
Overview

Credentialing is the process used by the Plan to evaluate the qualifications and credentials of providers, physicians, allied health professionals, hospitals and ancillary facilities/health care delivery organizations. Providers are required to be credentialed prior to being listed as participating network providers of care or services to Plan members.

The Credentialing department or its designee is responsible for gathering all relevant information and documentation through a formal application process. Primary source verifications are obtained in accordance with all accreditation agency requirements and Plan policies and procedures. An appropriate professional review body of the Plan evaluates the background, education, training, board certification, experience, demonstrated ability, patient-admitting capabilities, licensure, regulatory compliance, health status, and as applicable to provider type, accreditation status of each individual applicant.

Satisfactory site-inspection evaluations are required to be made at the office locations of all PCPs, and Obstetrics and Gynecology specialist physicians' offices. Some facilities also need a site-inspection evaluation to be completed, relative to accreditation status.

Credentialing may be done directly by the Plan or by an entity approved by the Plan for delegated credentialing. Prior to delegation of credentialing to an outside agency, the Plan will evaluate and establish that the entity clearly meets all regulatory requirements and is able to perform credentialing consistent with plan policies and procedures.

All participating providers or entities delegated for credentialing are to use the same standards as defined in this section. Compliance is monitored on a regular basis and formal audits are conducted annually. Ongoing oversight includes regular exchanges of network information, and the annual review of policies and procedures and credentialing forms and files.

Applicants Right to be Informed of Credentialing Application Status

Practitioners have the right to be informed of the status of their credentialing or re-credentialing application upon request. Upon receipt of a written request, the Plan will provide practitioners with the status of their credentialing or re-credentialing application within 15 business days. The information provided by the Plan will advise of any items still needing to be verified, of instances of non-response from the provider in obtaining verifications, and any discrepancies in verification information received compared to information provided by the provider. Status requests should be e-mailed to credentialing@wellcare.com.

Applicant's Right to Review Credentialing Information

Practitioners have the right to review information submitted in support their credentialing or re-credentialing application. Practitioners may review any documentation submitted by them in support of their credentialing or re-credentialing application, together with any discrepant information relating, but not limited to - education or training; liability claims history; state licensing; certification boards; professional societies, etc. Peer review information obtained by the Plan may not be reviewed by the provider.

Applicant's Right to Correct Credentialing Information

Practitioners have the right to correct erroneous information and receive notification of the process and timeframe.

- In the event the credentials verification processes reveal information submitted by a practitioner that differs from the verification information obtained by the Plan, the practitioner is allowed to submit corrections for the erroneous information. Discrepancies will be notified by the Plan to the practitioner in writing within 15 business days.

The Plan's notification communication will include:

- the nature of the discrepant information;
- the process for correcting erroneous information submitted by another source;

- the format for submitting corrections;
- the timeframe for submitting the corrections;
- the addressee to whom corrections must be sent;
- the Plan's documentation process for receipt of the corrected information from the applicant;
- the Plan's review process.

The Plan's notification process will include:

- a cover sheet indicating the name and address of the person to whom a response should be sent;
- a copy of the application with the discrepant information identified;
- a request to make the necessary corrections on the page(s) provided, to initial and date the corrected information and return the documentation to the Plan together with a written explanation within fifteen business days of receipt of the request;
- a request that the correction information be mailed to the Credentialing Specialist named on the cover sheet at the address also provided on the cover sheet;
- upon receipt of the correction information by the Plan, the completed credentialing application which includes the appropriate verifications and also the correction information provided by the practitioner is then submitted through the Plan's credentialing approval process;

- o notification of the credentialing decision is provided to the practitioner within applicable state required notification timeframes. In the absence of a state required notification timeframe, notifications are made within 60-days.

Any questions or concerns regarding the credentialing processes should be emailed to the Credentialing department at credentialing@wellcare.com.

Baseline Criteria

Baseline criteria for provider network participation:

License to Practice

Practitioners must have a current valid license to practice;

Board Certification

Physicians (M.D., D.O., D.P.M.) maintain Board Certification in the specialty being practiced as a provider for the Plan or accredited training that renders a physician eligible to sit for the Board Certification examination;

Hospital Admitting Privileges

Specialist practitioners shall have hospital admitting privileges at a Plan participating hospital (as applicable to specialty). PCPs may have hospital admitting privileges or may enter into a formal agreement with another Plan participating practitioner who has admitting privileges at a Plan participating hospital, for the admission of members.

Professional Liability Insurance

Plan providers (all disciplines) shall be required to carry and continue to maintain professional liability insurance in the following required limits:

Individual Practitioners

\$1,000,000 per occurrence;
\$3,000,000 aggregate;

Allied Mental Health Practitioners

\$1,000,000 per occurrence;
\$1,000,000 aggregate.

Covering Physicians

PCPs in solo practice must have a Plan participating covering physician willing to care for their members in their absence.

Allied Health Practitioners

Allied Health Professionals (AHPs), both dependent and independent, are credentialed by the Plan.

Dependent AHPs include the following, and are required to provide collaborative practice information to the Plan:

- Advanced Registered Nurse Practitioner (ARNP)
- Certified Nurse Midwife (CNM)
- Physician Assistant (PA)
- Osteopathic Assistant (OA)

Independent AHPs included, but not limited to the following:

- Licensed clinical social worker
- Licensed mental health counselor
- Licensed marriage and family therapist
- Physical therapist
- Occupational therapists
- Audiologist
- Speech/Language therapist/pathologist

Ancillary Health Care Delivery Organizations

Ancillary facilities, or health care delivery organizations, must complete a credentialing application and provide information on accreditation, licensure, regulatory status, claims history, liability insurance coverage and rating. In addition, depending on accreditation and/or Medicaid

status, a site-inspection evaluation may be required as part of the credentialing process.

Re-Credentialing

In accordance with state requirements and Plan policy and procedure, re-credentialing of all provider types shall be conducted at least once every three years.

Updated Documentation

Providers must furnish copies of current Professional Liability Insurance, License, DEA Certificate and Accreditation information, as applicable, to the Plan, prior to or concurrent with expiration.

Office of Inspector General Medicaid Sanctions Report

On a regular and ongoing basis, the Plan accesses the listings from the Department of Health and Human Services, Office of Inspector General Medicaid Sanctions (exclusions and reinstatements) Report, and the state's list of excluded providers for the most current available information. This information is cross-checked against the network of Plan providers. If providers are identified as being currently sanctioned, such providers are subject to immediate suspension. Notifications of termination of contract are given in accordance with Plan policies and procedures.

Hearing and Appellate Review

A practitioner whose provider status with the Plan is recommended for termination for reason(s) that may require a report to be made to the National Practitioner Data Bank shall be entitled to a hearing and appellate review.

Notification of the termination recommendation, together with reasons for the action, hearing and appellate review rights and the process for obtaining a hearing and appellate review, shall be provided to the practitioner within 30 days of the date of the termination recommendation. Notification to the practitioner shall be mailed by certified return receipt mail.

The practitioner shall have a period of 30 days in which to file a written request for a hearing and appellate

review. The request shall be mailed via certified return receipt mail.

Upon timely receipt of the request, the Chief Executive Officer or his designee shall notify the practitioner of the date, time and place of the hearing. Such hearing shall not take place less than 30 days from the date of the notice of the hearing.

The practitioner and the Plan shall be entitled to legal representation at the hearing. The practitioner has the burden of proving by clear and convincing evidence that the reason for the termination recommendation lacks any factual basis, or that such basis or the conclusion(s) drawn there-from, are arbitrary, unreasonable or capricious.

The Hearing and Appellate Review Committee shall consider and decide the case objectively and in good faith. Within 30 days after final adjournment of the hearing and appellate review, the Committee shall make a written report and forward its decision to the Plan's Quality Improvement Committee. Notification of the Plan's final decision will be provided to the practitioner within 30 days.