

ATTACHMENT A

PROVIDER APPROVAL CRITERIA

TYPE OF PROVIDER: **Physician - Allergy**

APPROVAL CRITERIA:

1. Licensed by the State of Illinois or the state in which the medical services are being provided.
2. Certified by the American Board of Allergy and Immunology.
3.
  - a. Certified by the American Board of Pediatrics, or;
  - b. Certified by the American Board of Internal Medicine with at least 50% of practice involving care of children.
4. Provide evidence of medical malpractice insurance by insurer licensed in the State of Illinois. Such malpractice insurance shall be in minimum amount of \$1,000,000 per claim and \$3,000,000 aggregate.

ADDITIONAL DESIRABLE CRITERIA:

1. Affiliation with the teaching hospital of a medical school.
2. Faculty appointment in a medical school.

TYPE OF PROVIDER: **Physician - Child Neurology**

APPROVAL CRITERIA:

1. Licensed by the State of Illinois or the state in which the medical services are being provided.
2. Be a member in good standing of the credentialed staff of the health care facility approved by DSCC for the services to be provided.
3. Certification by the American Board of Psychiatry and Neurology, Inc. with a certificate in neurology with special qualifications in child neurology.
4. Provide evidence of medical malpractice insurance by insurer licensed in the State of Illinois. Such malpractice insurance shall be in minimum amount of \$1,000,000 per claim and \$3,000,000 aggregate.

ADDITIONAL DESIRABLE CRITERIA:

1. Member of multidisciplinary team.
2. Affiliated with the teaching hospital of a medical school.
3. Faculty appointment in a medical school.

**TYPE OF PROVIDER: Physician - Child Psychiatry**

**APPROVAL CRITERIA:**

1. Licensed by the State of Illinois or the state in which the medical services are being provided.
2. A member in good standing of the credentialed staff of the health care facility approved by DSCC for the services to be provided.
3. Certified by the American Board of Psychiatry and Neurology, Inc., with a certificate in psychiatry with subspecialty training and certification in child psychiatry.
4. Provide evidence of medical malpractice insurance insurer licensed in Illinois. Such medical malpractice insurance shall be in minimum amounts of \$1,000,000 per claim and \$3,000,000 aggregate.

**ADDITIONAL DESIRABLE CRITERIA:**

1. Member of multidisciplinary team.
2. Affiliated with the teaching hospital of a medical school.
3. Faculty appointment in a medical school

**TYPE OF PROVIDER: Physician - Gastroenterology**

**APPROVAL CRITERIA:**

1. Licensed by the State of Illinois or the state in which the medical services are to be provided.
2. A member in good standing of the credentialed staff of the health care facility approved by DSCC for the services to be provided.
3. Certification by the American Board of Pediatrics and two years postgraduate training in pediatric gastroenterology in a university based program in the United States or Canada,  
or  
certification by the American Board of Pediatrics with subspecialty certification in pediatric gastroenterology  
or  
certification by the American Board of Internal Medicine with subspecialty certification in gastroenterology with a current caseload consisting of 20% pediatric patients (or more).
4. Provide evidence of medical malpractice insurance by insurer licensed in Illinois. Such medical malpractice insurance shall be in minimum amounts of \$1,000,000 per claim and \$3,000,000 aggregate.

**ADDITIONAL DESIRABLE CRITERIA:**

1. Affiliated with the teaching hospital of a medical school
2. Faculty appointment in a medical school

**TYPE OF PROVIDER: Physician - Hand Surgery**

**APPROVAL CRITERIA:**

1. Licensed in the State of Illinois or the state in which the medical services are being provided.
2. A member in good standing of the credentialed staff of the health care facility approved by DSCC for the services to be provided.
3. Certification by the American Board of Orthopedic Surgery or American Board of Plastic Surgery.
4. Minimum of one year postgraduate subspecialty training in hand surgery in a university based program in the United States or Canada.
5. Provide evidence of medical malpractice insurance by insurer licensed in the State of Illinois. Such medical malpractice insurance shall be in minimum amount of \$1,000,000 per claim and \$3,000,000 aggregate.

**ADDITIONAL DESIRABLE CRITERIA:**

1. Affiliated with the teaching hospital of a medical school
2. Pediatric experience.
3. Faculty appointment in a medical school.

**TYPE OF PROVIDER: Physician - Infectious Diseases**

**APPROVAL CRITERIA:**

1. Licensed by the State of Illinois or the state in which the medical services are being provided.
2. A member in good standing of the credentialed staff of the health care facility approved by DSCC for the services to be provided.
3. Certified by the American Board of Pediatrics.
4. Two years postgraduate training in Infectious Diseases in a university based program in the United States or Canada.
5. Provide evidence of medical malpractice insurance by insurer licensed in Illinois. Such medical malpractice insurance shall be in minimum amounts of \$1,000,000 per claim and \$3,000,000 aggregate.

**ADDITIONAL DESIRABLE CRITERIA:**

1. Affiliated with the teaching hospital of a medical school.
2. Faculty appointment in a medical school.

**TYPE OF PROVIDER: Physician - Medical Genetics**

**CRITERIA:**

1. Licensed by the State of Illinois or the state in which the medical services are being provided.

2. A member in good standing of the credentialed staff of the health care facility approved by DSCC for the services to be provided.
3.
  - a. Certified by the American Board of Pediatrics, or;
  - b. Certified by the American Board of Internal Medicine with at least 30% practice involving care of children.
4. Completion of formal fellowship of at least two years in medical genetics in a university based program in the United States or Canada.
5. Provide written evidence of certification in clinical genetics by the American Board of Medical Genetics.
6. Provide evidence of medical malpractice insurance by insurer licensed in Illinois. Such medical malpractice insurance shall be in minimum amounts of \$1,000,000 per claim and \$3,000,000 aggregate.

**ADDITIONAL DESIRABLE CRITERIA:**

1. Member of multi-disciplinary team.
2. Affiliation with the teaching hospital of a medical school

**TYPE OF PROVIDER: Physician - Nephrology**

**APPROVAL CRITERIA:**

1. Licensed by the State of Illinois or the state in which the medical services are being provided.
  2. A member in good standing of the credentialed staff of the health care facility approved by DSCC for the services to be provided.
  3. Certification by the American Board of Pediatrics with subspecialty certification in pediatric nephrology
- OR
4. Certification by the American Board of Internal Medicine with subspecialty certification in nephrology with a current caseload consisting of 20% pediatric patients (or more).
  4. Provide evidence of medical malpractice insurance by insurer licensed in Illinois. Such medical malpractice insurance shall be in minimum amounts of \$1,000,000 per claim and \$3,000,000 aggregate.

**ADDITIONAL DESIRABLE CRITERIA:**

1. Affiliated with the teaching hospital of a medical school
2. Faculty appointment in a medical school

**TYPE OF PROVIDER: Physician - Neurological Surgery**

**APPROVAL CRITERIA:**

1. Licensed by the State of Illinois or the state in which the medical services are being provided.

2. Be a member in good standing of the credentialed staff of the health care facility approved by DSCC for the services to be provided.
3. Certified by the American Board of Neurological Surgery.
4. At least 30% of practice involves care of children.
5. Provide evidence of medical malpractice insurance by insurer licensed in Illinois. Such medical malpractice insurance shall be in minimum amounts of \$1,000,000 per claim and \$3,000,000 aggregate.

ADDITIONAL DESIRABLE CRITERIA:

1. Completion of at least one year formal postgraduate training in Pediatric Neurological Surgery.
2. Affiliation with the teaching hospital of a medical school.
3. Member of multidisciplinary team.
4. Faculty appointment in a medical school.

TYPE OF PROVIDER: **Physician - Neurology**

APPROVAL CRITERIA:

1. Licensed by the State of Illinois or the state in which the medical services are being provided.
2. Be a member in good standing of the credentialed staff of the health care facility approved by DSCC for the services to be provided.
3. Certified by the American Board of Psychiatry and Neurology, Inc. with certificate in Neurology.
4. At least 30% of practice involves care of children.
5. Provide evidence of medical malpractice insurance by insurer licensed in Illinois. Such medical malpractice insurance shall be in minimum amounts of \$1,000,000 per claim and \$3,000,000 aggregate.

ADDITIONAL DESIRABLE CRITERIA:

1. Additional pediatric training and experience.
2. Member of multidisciplinary team.
3. Affiliated with the teaching hospital of a medical school.
4. Faculty appointment in a medical school.

**TYPE OF PROVIDER: Physician - Ophthalmology**

1. Licensed by the State of Illinois or the state in which the medical services are being provided.
2. Be a member in good standing of the credentialed staff of the health care facility approved by DSCC for the services to be provided.
3. Certified by the American Board of Ophthalmology.
4. At least 30% of practice involves care of children.
5. Provide evidence of medical malpractice insurance by insurer licensed in Illinois. Such medical malpractice insurance shall be in minimum amounts of \$1,000,000 per claim and \$3,000,000 aggregate.

**ADDITIONAL DESIRABLE CRITERIA:**

1. Formal pediatric training and experience.
2. Affiliated with the teaching hospital of a medical school.
3. Faculty appointment in a medical school.

**TYPE OF PROVIDER: Physician - Ophthalmology, Glaucoma**

**APPROVAL CRITERIA:**

1. Licensed by the State of Illinois or the state in which the medical services are being provided.
2. Be a member in good standing of the credentialed staff of the health care facility approved by DSCC for the services to be provided.
3. Certified by the American Board of Ophthalmology.
4. One year postgraduate fellowship training in glaucoma in an approved program in the United States or Canada.
5. Provide evidence of medical malpractice insurance by insurer licensed in Illinois. Such medical malpractice insurance shall be in minimum amounts of \$1,000,000 per claim and \$3,000,000 aggregate.

**ADDITIONAL DESIRABLE CRITERIA:**

1. Affiliated with the teaching hospital of a medical school.
2. Faculty appointment in a medical school.

**TYPE OF PROVIDER: Physician - Ophthalmology, Retina**

**APPROVAL CRITERIA:**

1. Licensed by the State of Illinois or the state in which the medical services are being provided.
2. Be a member in good standing of the credentialed staff of the health care facility approved by DSCC for the services to be provided.
3. Certified by the American Board of Ophthalmology.
4. One year postgraduate retina fellowship training in an approved fellowship program in the United States or Canada.
5. Provide evidence of medical malpractice insurance by insurer licensed in Illinois.

Such medical malpractice insurance shall be in minimum amounts of \$1,000,000 per claim and \$3,000,000 aggregate.

**ADDITIONAL DESIRABLE CRITERIA:**

1. Affiliated with the teaching hospital of a medical school.
2. Faculty appointment in a medical school.

**TYPE OF PROVIDER: Orthopedic Surgery**

**APPROVAL CRITERIA:**

1. Licensed by the State of Illinois or the state in which the medical services are being provided.
2. Be a member in good standing of the credentialed staff of the health care facility approved by DSCC for the services to be provided.
3. Certified by the American Board of Orthopedic Surgery, Inc.
4. At least 50% of practice involves the care of children.
5. Provide evidence of medical malpractice insurance by insurer licensed in Illinois. Such medical malpractice insurance shall be in minimum amounts of \$1,000,000 per claim and \$3,000,000 aggregate.

**ADDITIONAL DESIRABLE CRITERIA:**

1. Additional pediatric training and experience beyond the basic six months requirement.
2. Member of multidisciplinary team.
3. Affiliated with the teaching hospital of a medical school.
4. Faculty appointment in a medical school.

**TYPE OF PROVIDER: Physician - Otolaryngology**

**APPROVAL CRITERIA:**

1. Licensed in the State of Illinois or the state in which the medical services are being provided.
2. A member in good standing of the credentialed staff of the health care facility approved by DSCC for the services to be provided.
3. Certification by the American Board of Otolaryngology.
4. At least 50% of practice involves care of children.
5. Provide evidence of medical malpractice insurance by insurer licensed in Illinois. Such medical malpractice insurance shall be in minimum amounts of \$1,000,000 per claim and \$3,000,000 aggregate.

ADDITIONAL DESIRABLE CRITERIA:

1. Specialized pediatric training and experience.
2. Member of multidisciplinary team.
3. Affiliated with the teaching hospital of a medical school.
4. Faculty appointment in a medical school.

TYPE OF PROVIDER: **Physician - Otolaryngology, Cochlear Implant**

APPROVAL CRITERIA:

1. Licensed by the State of Illinois or the state in which the medical services are being provided.
2. A member in good standing of the credentialed staff of the health care facility approved by DSCC for the services to be provided.
3. Certification by the American Board of Otolaryngology.
4. Practice restricted to otology.
5. Current experience with cochlear implantation in adults (or children).
6. Member or associated with a cochlear implant team for children.
7. Provide evidence of medical malpractice insurance by insurer licensed in Illinois. Such medical malpractice insurance shall be in minimum amounts of \$1,000,000 per claim and \$3,000,000 aggregate.

ADDITIONAL DESIRABLE CRITERIA:

1. Fellowship in neurotology of one or more years.
2. Affiliated with the teaching hospital of a medical school.
3. Faculty appointment in a medical school.

TYPE OF PROVIDER: **Physician - Pediatric Cardiology**

APPROVAL CRITERIA:

1. Licensed by the State of Illinois or the state in which the medical services are being provided.
2. A member in good standing of the credentialed staff of the health care facility approved by DSCC for the services to be provided.
3. Certification by the American Board of Pediatrics, Inc. with subspecialty certification in Pediatric Cardiology.
4. Provide evidence of medical malpractice insurance by insurer licensed in Illinois. Such medical malpractice insurance shall be in minimum amounts of \$1,000,000 per claim and \$3,000,000 aggregate.

ADDITIONAL DESIRABLE CRITERIA:

1. Member of approved cardiac center.
2. Affiliated with the teaching hospital of a medical school.
3. Faculty appointment in a medical school.

TYPE OF PROVIDER: **Physician - Pediatric Endocrinology**

APPROVAL CRITERIA:

1. Licensed by the State of Illinois or the state in which the medical services are being provided.
2. A member in good standing of the credentialed staff of the health care facility approved by DSCC for the services to be provided.
3. Certification by the American Board of Pediatrics , Inc., with subspecialty certification in Pediatric Endocrinology or membership in the Lawson Wilkins Society.
4. Provide evidence of medical malpractice insurance by insurer licensed in Illinois. Such medical malpractice insurance shall be in minimum amounts of \$1,000,000 per claim and \$3,000,000 aggregate.

ADDITIONAL DESIRABLE CRITERIA:

1. Affiliated with the teaching hospital of a medical school.
2. Faculty appointment in a medical school.

TYPE OF PROVIDER: **Physician - Pediatric Hematology/Oncology**

APPROVAL CRITERIA:

1. Licensed in the State of Illinois or the state in which the medical services are being provided.
2. A member in good standing of the credentialed staff of the health care facility approved by DSCC for the services to be provided.
3. Certification by the American Board of Pediatrics, Inc., with subspecialty certification in Pediatric Hematology/Oncology.
4. Provide evidence of medical malpractice insurance by insurer licensed in Illinois. Such medical malpractice insurance shall be in minimum amounts of \$1,000,000 per claim and \$3,000,000 aggregate.

ADDITIONAL DESIRABLE CRITERIA:

1. Affiliated with the teaching hospital of a medical school.
2. Faculty appointment in a medical school.

TYPE OF PROVIDER: **Physician - Pediatric Ophthalmology**

APPROVAL CRITERIA:

1. Licensed in the State of Illinois or the state in which the medical services are being provided.
2. Be a member in good standing of the credentialed staff of the health care facility approved by DSCC for services to be provided.
3. Certified by the American Board of Ophthalmology.
4. One year postgraduate training in pediatric ophthalmology in a university-based program in the United States or Canada.
5. Provide evidence of medical malpractice insurance by insurer licensed in Illinois. Such medical malpractice insurance shall be in minimum amounts of \$1,000,000 per

claim and \$3,000,000 aggregate.

**ADDITIONAL DESIRABLE CRITERIA:**

1. Affiliated with the teaching hospital of a medical school.
2. Faculty appointment in a medical school.

**TYPE OF PROVIDER: Physician - Pediatric Pulmonology**

**APPROVAL CRITERIA:**

1. Licensed by the State of Illinois or the state in which the medical services are being provided.
2. A member in good standing of the credentialed staff of the health care facility approved by DSCC for the services to be provided.
3. Certified by the American Board of Pediatrics.
4. Successful completion of a formal fellowship of at least two years in pediatric pulmonary medicine in a university based program in the United States or Canada.
5. Provide evidence of medical malpractice insurance by insurer licensed in Illinois. Such medical malpractice insurance shall be in minimum amounts of \$1,000,000 per claim and \$3,000,000 aggregate.

**ADDITIONAL DESIRABLE CRITERIA:**

1. Affiliation with the teaching hospital of a medical school.
2. Member of a cystic fibrosis center.

**TYPE OF PROVIDER: Physician - Pediatric Rehabilitation**

**APPROVAL CRITERIA:**

1. Licensed by the State of Illinois or the state in which the medical services are being provided.
2. A member in good standing of the credentialed staff of the health care facility approved by DSCC for the services to be provided.
3. Certified by the American Board of Pediatrics.
4. A minimum of one year formal postgraduate training in the care of physically disabled/chronically ill children in a university based program in the United States or Canada, or, the equivalent of one year of full-time experience as a pediatric specialist in the multi-specialty care of physically disabled/chronically ill children.
5. Current active participation as a pediatric specialist with an organized hospital based or sponsored multi-medical specialty, service delivery program for physically disabled/chronically ill children.
6. Provide evidence of medical malpractice insurance by insurer licensed in Illinois. Such medical malpractice insurance shall be in minimum amounts of \$1,000,000 per claim and \$3,000,000 aggregate.

**ADDITIONAL DESIRABLE CRITERIA:**

1. Affiliated with the teaching hospital of a medical school.

2. Faculty appointment in a medical school.

**TYPE OF PROVIDER: Physician - Pediatric Rheumatology**

**APPROVAL CRITERIA:**

1. Licensed by the State of Illinois or the state in which the medical services are being provided.
2. A member in good standing of the credentialed staff of the health care facility approved by DSCC for the services to be provided.
3. Certified by the American Board of Pediatrics.
4. Two years postgraduate training in Pediatric Rheumatology in a university based program in the United States or Canada.
5. Provide evidence of medical malpractice insurance by insurer licensed in Illinois. Such medical malpractice insurance shall be in minimum amounts of \$1,000,000 per claim and \$3,000,000 aggregate.

**ADDITIONAL DESIRABLE CRITERIA:**

1. Affiliated with the teaching hospital of a medical school.
2. Faculty appointment in a medical school.

**TYPE OF PROVIDER: Physician - Pediatric Surgery**

**APPROVAL CRITERIA:**

1. Licensed by the State of Illinois or the state in which the medical services are being provided.
2. A member in good standing of the credentialed staff of the health care facility approved by DSCC for the services to be provided.
3. Certified by the American Board of Surgery, Inc.
4. At least 2 years formal subspecialty training in Pediatric Surgery in a university based program in the United States or Canada.
5. Patient caseload consisting of at least 80% pediatric surgery cases.
6. Provide evidence of medical malpractice insurance by insurer licensed in Illinois. Such medical malpractice insurance shall be in minimum amounts of \$1,000,000 per claim and \$3,000,000 aggregate.

**ADDITIONAL DESIRABLE CRITERIA:**

1. Affiliated with the teaching hospital of a medical school.
2. Faculty appointment in a medical school.

TYPE OF PROVIDER: **Physician - Physical Medicine and Rehabilitation**

APPROVAL CRITERIA:

1. Licensed in the State of Illinois or in the state in which the services are being provided.
2. A member in good standing of the credentialed staff of the health care facility approved by DSCC for the services to be provided.
3. Certification by the American Board of Physical Medicine and Rehabilitation, Inc.
4. At least 50% of practice involving rehabilitation of children with chronic illness and/or physical disabilities.
5. Provide evidence of medical malpractice insurance by insurer licensed in Illinois. Such medical malpractice insurance shall be in minimum amounts of \$1,000,000 per claim and \$3,000,000 aggregate.

ADDITIONAL DESIRABLE CRITERIA:

1. Formal pediatric postgraduate training.
2. Affiliated with a teaching facility associated with a medical school.
3. Faculty appointment in a medical school.

TYPE OF PROVIDER: **Physician - Plastic Surgery**

APPROVAL CRITERIA:

1. Licensed by the State of Illinois or the state in which the medical services are being provided.
2. A member in good standing of the credentialed staff of the health care facility approved by DSCC for the services to be provided.
3. Certified by the American Board of Plastic Surgery, Inc.
4. At least 30% of practice involves care of children.
5. Provide evidence of medical malpractice insurance by insurer licensed in Illinois. Such medical malpractice insurance shall be in minimum amounts of \$1,000,000 per claim and \$3,000,000 aggregate.

ADDITIONAL DESIRABLE CRITERIA:

1. Additional formal pediatric training and experience.
2. Member of multidisciplinary craniofacial disabilities team.
3. Affiliated with the teaching hospital of a medical school.
4. Faculty appointment in a medical school.

TYPE OF PROVIDER: **Physician - Plastic Surgery, Craniofacial**

APPROVAL CRITERIA:

1. Licensed by the State of Illinois or the state in which the services are being provided.
2. A member in good standing of the credentialed staff of the health care facility approved by DSCC for the services to be provided.
3. Certified by the American Board of Plastic Surgery, Inc.

4. One year additional postgraduate training and experience in craniofacial surgery in a university based program in the United States or Canada.
5. Member of craniofacial deformity team practicing in an approved center.
6. Provide evidence of medical malpractice insurance by insurer licensed in Illinois. Such medical malpractice insurance shall be in minimum amounts of \$1,000,000 per claim and \$3,000,000 aggregate.

**ADDITIONAL DESIRABLE CRITERIA:**

1. Affiliated with the teaching hospital of a medical school.
2. Faculty appointment in a medical school.

**TYPE OF PROVIDER: Physician - Rheumatology**

**APPROVAL CRITERIA:**

1. Licensed in the State of Illinois or the state in which the medical services are being provided.
2. Member in good standing of the credentialed staff of the health care facility approved by DSCC for the services to be provided.
3. Certified by the American Board of Internal Medicine with subspecialty certification in Rheumatology.
4. At least 30% of practice involving care of children.
5. Provide evidence of medical malpractice insurance by insurer licensed in Illinois. Such medical malpractice insurance shall be in minimum amounts of \$1,000,000 per claim and \$3,000,000 aggregate.

**ADDITIONAL DESIRABLE CRITERIA:**

1. Affiliated with the teaching hospital of a medical school.
2. Faculty appointment in a medical school.

**TYPE OF PROVIDER: Physician - Spinal Surgery**

**APPROVAL CRITERIA:**

1. Licensed by the State of Illinois or the state in which the services are being provided.
2. A member in good standing of the credentialed staff of the health care facility approved by DSCC for the services to be provided.
3. Certification by the American Board of Orthopedic Surgery.
4. Minimum of one year postgraduate subspecialty training in Spinal Surgery in a university based program in the United States or Canada.
5. At least 30% of practice involving spinal disorders of children.
6. Provide evidence of medical malpractice insurance by insurer licensed in Illinois. Such medical malpractice insurance shall be in minimum amounts of \$1,000,000 per claim and \$3,000,000 aggregate.

ADDITIONAL DESIRABLE CRITERIA:

1. Affiliated with the teaching hospital of a medical school.
2. Faculty appointment in a medical school.

TYPE OF PROVIDER: **Physician - Thoracic Surgery**

APPROVAL CRITERIA:

1. Licensed by the State of Illinois or the state in which the medical services are being provided.
2. A member in good standing of the credentialed staff of the health care facility approved by DSCC for the services to be provided.
3. Certified by the American Board of Thoracic Surgery.
4. Patient caseload shall consist of at least 25% pediatric cases.
5. Provide evidence of medical malpractice insurance by insurer licensed in Illinois. Such medical malpractice insurance shall be in minimum amounts of \$1,000,000 per claim and \$3,000,000 aggregate.

ADDITIONAL DESIRABLE CRITERIA:

1. Member of multidisciplinary team.
2. Affiliation with the teaching hospital of a medical school.
3. Extensive pediatric experience.

TYPE OF PROVIDER: **Physician - Urology**

APPROVAL CRITERIA:

1. Licensed by the State of Illinois or the state in which the medical services are being provided.
2. A member in good standing of the credentialed staff of the health care facility approved by DSCC for services to be provided.
3. Certified by the American Board of Urology.
4. Practice which consists of at least 50% pediatric patients, or, one year formal postgraduate training in Pediatric Urology in a university based program in the United States or Canada.
5. Provide evidence of medical malpractice insurance by insurer licensed in Illinois. Such medical malpractice insurance shall be in minimum amounts of \$1,000,000 per claim and \$3,000,000 aggregate.

ADDITIONAL DESIRABLE CRITERIA:

1. Member of multidisciplinary team.
2. Affiliated with the teaching hospital of a medical school.
3. Faculty appointment in a medical school.

**TYPE OF PROVIDER: Physician - Vascular Surgery**

**APPROVAL CRITERIA:**

1. Licensed by the State of Illinois or the state in which the services are being provided.
2. A member in good standing of the credentialed staff of the health care facility approved by DSCC for the services to be provided.
3. Certified by the American Board of Surgery with subspecialty certification in vascular surgery.
4. Provide evidence of medical malpractice insurance by insurer licensed in Illinois. Such Medical malpractice insurance shall be in minimum amounts of \$1,000,000 per claim and \$3,000,000 aggregate.

**ADDITIONAL DESIRABLE CRITERIA:**

1. Affiliation with the teaching hospital of a medical school.
2. Extensive pediatric experience.

**TYPE OF PROVIDER: Dentist - Endodontics**

**APPROVAL CRITERIA:**

1. Licensed as a dentist by the State of Illinois or the state in which the services are being provided.
2. Licensed as an endodontist by the State of Illinois or the state in which the services are being provided.
3. A member in good standing of the professional staff of the health care facility approved by DSCC for the services to be provided.
4. Provide evidence of medical malpractice insurance by insurer licensed in Illinois. Such medical malpractice insurance shall be in minimum amounts of \$1,000,000 per claim and \$3,000,000 aggregate.

**ADDITIONAL DESIRABLE CRITERIA:**

1. Member of multidisciplinary team.
2. Affiliated with medical/dental school.
3. Experience with pediatric population.

**TYPE OF PROVIDER: Dentist - Oral Surgery**

**APPROVAL CRITERIA:**

1. Licensed as a dentist by the State of Illinois or the state in which the services are being provided.
2. Licensed as an oral surgeon by the State of Illinois or the state in which the services are being provided.
3. Practice restricted to oral surgery.
4. Patient caseload consists of at least 20% pediatric cases.
5. A member in good standing of the professional staff of the health care facility approved by DSCC for the services to be provided.

6. Provide evidence of medical malpractice insurance by insurer licensed in Illinois. Such medical malpractice insurance shall be in minimum amounts of \$1,000,000 per claim and \$3,000,000 aggregate.

ADDITIONAL DESIRABLE CRITERIA:

1. Member of craniofacial anomalies team.
2. Affiliated with medical/dental school.
3. Extensive experience with pediatric population.
4. Extensive experience with patients with craniofacial anomalies.

TYPE OF PROVIDER: **Dentist - Orthodontics**

1. Licensed as a dentist by the State of Illinois or the state in which the services are being provided.
2. Licensed as an orthodontist by the State of Illinois or the state in which the services are being provided.
3. Minimum of 50% of practice involving children.
4. A member in good standing of the professional staff of the health care facility approved by DSCC for the services to be provided.
5. Provide evidence of medical malpractice insurance by insurer licensed in Illinois. Such medical malpractice insurance shall be in minimum amounts of \$1,000,000 per claim and \$3,000,000 aggregate.

ADDITIONAL DESIRABLE CRITERIA:

1. Member of craniofacial anomalies team.
2. Affiliated with medical/dental school.
3. Experience with craniofacial malformations.

TYPE OF PROVIDER: **Dentist - Pediatric Dentistry**

APPROVAL CRITERIA

1. Licensed as a dentist by the State of Illinois or the state in which the services are being provided.
2. Licensed as a Pediatric Dentist by the State of Illinois or the state in which the services are being provided.
3. A member in good standing of the professional staff of the health care facility approved by DSCC for the services to be provided.
4. Provide evidence of medical malpractice insurance by insurer licensed in Illinois. Such medical malpractice insurance shall be in minimum amounts of \$1,000,000 per claim and \$3,000,000 aggregate.

ADDITIONAL DESIRABLE CRITERIA:

1. Member of multidisciplinary team.
2. Affiliated with medical/dental school.

TYPE OF PROVIDER: **Dentist - Periodontics**

APPROVAL CRITERIA:

1. Licensed as a dentist by the State of Illinois or the state in which the services are being provided.
2. Licensed as a periodontist by the State of Illinois or the state in which the services are being provided.
3. A member in good standing of the professional staff of the health care facility approved by DSCC for the services to be provided.
4. Provide evidence of medical malpractice insurance by insurer licensed in Illinois. Such medical malpractice insurance shall be in minimum amounts of \$1,000,000 per claim and \$3,000,000 aggregate.

ADDITIONAL DESIRABLE CRITERIA:

1. Member of multidisciplinary team.
2. Affiliated with medical/dental school.
3. Experience with pediatric population.

TYPE OF PROVIDER: **Dentist - Prosthodontics**

APPROVAL CRITERIA:

1. Licensed as a dentist by the State of Illinois or the state in which the services are being provided.
2. Licensed as a prosthodontist by the State of Illinois or the state in which the services are being provided.
3. Patient caseload is at least 10% pediatric.
4. A member in good standing of the professional staff of the health care facility approved by DSCC for the services to be provided.
5. Provide evidence of medical malpractice insurance by insurer licensed in Illinois. Such medical malpractice insurance shall be in minimum amounts of \$1,000,000 per claim and \$3,000,000 aggregate.

ADDITIONAL DESIRABLE CRITERIA:

1. Member of craniofacial anomalies team.
2. Affiliated with medical/dental school.

**TYPE OF PROVIDER: Audiologist**

**APPROVAL CRITERIA:**

1. Master's degree in audiology and/or communication disorders from an ASHA accredited institution.
2. Licensed as an audiologist in Illinois or in the state in which services are being provided.
3. Minimum of two years paid professional experience in working with the pediatric population.
4. Patient caseload which consists of at least 50% pediatric patients.
5. Meet requirements of a hearing aid dispenser if hearing aid evaluations/fittings are being done.
6. Provide evidence of professional liability insurance by insurer licensed in the State of Illinois. Such professional liability insurance shall be in minimum amount of \$1,000,000 per claim and \$3,000,000 aggregate.

**DESIRABLE CRITERIA:**

1. Member of multidisciplinary team.
2. Affiliation with medical center/school.
3. CCC/A.

**TYPE OF PROVIDER: Genetic Counselor**

**APPROVAL CRITERIA:**

1. Master's degree with a major in genetics/genetic counseling.
2. Provide written evidence of certification in genetic counseling by the American Board of Genetic Counseling.
3. Provide evidence of professional liability insurance by insurer licensed in the State of Illinois. Such professional liability insurance shall be in minimum amount of \$1,000,000 per claim and \$3,000,000 aggregate.

**ADDITIONAL DESIRABLE CRITERIA:**

1. Affiliated with Regional Genetics Program.
2. Extensive pediatric experience.
3. Affiliation with the teaching hospital of a medical school.

**TYPE OF PROVIDER: Hearing Aid Dispenser**

**APPROVAL CRITERIA:**

1. Certified as a hearing aid dispenser by the Illinois Department of Public Health.
2. Provide evidence of professional liability insurance by insurer licensed in the State of Illinois. Such professional liability insurance shall be in minimum amount of \$1,000,000 per claim and \$3,000,000 aggregate.

**ADDITIONAL DESIRABLE CRITERIA:**

Extensive experience with pediatric population.

TYPE OF PROVIDER: **Occupational Therapist**

APPROVAL CRITERIA:

1. Bachelor's degree/certificate in occupational therapy.
2. Certification as occupational therapist, registered (OTR).
3. Licensed as an occupational therapist in the State of Illinois or the state in which the services are being provided (if license required by that state).
4. Equivalent of one years paid professional experience in working with physically disabled children; minimum of two years experience if performing wheelchair evaluations.
5. At least 20% of practice involves treatment of children.
6. Provide evidence of professional liability insurance by insurer licensed in the State of Illinois. Such professional liability insurance shall be in minimum amount of \$1,000,000 per claim and \$3,000,000 aggregate.

TYPE OF PROVIDER: **Ocularist**

APPROVAL CRITERIA:

1. Certified by the American Society of Ocularists.
2. Provide evidence of professional liability insurance by insurer licensed in the State of Illinois. Such professional liability insurance shall be in minimum amount of \$1,000,000 per claim and \$3,000,000 aggregate.

ADDITIONAL DESIRABLE CRITERIA:

Affiliation with medical center/school.

TYPE OF PROVIDER: **Orthotist**

APPROVAL CRITERIA:

1. Certified by American Board for Certification in Orthotics and Prosthetics, Inc.
2. Be an approved provider for the Illinois Department of Public Aid.
3. Be affiliated with a vending facility currently approved under the Facility Accreditation Program administered by the American Board for Certification in Orthotics and Prosthetics, Inc.
4. Provide evidence of professional liability insurance by insurer licensed in the State of Illinois. Such professional liability insurance shall be in minimum amount of \$1,000,000 per claim and \$3,000,000 aggregate.

ADDITIONAL DESIRABLE CRITERIA:

Working relationship/affiliation with rehabilitation/amputee center.

TYPE OF PROVIDER: **Physical Therapist**

APPROVAL CRITERIA:

1. Bachelor's degree/certificate in physical therapy.
2. Licensed by the State of Illinois or the state in which the services are being provided.
3. Equivalent of one years paid professional experience working exclusively with physically disabled children; minimum of two years experience if performing wheelchair evaluations.
4. At least 20% of practice involves treatment of children.
5. Provide evidence of professional liability insurance by insurer licensed in the State of Illinois. Such professional liability insurance shall be in minimum amount of \$1,000,000 per claim and \$3,000,000 aggregate.

DESIRABLE QUALIFICATIONS:

1. Member of multidisciplinary team.
2. Affiliation with medical center/school.

TYPE OF PROVIDER: **Prosthetist**

APPROVAL CRITERIA:

1. Certified by American Board for Certification in Orthotics and Prosthetics, Inc.
2. Be an approved provider of the Illinois Department of Public Aid.
3. Be affiliated with a vending facility approved under the Facility Accreditation Program administered by the American Board for certification in Orthotics and Prosthetics, Inc.
4. Provide evidence of professional liability insurance by insurer licensed in the State of Illinois. Such professional liability insurance shall be in minimum amount of \$1,000,000 per claim and \$3,000,000 aggregate.

ADDITIONAL DESIRABLE CRITERIA:

Working relationship/affiliation with rehabilitation/amputee center.

TYPE OF PROVIDER: **Speech - Language Pathologist**

APPROVAL CRITERIA:

1. Master's degree in speech pathology and/or communication disorders from an ASHA accredited institution.
2. Minimum of two years paid professional experience in working with physically disabled children, including a supervised clinical fellowship year.
3. Patient population consists of at least 80% pediatric cases.

4. Licensed as a speech language pathologist.
5. Provide evidence of professional liability insurance by insurer licensed in the State of Illinois. Such professional liability insurance shall be in minimum amount of \$1,000,000 per claim and \$3,000,000 aggregate.

**DESIRABLE QUALIFICATIONS:**

1. Member of multidisciplinary team.
2. Extensive experience with organic speech problems.
3. Affiliation with medical center/school.
4. Certificated by the Illinois State Board of Education.
5. CCC/SP.

**TYPE OF PROVIDER: Teacher of the Blind**

**APPROVAL CRITERIA:**

1. Bachelor's degree in education of the blind.
2. Certified as a teacher of the blind by the Illinois State Board of Education.
3. Minimum of two years paid professional experience in working with physically disabled children who are blind.
4. Provide evidence of professional liability insurance by insurer licensed in the State of Illinois. Such professional liability insurance shall be in minimum amount of \$1,000,000 per claim and \$3,000,000 aggregate.

**TYPE OF PROVIDER: Teacher of the Deaf**

**APPROVAL CRITERIA:**

1. Bachelor's degree in deaf education.
2. Certified as a teacher of the deaf by the Illinois State Board of Education.
3. Minimum of two years paid professional experience in working with children with hearing disorders.
4. Provide evidence of professional liability insurance by insurer licensed in the State of Illinois. Such professional liability insurance shall be in minimum amount of \$1,000,000 per claim and \$3,000,000 aggregate.

**TYPE OF CENTER: Cardiac Center and Cardiac Center Affiliate**

**APPROVAL CRITERIA:**

The document Standards for Pediatric Cardiology Diagnostic and Treatment Centers is maintained in the Central Administrative Office. Inquiries about cardiac center standards should be directed to the DSCC Health Care Provider Liaison in the Central Administrative Office.

**TYPE OF TEAM: Cleft Lip/Palate and Craniofacial Anomalies Teams**

## APPROVAL CRITERIA:

A **cleft lip/palate core team** must include a DSCC credentialed:

1. plastic surgeon,
2. speech-language pathologist,
3. dental specialist (usually a pediatric dentist or orthodontist), and
4. otologist or audiologist.

It is important that a credentialed geneticist and a credentialed oral surgeon also be available as needed. Other members (non-credentialed) who should be available when required include:

1. primary care physician (preferably a pediatrician)
2. psychologist
3. nurse
4. social worker

In addition to the above listed specialists, a **craniofacial anomalies core team** must also include a DSCC credentialed:

1. neurological surgeon,
2. neurologist,
3. ophthalmologist, and
4. plastic surgeon who meets the requirements for a craniofacial plastic surgeon.

Before a team can be approved for participation in the care of DSCC patients, information must be obtained that indicates:

1. the core team meets together on a regularly scheduled basis,
2. the team conducts and records interdisciplinary staffings, and
3. non-credentialed team members (nurses, psychologists, etc.) meet team standards and all applicable licensing and regulatory requirements of the state in which the services are provided.

## TYPE OF TEAM: **Cochlear Implant Team**

### APPROVAL CRITERIA:

A DSCC credentialed cochlear implant team must include DSCC credentialed:

1. cochlear implant otologist,
2. audiologist,
3. speech-language pathologist, and
4. deaf educator.

Additionally, the team must include the following non-credentialed specialists:

1. psychologist

2. social worker.

Before a team can be approved for participation in the care of DSCC patients, information must be obtained that indicates the team:

1. is a coordinated, single center team, and
2. has current experience with cochlear implantation.

**TYPE OF CENTER: Cystic Fibrosis Center**

**APPROVAL CRITERIA:**

DSCC approval of a cystic fibrosis center or center satellite requires:

1. center/satellite approval by the National Cystic Fibrosis Foundation, and
2. DSCC approval of all physicians and staff in specialties approved by DSCC (e.g., pediatric pulmonology, pediatric gastroenterology, pediatric rehabilitation).

**TYPE OF CENTER: Epilepsy Surgery Center**

**APPROVAL CRITERIA:**

The document Standards for Epilepsy Surgery Centers for Children is maintained in the Central Administrative Office. Inquiries should be directed to the DSCC Health Care Provider Liaison in the Central Administrative Office.

**TYPE OF CENTER: Genetic Evaluation Center**

**APPROVAL CRITERIA:**

DSCC approval of a genetic evaluation center requires:

1. center approval by the Illinois Department of Public Health, and
2. approval of physicians and staff in disciplines approved by DSCC, e.g., medical genetics, endocrinology (pediatric preferred), genetic counselor.

**TYPE OF CENTER: Hemophilia Center**

**APPROVAL CRITERIA:**

DSCC approval of a hemophilia center requires:

1. certification of the center by the Illinois Department of Human Services and
2. approval of physicians and staff in disciplines usually approved by DSCC, e.g., pediatric hematology, physical therapy, occupational therapy.

**TYPE OF TEAM: Selective Posterior Rhizotomy Team**

**APPROVAL CRITERIA:**

A selective posterior rhizotomy team must include a DSCC credentialed:

1. neurological surgeon,
2. orthopedic surgeon,
3. pediatric physiatrist (physical medicine and rehabilitation) or pediatric rehabilitation specialist,
4. physical therapist.

Credentialed specialists who must be available as needed include:

1. neurologist and
2. occupational therapist.

Non-credentialed members who should be available when required include:

1. psychologist
2. social worker.

Before a team can be approved for participation in the care of DSCC patients, information must be obtained that indicates:

1. the core team meets together on a regularly scheduled basis,
2. the team conducts and records interdisciplinary staffings,
3. non-credentialed team members (psychologist, social worker) meet team standards and all applicable licensing and regulatory requirements of the state in which the services are provided, and
4. the team members have experience with the rehabilitation process and understand expected outcomes of children following selective posterior rhizotomy.

**TYPE OF GROUP: Center or Hospital Based Therapy Group**

**APPROVAL CRITERIA:**

See DSCC Policy 98-1, Authorization to Center Based Therapy Groups for additional guidance. DSCC approval of a center or hospital based therapy group requires that:

1. the center is approved by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the American Osteopathic Association (AOA), or the Commission on the Accreditation of Rehabilitation Facilities (CARF),
2. the center, if a hospital, has a physically definable pediatric unit to which only children are admitted, or if in an outpatient rehabilitation facility, has a physically definable pediatric unit in which only children are treated,
3. the center employs a minimum of four therapists in the particular discipline being considered for authorization (at least one of these therapists must be credentialed as an approved DSCC provider of therapy in this discipline),

4. all therapists providing services in this discipline have professional liability insurance coverage in amounts required for their discipline, either through individual policies or through coverage provided by the center for its employees, and
5. a supervisor or senior member of the center (or department) staff who has authority to do so affirms that all services to DSCC clients will be provided by, or directly supervised by a therapist credentialed by DSCC in the therapist's discipline.