SecureCare Credentialing Guidelines/Criteria
Eligibility Requirements for Participating Practitioners

All individual provider credentialing file contents are reviewed against the SecureCare Credentialing Guidelines/Criteria by the credentialing staff to ensure uniformity and to confirm that applicants meet the SecureCare requirements for participation in the SecureCare Network. Provisional credentialing requirements are client/health plan specific and conducted according to the client/health plan policies.

All information collected by the Credentialing Department about a provider including, but not limited to, malpractice claims, sanctions, board actions, quality of care issues documented by SecureCare, shall be considered by the credentialing staff against the Credentialing Guidelines/Criteria. All practitioners must verify/attest that the application information submitted is accurate and truthful. Providers must respond to SecureCare requests for any missing information or additional information related to the credentialing/recredentialing process. Providers are given the opportunity to submit information to correct erroneous information related to their credentialing application.

The Credentialing Guidelines/Criteria are utilized during initial credentialing and recredentialing. If, after a file is reviewed against the Credentialing Guidelines/Criteria, a question still exists as to whether or not the provider file evidence verifies compliance with the Guidelines/Criteria, the SecureCare Medical Director shall be consulted in order to make a determination about the practitioner's eligibility and any further next steps with respect to Credentialing Committee consideration.

The SecureCare Credentialing Guidelines/Criteria and parameters apply to the credentialing of Chiropractic Doctors. Required provider information and evidence must verify the following:

1. Malpractice Insurance current with evidence of:
    a. minimum limits of:
        i. at least $100,000/$300,000 (unless state law or client health plan mandates higher minimum limits), i.e. *Professional Liability (Malpractice) coverage in the amount of* ***$1 million per incident and $3 million aggregate.***
    b. coverage dates must be current
    c. coverage by an approved carrier
    d. No malpractice claims settled within the last ten (10) years
2. No unexplained lapse in work history greater than (6) months
3. No Medicare/Medicaid Sanctions
4. Valid Medicare Number
5. Valid National Provider Identifier (NPI) Number with:
    a. individual
    b. organizational
6. Attestation present for all application question answers marked 'YES'
    a. NPDB/HIPDB issues verified and explanation present if 'yes'
    b. OIG issues verified and explanation present if 'yes'
    c. DHHS issues verified and explanation present if 'yes'
    d. EPLS issues verified and explanation present if 'yes'
7. Practitioner license/s to include:
    a. license number
    b. license state

c. issue date
d. expiration date
e. actions

8. Practitioners must maintain compliance with:
    i. SecureCare professional behavior, practitioner participation and quality performance requirements on an ongoing basis
    ii. SecureCare practitioner participation contract requirements
    iii. the required state healthcare professional license/s:

        1. Restriction: any practitioner participating in SecureCare networks with a restriction or condition acknowledged by the Credentialing Committee must agree in writing their understanding of the restriction and agree to comply with such.
        2. Revocation: SecureCare must be notified immediately by the practitioner if the practitioner's license is revoked, suspended or restricted in any manner.
9. Practitioner education evidence must indicate graduation from a chiropractic college, accredited by an agency approved by the U. S. Department of Education , with:
    a. degree evidence
    b. post-graduate chiropractic board certification (if applicable)
    c. facility name
    d. start date
    e. completion date

A "Routine Review/Clean Application" is defined as:

- All professional attestation questions are answered "NO" (no actions have been reported)
- No lapse in education or work history greater than 6 months have occurred
- No issues are identified regarding license or sanctions/restrictions, felony, sexual abuse, loss of hospital privileges, professional conduct, active substance abuse condition, physical or mental health conditions
- No quality of care issues
- No instances of Fraud, Waste or Abuse
- Malpractice history shows no cases settled
- All other Credentialing Guidelines/Criteria are met
    - Routine Review files are reviewed by the Medical Director and the files are brought to the Credentialing Committee for approval

A "Committee Review" is defined as any provider file that falls outside the definition of a "Routine Review/Clean Application."

- Applicants designated as "Committee Review" have all accompanying documentation sent to the entire Credentialing Committee and their applications are brought to the Credentialing Committee for discussion and final determination.