedic
Hancock	Physician	Orthopedic Surgeons
Hancock	Facility	Orthotics/Prosthetics
Hancock	Physician	Otolaryngologist/Otorhinolaryngologic
Hancock	Facility	Outpatient SUD Provider
Hancock	Physician	Pathology
Hancock	Physician	Pediatric or Age appropriate Primary: Care Physicians (PCPs)
Hancock	Facility	Physical Therapy
Hancock	Physician	Plastic Surgery
Hancock	Physician	Podiatry
Hancock	Physician	Primary Care Physicians (PCPs)
Hancock	Physician	Psychiatrists
Hancock	Physician	Psychologists
Hancock	Physician	Pulmonologists
Hancock	Facility	Radiology Services
Hancock	Physician	Thoracic Surgery
Hancock	Facility	Urgent Care Facilities
Hancock	Physician	Urology
Hardy	Facility	Acute Inpatient Hospitals
Hardy	Physician	Allergists
Hardy	Physician	Anesthesiology
Hardy	Physician	Audiologists
Hardy	Physician	Cardiologists
Hardy	Physician	Chiropractic
Hardy	Physician	Dentist for Pediatric only
Hardy	Physician	Dermatologists
Hardy	Facility	Dialysis
Hardy	Facility	Durable Medical Equipment (DME)
Hardy	Facility	Emergency
Hardy	Physician	Endocrinology
Hardy	Physician	Gastroenterologists
Hardy	Physician	General Surgeon
Hardy	Physician	Hematology
Hardy	Facility	Home Health Services
Hardy	Facility	Laboratory
Hardy	Physician	Licensed Independent Clinical Social Worker
Hardy	Physician	Nephrology
Hardy	Physician	Neurologists

Hardy	Physician	Neurosurgery
Hardy	Physician	OB/GYNs and/or Nurse Midwives
Hardy	Physician	Occupational Therapy
Hardy	Physician	Oncologists
Hardy	Physician	Ophthalmologists
Hardy	Physician	Oral Surgeon
Hardy	Physician	Orthodontist
Hardy	Physician	Orthopedic
Hardy	Physician	Orthopedic Surgeons
Hardy	Facility	Orthotics/Prosthetics
Hardy	Physician	Otolaryngologist/Otorhinolaryngologic
Hardy	Facility	Outpatient SUD Provider
Hardy	Physician	Pathology
Hardy	Physician	Pediatric or Age appropriate Primary: Care Physicians (PCPs)
Hardy	Facility	Physical Therapy
Hardy	Physician	Plastic Surgery
Hardy	Physician	Podiatry
Hardy	Physician	Primary Care Physicians (PCPs)
Hardy	Physician	Psychiatrists
Hardy	Physician	Psychologists
Hardy	Physician	Pulmonologists
Hardy	Facility	Radiology Services
Hardy	Physician	Thoracic Surgery
Hardy	Facility	Urgent Care Facilities
Hardy	Physician	Urology
Harrison	Facility	Acute Inpatient Hospitals
Harrison	Physician	Allergists
Harrison	Physician	Anesthesiology
Harrison	Physician	Audiologists
Harrison	Physician	Cardiologists
Harrison	Physician	Chiropractic
Harrison	Physician	Dentist for Pediatric only
Harrison	Physician	Dermatologists
Harrison	Facility	Dialysis
Harrison	Facility	Durable Medical Equipment (DME)
Harrison	Facility	Emergency
Harrison	Physician	Endocrinology
Harrison	Physician	Gastroenterologists
Harrison	Physician	General Surgeon
Harrison	Physician	Hematology
Harrison	Facility	Home Health Services
Harrison	Facility	Laboratory
Harrison	Physician	Licensed Independent Clinical Social Worker
Harrison	Physician	Nephrology
Harrison	Physician	Neurologists
Harrison	Physician	Neurosurgery
Harrison	Physician	OB/GYNs and/or Nurse Midwives
Harrison	Physician	Occupational Therapy
Harrison	Physician	Oncologists
Harrison	Physician	Ophthalmologists
Harrison	Physician	Oral Surgeon
Harrison	Physician	Orthodontist
Harrison	Physician	Orthopedic
Harrison	Physician	Orthopedic Surgeons
Harrison	Facility	Orthotics/Prosthetics

Harrison	Physician	Otolaryngologist/Otorhinolaryngologic
Harrison	Facility	Outpatient SUD Provider
Harrison	Physician	Pathology
Harrison	Physician	Pediatric or Age appropriate Primary: Care Physicians (PCPs)
Harrison	Facility	Physical Therapy
Harrison	Physician	Plastic Surgery
Harrison	Physician	Podiatry
Harrison	Physician	Primary Care Physicians (PCPs)
Harrison	Physician	Psychiatrists
Harrison	Physician	Psychologists
Harrison	Physician	Pulmonologists
Harrison	Facility	Radiology Services
Harrison	Physician	Thoracic Surgery
Harrison	Facility	Urgent Care Facilities
Harrison	Physician	Urology
Jefferson	Facility	Acute Inpatient Hospitals
Jefferson	Physician	Allergists
Jefferson	Physician	Anesthesiology
Jefferson	Physician	Audiologists
Jefferson	Physician	Cardiologists
Jefferson	Physician	Chiropractic
Jefferson	Physician	Dentist for Pediatric only
Jefferson	Physician	Dermatologists
Jefferson	Facility	Dialysis
Jefferson	Facility	Durable Medical Equipment (DME)
Jefferson	Facility	Emergency
Jefferson	Physician	Endocrinology
Jefferson	Physician	Gastroenterologists
Jefferson	Physician	General Surgeon
Jefferson	Physician	Hematology
Jefferson	Facility	Home Health Services
Jefferson	Facility	Laboratory
Jefferson	Physician	Licensed Independent Clinical Social Worker
Jefferson	Physician	Nephrology
Jefferson	Physician	Neurologists
Jefferson	Physician	Neurosurgery
Jefferson	Physician	OB/GYNs and/or Nurse Midwives
Jefferson	Physician	Occupational Therapy
Jefferson	Physician	Oncologists
Jefferson	Physician	Ophthalmologists
Jefferson	Physician	Oral Surgeon
Jefferson	Physician	Orthodontist
Jefferson	Physician	Orthopedic
Jefferson	Physician	Orthopedic Surgeons
Jefferson	Facility	Orthotics/Prosthetics
Jefferson	Physician	Otolaryngologist/Otorhinolaryngologic
Jefferson	Facility	Outpatient SUD Provider
Jefferson	Physician	Pathology
Jefferson	Physician	Pediatric or Age appropriate Primary: Care Physicians (PCPs)
Jefferson	Facility	Physical Therapy
Jefferson	Physician	Plastic Surgery
Jefferson	Physician	Podiatry
Jefferson	Physician	Primary Care Physicians (PCPs)
Jefferson	Physician	Psychiatrists
Jefferson	Physician	Psychologists

Jefferson	Physician	Pulmonologists
Jefferson	Facility	Radiology Services
Jefferson	Physician	Thoracic Surgery
Jefferson	Facility	Urgent Care Facilities
Jefferson	Physician	Urology
Kanawha	Facility	Acute Inpatient Hospitals
Kanawha	Physician	Allergists
Kanawha	Physician	Anesthesiology
Kanawha	Physician	Audiologists
Kanawha	Physician	Cardiologists
Kanawha	Physician	Chiropractic
Kanawha	Physician	Dentist for Pediatric only
Kanawha	Physician	Dermatologists
Kanawha	Facility	Dialysis
Kanawha	Facility	Durable Medical Equipment (DME)
Kanawha	Facility	Emergency
Kanawha	Physician	Endocrinology
Kanawha	Physician	Gastroenterologists
Kanawha	Physician	General Surgeon
Kanawha	Physician	Hematology
Kanawha	Facility	Home Health Services
Kanawha	Facility	Laboratory
Kanawha	Physician	Licensed Independent Clinical Social Worker
Kanawha	Physician	Nephrology
Kanawha	Physician	Neurologists
Kanawha	Physician	Neurosurgery
Kanawha	Physician	OB/GYNs and/or Nurse Midwives
Kanawha	Physician	Occupational Therapy
Kanawha	Physician	Oncologists
Kanawha	Physician	Ophthalmologists
Kanawha	Physician	Oral Surgeon
Kanawha	Physician	Orthodontist
Kanawha	Physician	Orthopedic
Kanawha	Physician	Orthopedic Surgeons
Kanawha	Facility	Orthotics/Prosthetics
Kanawha	Physician	Otolaryngologist/Otorhinolaryngologic
Kanawha	Facility	Outpatient SUD Provider
Kanawha	Physician	Pathology
Kanawha	Physician	Pediatric or Age appropriate Primary: Care Physicians (PCPs)
Kanawha	Facility	Physical Therapy
Kanawha	Physician	Plastic Surgery
Kanawha	Physician	Podiatry
Kanawha	Physician	Primary Care Physicians (PCPs)
Kanawha	Physician	Psychiatrists
Kanawha	Physician	Psychologists
Kanawha	Physician	Pulmonologists
Kanawha	Facility	Radiology Services
Kanawha	Physician	Thoracic Surgery
Kanawha	Facility	Urgent Care Facilities
Kanawha	Physician	Urology
Lewis	Facility	Acute Inpatient Hospitals
Lewis	Physician	Allergists
Lewis	Physician	Anesthesiology
Lewis	Physician	Audiologists
Lewis	Physician	Cardiologists

Lewis	Physician	Chiropractic
Lewis	Physician	Dentist for Pediatric only
Lewis	Physician	Dermatologists
Lewis	Facility	Dialysis
Lewis	Facility	Durable Medical Equipment (DME)
Lewis	Facility	Emergency
Lewis	Physician	Endocrinology
Lewis	Physician	Gastroenterologists
Lewis	Physician	General Surgeon
Lewis	Physician	Hematology
Lewis	Facility	Home Health Services
Lewis	Facility	Laboratory
Lewis	Physician	Licensed Independent Clinical Social Worker
Lewis	Physician	Nephrology
Lewis	Physician	Neurologists
Lewis	Physician	Neurosurgery
Lewis	Physician	OB/GYNs and/or Nurse Midwives
Lewis	Physician	Occupational Therapy
Lewis	Physician	Oncologists
Lewis	Physician	Ophthalmologists
Lewis	Physician	Oral Surgeon
Lewis	Physician	Orthodontist
Lewis	Physician	Orthopedic
Lewis	Physician	Orthopedic Surgeons
Lewis	Facility	Orthotics/Prosthetics
Lewis	Physician	Otolaryngologist/Otorhinolaryngologic
Lewis	Facility	Outpatient SUD Provider
Lewis	Physician	Pathology
Lewis	Physician	Pediatric or Age appropriate Primary: Care Physicians (PCPs)
Lewis	Facility	Physical Therapy
Lewis	Physician	Plastic Surgery
Lewis	Physician	Podiatry
Lewis	Physician	Primary Care Physicians (PCPs)
Lewis	Physician	Psychiatrists
Lewis	Physician	Psychologists
Lewis	Physician	Pulmonologists
Lewis	Facility	Radiology Services
Lewis	Physician	Thoracic Surgery
Lewis	Facility	Urgent Care Facilities
Lewis	Physician	Urology
Marion	Facility	Acute Inpatient Hospitals
Marion	Physician	Allergists
Marion	Physician	Anesthesiology
Marion	Physician	Audiologists
Marion	Physician	Cardiologists
Marion	Physician	Chiropractic
Marion	Physician	Dentist for Pediatric only
Marion	Physician	Dermatologists
Marion	Facility	Dialysis
Marion	Facility	Durable Medical Equipment (DME)
Marion	Facility	Emergency
Marion	Physician	Endocrinology
Marion	Physician	Gastroenterologists
Marion	Physician	General Surgeon
Marion	Physician	Hematology

Marion	Facility	Home Health Services
Marion	Facility	Laboratory
Marion	Physician	Licensed Independent Clinical Social Worker
Marion	Physician	Nephrology
Marion	Physician	Neurologists
Marion	Physician	Neurosurgery
Marion	Physician	OB/GYNs and/or Nurse Midwives
Marion	Physician	Occupational Therapy
Marion	Physician	Oncologists
Marion	Physician	Ophthalmologists
Marion	Physician	Oral Surgeon
Marion	Physician	Orthodontist
Marion	Physician	Orthopedic
Marion	Physician	Orthopedic Surgeons
Marion	Facility	Orthotics/Prosthetics
Marion	Physician	Otolaryngologist/Otorhinolaryngologic
Marion	Facility	Outpatient SUD Provider
Marion	Physician	Pathology
Marion	Physician	Pediatric or Age appropriate Primary: Care Physicians (PCPs)
Marion	Facility	Physical Therapy
Marion	Physician	Plastic Surgery
Marion	Physician	Podiatry
Marion	Physician	Primary Care Physicians (PCPs)
Marion	Physician	Psychiatrists
Marion	Physician	Psychologists
Marion	Physician	Pulmonologists
Marion	Facility	Radiology Services
Marion	Physician	Thoracic Surgery
Marion	Facility	Urgent Care Facilities
Marion	Physician	Urology
Mineral	Facility	Acute Inpatient Hospitals
Mineral	Physician	Allergists
Mineral	Physician	Anesthesiology
Mineral	Physician	Audiologists
Mineral	Physician	Cardiologists
Mineral	Physician	Chiropractic
Mineral	Physician	Dentist for Pediatric only
Mineral	Physician	Dermatologists
Mineral	Facility	Dialysis
Mineral	Facility	Durable Medical Equipment (DME)
Mineral	Facility	Emergency
Mineral	Physician	Endocrinology
Mineral	Physician	Gastroenterologists
Mineral	Physician	General Surgeon
Mineral	Physician	Hematology
Mineral	Facility	Home Health Services
Mineral	Facility	Laboratory
Mineral	Physician	Licensed Independent Clinical Social Worker
Mineral	Physician	Nephrology
Mineral	Physician	Neurologists
Mineral	Physician	Neurosurgery
Mineral	Physician	OB/GYNs and/or Nurse Midwives
Mineral	Physician	Occupational Therapy
Mineral	Physician	Oncologists
Mineral	Physician	Ophthalmologists

Mineral	Physician	Oral Surgeon
Mineral	Physician	Orthodontist
Mineral	Physician	Orthopedic
Mineral	Physician	Orthopedic Surgeons
Mineral	Facility	Orthotics/Prosthetics
Mineral	Physician	Otolaryngologist/Otorhinolaryngologic
Mineral	Facility	Outpatient SUD Provider
Mineral	Physician	Pathology
Mineral	Physician	Pediatric or Age appropriate Primary: Care Physicians (PCPs)
Mineral	Facility	Physical Therapy
Mineral	Physician	Plastic Surgery
Mineral	Physician	Podiatry
Mineral	Physician	Primary Care Physicians (PCPs)
Mineral	Physician	Psychiatrists
Mineral	Physician	Psychologists
Mineral	Physician	Pulmonologists
Mineral	Facility	Radiology Services
Mineral	Physician	Thoracic Surgery
Mineral	Facility	Urgent Care Facilities
Mineral	Physician	Urology
Monongalia	Facility	Acute Inpatient Hospitals
Monongalia	Physician	Allergists
Monongalia	Physician	Anesthesiology
Monongalia	Physician	Audiologists
Monongalia	Physician	Cardiologists
Monongalia	Physician	Chiropractic
Monongalia	Physician	Dentist for Pediatric only
Monongalia	Physician	Dermatologists
Monongalia	Facility	Dialysis
Monongalia	Facility	Durable Medical Equipment (DME)
Monongalia	Facility	Emergency
Monongalia	Physician	Endocrinology
Monongalia	Physician	Gastroenterologists
Monongalia	Physician	General Surgeon
Monongalia	Physician	Hematology
Monongalia	Facility	Home Health Services
Monongalia	Facility	Laboratory
Monongalia	Physician	Licensed Independent Clinical Social Worker
Monongalia	Physician	Nephrology
Monongalia	Physician	Neurologists
Monongalia	Physician	Neurosurgery
Monongalia	Physician	OB/GYNs and/or Nurse Midwives
Monongalia	Physician	Occupational Therapy
Monongalia	Physician	Oncologists
Monongalia	Physician	Ophthalmologists
Monongalia	Physician	Oral Surgeon
Monongalia	Physician	Orthodontist
Monongalia	Physician	Orthopedic
Monongalia	Physician	Orthopedic Surgeons
Monongalia	Facility	Orthotics/Prosthetics
Monongalia	Physician	Otolaryngologist/Otorhinolaryngologic
Monongalia	Facility	Outpatient SUD Provider
Monongalia	Physician	Pathology
Monongalia	Physician	Pediatric or Age appropriate Primary: Care Physicians (PCPs)
Monongalia	Facility	Physical Therapy

Monongalia	Physician	Plastic Surgery
Monongalia	Physician	Podiatry
Monongalia	Physician	Primary Care Physicians (PCPs)
Monongalia	Physician	Psychiatrists
Monongalia	Physician	Psychologists
Monongalia	Physician	Pulmonologists
Monongalia	Facility	Radiology Services
Monongalia	Physician	Thoracic Surgery
Monongalia	Facility	Urgent Care Facilities
Monongalia	Physician	Urology
Morgan	Facility	Acute Inpatient Hospitals
Morgan	Physician	Allergists
Morgan	Physician	Anesthesiology
Morgan	Physician	Audiologists
Morgan	Physician	Cardiologists
Morgan	Physician	Chiropractic
Morgan	Physician	Dentist for Pediatric only
Morgan	Physician	Dermatologists
Morgan	Facility	Dialysis
Morgan	Facility	Durable Medical Equipment (DME)
Morgan	Facility	Emergency
Morgan	Physician	Endocrinology
Morgan	Physician	Gastroenterologists
Morgan	Physician	General Surgeon
Morgan	Physician	Hematology
Morgan	Facility	Home Health Services
Morgan	Facility	Laboratory
Morgan	Physician	Licensed Independent Clinical Social Worker
Morgan	Physician	Nephrology
Morgan	Physician	Neurologists
Morgan	Physician	Neurosurgery
Morgan	Physician	OB/GYNs and/or Nurse Midwives
Morgan	Physician	Occupational Therapy
Morgan	Physician	Oncologists
Morgan	Physician	Ophthalmologists
Morgan	Physician	Oral Surgeon
Morgan	Physician	Orthodontist
Morgan	Physician	Orthopedic
Morgan	Physician	Orthopedic Surgeons
Morgan	Facility	Orthotics/Prosthetics
Morgan	Physician	Otolaryngologist/Otorhinolaryngologic
Morgan	Facility	Outpatient SUD Provider
Morgan	Physician	Pathology
Morgan	Physician	Pediatric or Age appropriate Primary: Care Physicians (PCPs)
Morgan	Facility	Physical Therapy
Morgan	Physician	Plastic Surgery
Morgan	Physician	Podiatry
Morgan	Physician	Primary Care Physicians (PCPs)
Morgan	Physician	Psychiatrists
Morgan	Physician	Psychologists
Morgan	Physician	Pulmonologists
Morgan	Facility	Radiology Services
Morgan	Physician	Thoracic Surgery
Morgan	Facility	Urgent Care Facilities
Morgan	Physician	Urology

Ohio	Facility	Acute Inpatient Hospitals
Ohio	Physician	Allergists
Ohio	Physician	Anesthesiology
Ohio	Physician	Audiologists
Ohio	Physician	Cardiologists
Ohio	Physician	Chiropractic
Ohio	Physician	Dentist for Pediatric only
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Ohio	Physician	Psychiatrists
Ohio	Physician	Psychologists
Ohio	Physician	Pulmonologists
Ohio	Facility	Radiology Services
Ohio	Physician	Thoracic Surgery
Ohio	Facility	Urgent Care Facilities
Ohio	Physician	Urology
Pendleton	Facility	Acute Inpatient Hospitals
Pendleton	Physician	Allergists
Pendleton	Physician	Anesthesiology
Pendleton	Physician	Audiologists
Pendleton	Physician	Cardiologists
Pendleton	Physician	Chiropractic
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Pendleton	Facility	Radiology Services
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Pendleton	Facility	Urgent Care Facilities
Pendleton	Physician	Urology
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Pocahontas	Physician	Anesthesiology
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Pocahontas	Physician	Neurosurgery
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Pocahontas	Physician	Pulmonologists
Pocahontas	Facility	Radiology Services
Pocahontas	Physician	Thoracic Surgery
Pocahontas	Facility	Urgent Care Facilities
Pocahontas	Physician	Urology
Preston	Facility	Acute Inpatient Hospitals
Preston	Physician	Allergists
Preston	Physician	Anesthesiology
Preston	Physician	Audiologists
Preston	Physician	Cardiologists
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Preston	Physician	Oral Surgeon
Preston	Physician	Orthodontist
Preston	Physician	Orthopedic
Preston	Physician	Orthopedic Surgeons
Preston	Facility	Orthotics/Prosthetics

Preston	Physician	Otolaryngologist/Otorhinolaryngologic
Preston	Facility	Outpatient SUD Provider
Preston	Physician	Pathology
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Preston	Facility	Physical Therapy
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Preston	Physician	Podiatry
Preston	Physician	Primary Care Physicians (PCPs)
Preston	Physician	Psychiatrists
Preston	Physician	Psychologists
Preston	Physician	Pulmonologists
Preston	Facility	Radiology Services
Preston	Physician	Thoracic Surgery
Preston	Facility	Urgent Care Facilities
Preston	Physician	Urology
Putnam	Facility	Acute Inpatient Hospitals
Putnam	Physician	Allergists
Putnam	Physician	Anesthesiology
Putnam	Physician	Audiologists
Putnam	Physician	Cardiologists
Putnam	Physician	Chiropractic
Putnam	Physician	Dentist for Pediatric only
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Putnam	Physician	Plastic Surgery
Putnam	Physician	Podiatry
Putnam	Physician	Primary Care Physicians (PCPs)
Putnam	Physician	Psychiatrists
Putnam	Physician	Psychologists

Putnam	Physician	Pulmonologists
Putnam	Facility	Radiology Services
Putnam	Physician	Thoracic Surgery
Putnam	Facility	Urgent Care Facilities
Putnam	Physician	Urology
Raleigh	Facility	Acute Inpatient Hospitals
Raleigh	Physician	Allergists
Raleigh	Physician	Anesthesiology
Raleigh	Physician	Audiologists
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Raleigh	Physician	Psychologists
Raleigh	Physician	Pulmonologists
Raleigh	Facility	Radiology Services
Raleigh	Physician	Thoracic Surgery
Raleigh	Facility	Urgent Care Facilities
Raleigh	Physician	Urology
Randolph	Facility	Acute Inpatient Hospitals
Randolph	Physician	Allergists
Randolph	Physician	Anesthesiology
Randolph	Physician	Audiologists
Randolph	Physician	Cardiologists

Randolph	Physician	Chiropractic
Randolph	Physician	Dentist for Pediatric only
Randolph	Physician	Dermatologists
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Randolph	Physician	Nephrology
Randolph	Physician	Neurologists
Randolph	Physician	Neurosurgery
Randolph	Physician	OB/GYNs and/or Nurse Midwives
Randolph	Physician	Occupational Therapy
Randolph	Physician	Oncologists
Randolph	Physician	Ophthalmologists
Randolph	Physician	Oral Surgeon
Randolph	Physician	Orthodontist
Randolph	Physician	Orthopedic
Randolph	Physician	Orthopedic Surgeons
Randolph	Facility	Orthotics/Prosthetics
Randolph	Physician	Otolaryngologist/Otorhinolaryngologic
Randolph	Facility	Outpatient SUD Provider
Randolph	Physician	Pathology
Randolph	Physician	Pediatric or Age appropriate Primary: Care Physicians (PCPs)
Randolph	Facility	Physical Therapy
Randolph	Physician	Plastic Surgery
Randolph	Physician	Podiatry
Randolph	Physician	Primary Care Physicians (PCPs)
Randolph	Physician	Psychiatrists
Randolph	Physician	Psychologists
Randolph	Physician	Pulmonologists
Randolph	Facility	Radiology Services
Randolph	Physician	Thoracic Surgery
Randolph	Facility	Urgent Care Facilities
Randolph	Physician	Urology
Taylor	Facility	Acute Inpatient Hospitals
Taylor	Physician	Allergists
Taylor	Physician	Anesthesiology
Taylor	Physician	Audiologists
Taylor	Physician	Cardiologists
Taylor	Physician	Chiropractic
Taylor	Physician	Dentist for Pediatric only
Taylor	Physician	Dermatologists
Taylor	Facility	Dialysis
Taylor	Facility	Durable Medical Equipment (DME)
Taylor	Facility	Emergency
Taylor	Physician	Endocrinology
Taylor	Physician	Gastroenterologists
Taylor	Physician	General Surgeon
Taylor	Physician	Hematology

Taylor	Facility	Home Health Services
Taylor	Facility	Laboratory
Taylor	Physician	Licensed Independent Clinical Social Worker
Taylor	Physician	Nephrology
Taylor	Physician	Neurologists
Taylor	Physician	Neurosurgery
Taylor	Physician	OB/GYNs and/or Nurse Midwives
Taylor	Physician	Occupational Therapy
Taylor	Physician	Oncologists
Taylor	Physician	Ophthalmologists
Taylor	Physician	Oral Surgeon
Taylor	Physician	Orthodontist
Taylor	Physician	Orthopedic
Taylor	Physician	Orthopedic Surgeons
Taylor	Facility	Orthotics/Prosthetics
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Taylor	Facility	Outpatient SUD Provider
Taylor	Physician	Pathology
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Taylor	Physician	Primary Care Physicians (PCPs)
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Taylor	Physician	Psychologists
Taylor	Physician	Pulmonologists
Taylor	Facility	Radiology Services
Taylor	Physician	Thoracic Surgery
Taylor	Facility	Urgent Care Facilities
Taylor	Physician	Urology
Upshur	Facility	Acute Inpatient Hospitals
Upshur	Physician	Allergists
Upshur	Physician	Anesthesiology
Upshur	Physician	Audiologists
Upshur	Physician	Cardiologists
Upshur	Physician	Chiropractic
Upshur	Physician	Dentist for Pediatric only
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Upshur	Facility	Dialysis
Upshur	Facility	Durable Medical Equipment (DME)
Upshur	Facility	Emergency
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Upshur	Physician	Gastroenterologists
Upshur	Physician	General Surgeon
Upshur	Physician	Hematology
Upshur	Facility	Home Health Services
Upshur	Facility	Laboratory
Upshur	Physician	Licensed Independent Clinical Social Worker
Upshur	Physician	Nephrology
Upshur	Physician	Neurologists
Upshur	Physician	Neurosurgery
Upshur	Physician	OB/GYNs and/or Nurse Midwives
Upshur	Physician	Occupational Therapy
Upshur	Physician	Oncologists
Upshur	Physician	Ophthalmologists

Upshur	Physician	Oral Surgeon
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Upshur	Physician	Pulmonologists
Upshur	Facility	Radiology Services
Upshur	Physician	Thoracic Surgery
Upshur	Facility	Urgent Care Facilities
Upshur	Physician	Urology
Webster	Facility	Acute Inpatient Hospitals
Webster	Physician	Allergists
Webster	Physician	Anesthesiology
Webster	Physician	Audiologists
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Webster	Physician	Pathology
Webster	Physician	Pediatric or Age appropriate Primary: Care Physicians (PCPs)
Webster	Facility	Physical Therapy

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Webster	Physician	Pulmonologists
Webster	Facility	Radiology Services
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Webster	Facility	Urgent Care Facilities
Webster	Physician	Urology
Wyoming	Facility	Acute Inpatient Hospitals
Wyoming	Physician	Allergists
Wyoming	Physician	Anesthesiology
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Wyoming	Physician	Psychiatrists
Wyoming	Physician	Psychologists
Wyoming	Physician	Pulmonologists
Wyoming	Facility	Radiology Services
Wyoming	Physician	Thoracic Surgery
Wyoming	Facility	Urgent Care Facilities
Wyoming	Physician	Urology

UnitedHealthcare Credentialing Plan

2021–2023

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

United Healthcare

Table of Contents

Section 1

Introduction

Section 1.1—Purpose

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

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

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

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

Section 1.2—Credentialing policy

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

Section 1.3—Authority of credentialing entity and changes to credentialing plan

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

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

Section 2

Definitions

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

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

- **Hearing Panel** means a committee created by the Credentialing Entity to provide Appeals as required by Credentialing Authorities or the pertinent Participation Agreement.
- **Leased Network** means an existing organization of physicians, hospitals and other healthcare professionals that UnitedHealthcare contracts to allow access by Covered Persons and to which UnitedHealthcare has entered into a Credentialing Delegation Agreement.
- **Licensed Independent Practitioner** or **LIP** means any health care professional who is permitted by law to practice independently within the scope of the individual's license or certification, and includes but is not limited to medical doctors (MDs), doctors of osteopathy (DOs), dentists (DDS or DMD), chiropractors (DCs), doctors of podiatric medicine (DPM), psychologists (PhDs), social workers, licensed counselors, marriage and family therapists, certified registered nurse practitioners (CRNPs), physician assistants (PAs, certified nurse midwives (CNMs), physical, speech, occupational therapists and all other non physician practitioners who have an independent relationship with the Credentialing Entity and provide care under a Benefit Plan.
- **Material Restriction** means a restriction that includes but is not limited to the following: a requirement to obtain a second opinion from another practitioner prior to patient diagnosis or treatment; a limitation on prescription drug writing; a limitation on providing examination, diagnosis or procedure without a second person present or approving the procedure;) restriction, suspension or involuntary termination of hospital staff privileges if the LIP's specialty normally admits patients to a hospital; a limitation on the maximum numbers of hours (e.g. per day/week/month) the practitioner is permitted to practice; a restriction on the type of the practitioner's employment; a prohibition from engaging in the solo practice of medicine; or a restriction on or prohibition from performing a service or procedure typically provided by other practitioners in the same or similar specialty. The restrictions listed above are not exclusive. There may be other restrictions or conditions, not specifically identified in the definition above, that rise to the level of a material restriction.
- **NCQA** means the National Committee for Quality Assurance.
- **National Credentialing Committee** means a standing committee that implements the Credentialing Plan.
- **National Peer Review and Credentialing Policy Committee (NPRCPC)** is comprised of stakeholders from multiple UnitedHealthcare regions and meets regularly. The primary role of the NPRCPC is to ensure that the Regional Peer Review Committees (RPRCs) do not rely on an improper or discriminatory basis for making their decisions. The NPRCPC has the final decision making authority on all disciplinary actions the RPRC recommends that affect restriction, suspension or termination of participation status of physicians or health care professionals. In addition, this committee is responsible for review and approval of the UnitedHealthcare Credentialing Plan and interpretation of the Credentialing Plan as needed. The NPRCPC shall, when authorized by applicable state or federal law, endeavor to conduct its activities in a manner that constitutes Peer Review.
- **Network** means LIP's and Facilities contracted with UnitedHealthcare to provide or arrange for the provision of health care services to Covered Persons.
- **Newly Merged Network** means a network of LIP's and Facilities that had contracts to participate with an HMO, insurer or other managed care entity that was acquired by or merged into Credentialing Entity or any affiliated UnitedHealth Group company.
- **Notice** means: (1) depositing correspondence in the United States mail, using first class or certified mail, postage prepaid, addressed to the other party at the last known office address given by the party to the other party; or (2) delivering the correspondence to an overnight courier, delivery to the other party prepaid, addressed to the other party at the last known office address given by the other party; or (3) sending a facsimile transmission to the other party at the last known office facsimile number given by the party to the other party or (4) personally hand-delivering written notice to the other party.
- **NPDB** means the National Practitioner Data Bank.
- **NTIS** is the National Technical Information Service.
- **Participating LIP/Facility** means a Licensed Independent Practitioner or Facility who has entered into a Participation Agreement with the Credentialing Entity or as an employee of a Delegated Entity.
- **Participation Agreement** means a direct or indirect (such as an IPA or PHO) agreement between the Credentialing Entity and an LIP or a Facility that sets forth the terms and conditions under which the LIP or Facility participates in the Credentialing Entity's Network.

- **PCP** means primary care physician/practitioner, and always includes family practice, geriatrics, internal medicine, pediatric general practice and general practice physicians. In some states and for some Credentialing Entities, PCP's may also include OB/GYNs, certified registered nurse practitioners and physician assistants.
- **Peer Review** is the evaluation or review of the performance of physicians, health care professionals or facilities by professionals with similar types and degrees of expertise (e.g., the evaluation of one physician's practice by another physician).
- **Primary Source Verify** means to verify directly with an educational, accrediting, licensing, other entity, or NCQA approved entity that the information provided by Applicant is correct and current.
- **Protected Health Information** (PHI) has the same meaning it has under the Health Insurance Portability and Accountability Act and its implementing and interpretative regulations.
- **Quality Oversight Committee** means the Credentialing Entity committee that may review and approve changes to the Credentialing Plan required to meet regulatory requirements or other organizational and business needs. A Credentialing Entity may have a different name for this committee but the intent of the meaning applies.
- **Quality of Care (QOC)** means the degree to which health services for Covered Persons increase the likelihood of desired health outcomes and are consistent with current professional knowledge.
- **Regional Peer Review Committee (RPRC)** is a subcommittee of the National Peer Review and Credentialing Policy Committee (NPRCPC), convened pursuant to the UnitedHealthcare Quality Improvement Program. It is responsible for investigating and evaluating Enrollee/Member Quality of Care (QOC) complaints and referrals regarding Participating LIPs / Facilities and determining, or recommending to the National Peer Review and Credentialing Policy Committee, whether and what type of improvement action plan / disciplinary action should be taken in relation to such complaints or referrals. The RPRC shall comply with applicable state peer review requirements, shall be comprised of a majority of LIPs and shall include Medical Directors and QOC clinical staff. The RPRC shall, when authorized by applicable state or federal law, endeavor to conduct its activities in a manner that constitutes Peer Review.
- **UnitedHealthcare Quality of Care Department (QOC)** refers to the department within UnitedHealthcare that investigates and documents resolution of quality of care concerns.

Section 3

Responsibilities of Board of Directors, National Credentialing Committee, medical directors, hearing panels and applicants

Section 3.1—Credentialing entity board of directors (Board of Directors)

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

Section 3.2—Medical Director

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

Section 3.3—National Credentialing Committee

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

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

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

Section 3.4—Process for initial credentialing and recredentialing of LIPs

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

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

LIPs who do not meet Credentialing Entity's established Credentialing Criteria are presented to the National Credentialing Committee. The information provided to the National Credentialing Committee includes the LIP's profile and all documentation

related to the issue or issues in question. The information provided to the National Credentialing Committees does not include references to ethic/national identity, age, gender, race, sexual orientation or type of procedure or patients in which the practitioner specializes, so decisions are made in a nondiscriminatory manner. The National Credentialing Committee may request further information from any persons or organizations, including the LIP, in order to assist with the evaluation process.

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

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

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

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

Section 3.5—Disclosing reasons for non-acceptance or termination

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

Section 3.6—Applicant

Applicant is responsible for timely completion of the Application, providing all requested information, and disclosing all facts that a Credentialing Entity would consider in making a reasonable Credentialing decision. Applicant or a Participating LIP or Participating Facility must inform Credentialing Entity of any material change to the information on the Application including but not limited to: any change in staff privileges, prescribing ability, accreditation, ability to perform professional duties, imposition of an OIG sanction, GSA debarment, or Material Restrictions on licensure. Failure to inform Credentialing Entity immediately of a status change is a violation of this Credentialing Plan and the Participation Agreement may result in termination from the Network.

Section 4

Initial credentialing of Licensed Independent Practitioner applicants

Section 4.1—Scope of Licensed Independent Practitioner (LIP) credentialing

Credentialing is required for all LIPs, as defined in Section 2.0, to whom UnitedHealthcare directs Covered Persons to receive care under a Benefit Plan as part of UnitedHealthcare's Network of Participating LIPs, including LIPs participating through a Leased Network agreement. In the event of Leased Networks, Credentialing may be delegated and will be subject to the requirements of Section 11 of this Credentialing Plan. Credentialing is generally not required for health care professionals who are permitted to furnish services only under the direct supervision of another LIP or for hospital-based or Facility-based health care professionals who provide services to Covered Persons incidental to hospital or Facility services. However, Credentialing is required for hospital or Facility-based LIPs to whom UnitedHealthcare directs Covered Persons to receive care under a Benefit Plan or if mandated by Credentialing Authorities.

In certain circumstances a participating LIP may be subject to initial credentialing standards, for example: when an LIP was previously credentialed by a Delegated Entity but is new to direct credentialing by the Credentialing Entity, or when credentialing status is identified as requiring an update due to a contracting change, history of Quality of Care concerns will be reviewed and considered by the Credentialing Committee.

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

Section 4.2—Credentialing criteria/source verification requirements

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

1. **Required medical or professional education and training. (**Verification time limit: Board certification 180 days of the Decision Date, education and training prior to the decision date.) MDs and DOs must graduate from allopathic or osteopathic medical school and successfully complete a residency program or other clinical training and experience as appropriate for specialty and scope of practice as determined by the Credentialing Committee. DCs must graduate from Chiropractic College; DDSs or DMDs must graduate from dental school; and DPMs must graduate from podiatry school and successfully complete a hospital residency program. All mid-level practitioners must graduate from an accredited professional school and successfully complete a training program. If Applicant claims to be board certified, Credentialing Entity will Primary Source Verify board certification from the most current edition of an NCQA approved source, but need not Primary Source Verify each level of education and training if the certifying board has already Primary Source Verified it. If Applicant is not board certified, then Primary Source Verification of the highest level of education listed on the Application is required, except that each level of education must be primary source verified for dentists.
2. **Verification of post-graduate education or training not listed in (1) above.** The Credentialing Entity will Primary Source Verify any post-graduate education or training disclosed in the Application and not considered in (1) above if relevant to LIP's scope of practice (for example Fellowship).
3. **Current licensure or certification.** The Credentialing Entity will Primary Source Verify that the Applicant maintains current, valid licensure or certification, without Material Restrictions, conditions, or other disciplinary action, in all states where

the applicant practices. Any finding of sanctions or restrictions on the LIP from any government agency or authority, including but not limited to a state licensing authority may result in denial of Credentialing. A committee may recommend accepting an LIP to the Network if the restriction does not limit or impact the LIP's practice, except that a Committee cannot recommend accepting an LIP into the Network if the LIP has a Material Restriction in any state where the LIP practices. If the LIP has a Material Restriction in a state in which the LIP does not practice, a Committee has the discretion to recommend acceptance into the Network after reviewing the circumstances of the Material Restriction.

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

   Any failed site visit will result in the Applicant being required to re-apply for Credentialing after at least six months have passed. The Credentialing Entity may agree to permit an Applicant to re-apply for Credentialing prior to the six month wait period if the Applicant can first demonstrate improvements in the areas previously found deficient by providing documentation of such improvements in an improvement action plan. If the Credentialing Entity accepts the improvement action plan, the Applicant must agree to allow the Credentialing Entity to conduct an office site visit of Applicant's practice as further documented in Attachment B, and must receive a passing score for the site visit as part of the initial Credentialing Criteria.
10. **Sanction and Limitation on Licensure.** In addition to primary source verification of license or certification as noted in section 4.2(3) above Credentialing Entity will obtain information about the Applicant through a review of NPDB, FSMB or

state licensing Board reports. Any finding of a Material Restriction on the LIP from licensing authority shall be processed as discussed in section 4.2(3) above.

11. **No prior denials or terminations.** At the discretion of the Credentialing Entity, the Applicant must not have been denied initial participation or had participation terminated (for reasons other than network need) by the Credentialing Entity or any Newly Merged Network within the preceding 24 months.
12. **Hospital Staff Privileges.** Applicant must have full hospital admitting privileges, without Material Restrictions, conditions or other disciplinary actions, at a minimum of one Participating (Network) hospital, or arrangements with a Participating LIP to admit and provide hospital coverage to Covered Persons at a Participating (Network) hospital acceptable to the Credentialing Entity, if the Credentialing Entity determines that Applicant's practice requires such privileges. The Applicant's attestation is sufficient verification of this requirement unless otherwise required by Credentialing Authority. The National Credentialing Committee may recommend accepting an LIP to the Network if the restriction does not limit or impact the LIP's practice.
13. **Affirmative responses to Disclosure Questions on the Credentialing Application.** Applicant is required to provide details on all affirmative responses to Disclosure Questions on the Credentialing Application, which may be reviewed by a Medical Director, and at the discretion of the Medical Director, may be reviewed by Credentialing Committee for a determination of LIP's acceptance into Credentialing Entity's Network.

Section 4.3—Status of applicant after National Credentialing Committee decision date

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

Section 4.4—Consequences of license suspension

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

Section 5

Recredentialing of participating Licensed Independent Practitioners

Section 5.1—Recredentialing participating LIPs: Application

LIPs will be Recredentialed at least every 36 months. Participating LIPs must complete an Application with criteria as outlined in Attachment A. In certain circumstances a participating LIP may be subject to initial credentialing standards, for example: when an LIP was previously credentialed by a Delegated Entity but is new to direct credentialing by the Credentialing Entity, or when credentialing status is identified as requiring an update due to a contracting change, history of Quality of Care concerns will be reviewed and considered by the Credentialing Committee.

Section 5.2—Recredentialing criteria of participating LIPs

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

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

Section 6

Licensed Independent Practitioner site assessment

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

Section 7

Credentialing and recredentialing of facilities

Section 7.1—Criteria for credentialing and recredentialing facilities

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

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

Section 7.2—Recredentialing periodically required

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

Section 7.3—Status of applicant after National Credentialing Committee decision

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

Section 8

Confidentiality and applicant rights

Section 8.1—Confidentiality of applicant information

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

Section 8.2—Applicant rights

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

Applicants also have the right to obtain information about the status of their Application upon their request. The Applicant can check on the status of an application by emailing Networkhelp@uhc.com. Include the Applicant's full name, National Provider Identifier (NPI), Tax Identification Number (TIN) and a brief description of the request. Credentialing Entity is not required to allow an Applicant to review personal or professional references, or other information that is peer review protected. Applicants have the right to be notified of the credentialing decision within 60 calendar days of the National Credentialing Committee's decision and recredentialing denials within 60 days of decision date, notwithstanding this provision, credentialing time frames and notification will not exceed timelines required by the Credentialing Authority.

Section 8.3—Appeal process

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

Section 9

Ongoing monitoring and reporting

Section 9.1—National Peer Review and Credentialing Policy Committee

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

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

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

The National Peer Review and Credentialing Policy Committee may affirm or reject and modify the recommendation of the Reginal Peer Review Committee. If not affirmed, the matter will be remanded back to the Regional Peer Review Committee to implement the modification.

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

Section 9.3—Fair process considerations

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

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

- In the reasonable belief that the action is in the furtherance of quality health care;
- After a reasonable effort to obtain the facts of the matter;

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

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

Section 9.4—Hearing Panel

A Hearing Panel is convened when an LIP appeals an adverse action based on quality of care concerns. The Hearing Panel's responsibility is to conduct hearings or reviews and make determinations or recommendations.

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

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

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

- Decisions to suspend, restrict or terminate participation
- Decisions regarding the outcome of the appeal hearing

Section 9.5—Reporting requirements

A. NPDB reporting

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

Reportable actions

Actions taken that fit into any of the following categories must be reported.

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

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

The Health Care Quality Improvement Act leaves largely undefined the types of acts or omissions that relate to "competence or professional conduct." The Act, however, makes it clear that certain factors, such as membership in a professional society, fees, advertising practices, competitive acts intended to solicit or retain business, or support for allied health professionals do not relate to professional competence or conduct. Failure to attend staff meetings or to complete medical records are not viewed as related to competence or professional conduct, unless they reach the point of adversely affecting the health or welfare of patients. The legislative history of the Act indicates that felonies or crimes of moral turpitude, illicit transactions involving drugs, serious sexual offenses, violent behavior and other similar acts are activities that could adversely affect patients. The database for reporting adverse actions offers some additional guidance by listing adverse action classification codes for certain types of activities.

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

Section 9.6—Ongoing monitoring

A. Sanctions monitoring

State and Federal reports, as well as publicly available health care entity reports, will be reviewed within thirty days of their release, or as soon as possible thereafter, in order to identify Participating LIPs who have had OIG sanctions on Medicare or Medicaid participations, GSA debarments, or other sanctions or restriction on their ability to practice. If Credentialing Entity identifies a professional license that is not valid, an OIG sanction on Medicare or Medicaid participation, GSA debarment, Office of Personnel Management (OPM), CMS Preclusion and Revocation Lists or other Material Restriction on an LIP's ability to practice, action shall be taken to terminate the LIP from the Network in accordance with the authority established in Section 4 of this Credentialing Plan. Sanctions and restrictions monitoring, tracking and reporting will be done in accord with UnitedHealthcare's policy. (See Section 8.3 of the Credentialing Plan for a description of the appeal process for adverse actions based on credentialing and sanctions monitoring determinations.)

B. Quality monitoring

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

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

C. Imminent threats to patient safety

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

D. Quality site visit

As required by Credentialing Authority, Credentialing Entity in conjunction with the UnitedHealthcare Quality of Care Department or its designee (collectively "QOC Department") monitors complaints concerning Participating LIPs/Facilities.

Complaints about an office site and Facilities are recorded, investigated and appropriate follow-up is conducted to assure that Covered Persons receive care in a clean, accessible and appropriate environment.

Applicant must agree to allow the Credentialing Entity to conduct an office site visit of Applicant's practice, including, but not limited to, physical accessibility, physical appearance, adequacy of waiting and exam rooms, availability of appointments and adequacy of medical record-keeping and must receive a passing score for the site assessment and medical record keeping assessment. Applicants whose office site or facility does not meet thresholds for site assessment and medical record keeping assessment will be offered actions to improve office site and facilities and effectiveness of offered actions will be re-assessed.

E. Quality and efficiency performance management

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

Section 9.7—Use of participating facilities

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

Section 10

Newly merged networks

Section 10.1—Newly merged networks

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

Section 10.2—Status of "merged" LIPs and facilities

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

Section 11

Delegated credentialing

Section 11.1—Delegated credentialing authorized

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

Section 11.2—Credentialing delegation agreement

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

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

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

Section 11.3—Sub-delegation

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

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

Section 11.4—Preassessment responsibilities of credentialing entity

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

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

A. NCQA accredited or certified potential delegated entities:

1. Verification of the potential Delegated Entity's accreditation or certification by NCQA.

2. A pre-delegation assessment of the potential Delegated Entity's ability to meet Credentialing Authorities' and Credentialing Entity's standards, including, but not limited to: Credentialing and Recredentialing policies and procedures, Credentialing and Recredentialing application and attestation, and other relevant Credentialing and Recredentialing documents or files, including those related to suspension and/or restriction actions, termination and notification to authorities, confidentiality, provision for the protection of Protected Health Information, if applicable, and for the elements not certified or accredited by NCQA.

B. Non-NCQA accredited or certified potential delegated entities:

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

Section 11.5—Annual evaluation

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

Section 11.6—Review of oversight and monitoring reports

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

Section 11.7—Required follow-up

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

Section 11.8—Process for acceptance/rejection of delegated entity's approved LIPs and facilities

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

Section 11.9—Credentialing and recredentialing after termination of credentialing delegation agreement

Upon termination of a Credentialing Delegation Agreement, Credentialing Entity will place the LIPs or Facilities in a queue for Recredentialing if the Delegated Entity provides Participating LIP and Facility Credentialing and Recredentialing files to the Credentialing Entity and the files are found to be compliant with Credentialing Entity requirements. If the Delegated Entity does not provide Credentialing and Recredentialing files, or the files do not meet Credentialing Entity requirements, LIPs or Facilities will be placed in a queue for initial Credentialing by the Credentialing Entity to be completed within six months of the Credentialing Delegation Agreement termination date. Acceptance of Credentialing or Recredentialing of LIPs and Facilities from terminated Credentialing Delegation Agreements is contingent upon the Credentialing Entity's Network needs and the LIP's or Facility's willingness to sign a Participation Agreement.

Section 11.10—Procedure when LIP or facility has contracts with both credentialing entity and delegated entity

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

Section 11.11—Delegated functions

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

Attachment A

LIP application credentialing criteria

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

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

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

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

Attachment B

Site assessment and medical record keeping assessment

Credentialing/recredentialing requirements for LIPs

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

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

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

Credentialing/recredentialing site assessment criteria and credentialing/ recredentialing medical record-keeping assessment

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

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

- Confidentiality of the record
- Consistent organization of the record

Attachment C

Facility required credentialing

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

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

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

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

Acceptable accreditation entities:

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

Organizations not accredited or certified as noted above

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

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

Attachment D

Facility site visits for credentialing/recredentialing

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

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

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

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

The following minimum criteria must be reviewed:

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

Attachment E

State and federal regulatory addendum

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

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

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

Attachment F

UnitedHealthcare Community Plan Peer Review addendum

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

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

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

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

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

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

Addition to Section 2.0 Definitions

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

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

United Healthcare