
Overview

Credentialing is the process by which the appropriate peer review bodies of the Plan evaluate the credentials and qualifications of providers, including physicians, allied health professionals, hospitals and ancillary facilities/health care delivery organizations.

This includes (as applicable to provider type):

- Background;
- Education;
- Postgraduate training;
- Experience;
- Work history and demonstrated ability;
- Patient admitting capabilities;
- Licensure, regulatory compliance and health status which may affect a practitioner's ability to provide health care; and
- Accreditation status, as applicable to non-individuals.

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. The practitioner credentialing application must be attested to by the applicant as being correct and complete. The application captures professional credentials and contains a questionnaire section that asks for professional liability claims history and suspension or restriction of hospital privileges, licensure, DEA certification or Medicare/Medicaid sanctions.

Primary source verifications are obtained in accordance with state and federal regulatory agencies, accreditation and Plan policy and procedure requirements, and include a query to the National Practitioner Data Bank.

Physicians, allied health professionals and ancillary facilities/health care delivery organizations are required to be credentialed in order to be network providers of services to Plan members.

Satisfactory site inspection evaluations are required to be performed in accordance with state, federal and accreditation requirements.

After the credentialing process has been completed, notification of the credentialing decision is forwarded to the provider within 60 calendar days of the committee's decision.

Credentialing may be done directly by the Plan or by an entity approved by the Plan for delegated credentialing. In the event that credentialing is delegated to an outside agency, the Plan is required to establish that the credentialing capabilities of the delegated entity clearly meet state, federal, accreditation (as applicable) and Plan requirements. 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, credentialing forms and files.

Practitioner's Right to Be Informed of Credentialing/ Re-Credentialing Application Status

Written requests may be emailed to credentialing@wellcare.com. Upon receipt of a written request, the Plan will provide written information to the practitioner on the status of the credentialing/re-credentialing application, generally within 15 business days. The information provided will advise of any items still needing to be verified, any non-response in obtaining verifications and any discrepancies in verification information received compared with the information provided by the practitioner.

**Practitioner's
Right to Review
Information
Submitted in
Support of
Credentialing/
Re-Credentialing
Application and
Right to Correct
Erroneous
Credentialing/
Re-Credentialing
Information**

In the event the credentials verification process reveals information submitted by the practitioner that differs from the verification information obtained by the Plan, the practitioner has the right to review the information that was submitted in support of his/her application, and has the right to correct the erroneous information. The Plan will provide written notification to the practitioner of the discrepant information.

The Plan's written notification to the practitioner includes:

- The nature of the discrepant information;
- The process for correcting the erroneous information submitted by another source;
- The format for submitting corrections;
- The time frame for submitting the corrections;
- The addressee in Credentialing to whom corrections must be sent;
- The Plan's documentation process for receiving the correction information from the practitioner; and
- The Plan's review process.

The practitioner may review documentation submitted by himself/herself in support of the application/re-credentialing application, together with any discrepant information received from professional liability insurance carriers, state licensing agencies and certification boards, subject to any restrictions of the Plan. The Plan, or its designee, will review the corrected information and explanation at the time of considering the practitioner's credentials for provider network participation or re-credentialing.

The practitioner may not review peer review information obtained by the Plan.

**Baseline
Criteria**

Baseline criteria for provider network participation:

License to Practice

Practitioners must have a current valid license to practice;

DEA Certificate

Physicians (M.D., D.O., D.P.M.), as applicable to specialty, must have a current DEA Certificate;

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; Primary Care Physicians in the specialties of Pediatrics and Family Practice participating with Healthy Kids must maintain board certification, unless granted a board certification exemption/waiver by the Agency for Health Care Administration (AHCA).

Hospital Admitting Privileges

Practitioners (as applicable to specialty) shall have hospital admitting privileges at a Plan participating hospital. PCP's who do not have hospital admitting privileges shall have a formal agreement with another Plan participating practitioner who has admitting privileges at a Plan participating hospital.

**Florida Patient's
Bill of Rights &
Responsibilities**

Plan providers are required to prominently display a copy of the summary of the Florida Patient's Bill of Rights and Responsibilities in the waiting room or reception area, for the benefit of members. Providers are also required to have a complete copy of the Florida Patient's Bill of Rights and Responsibilities available upon request by the member, at each of the provider's locations.

**AHCA's Statewide
Consumer Call
Center &
Consumer
Assistance Notice**

Plan providers are required to prominently display the Consumer Assistance Notice and the AHCA's Consumer Call Center telephone number, including the hours of operation, in the provider's waiting room or reception area, for the benefit of members.

Liability Insurance

Plan providers (all disciplines) are required to carry and continue to maintain professional liability insurance in the minimum limits of \$250,000/\$750,000.

Providers must furnish copies of current professional liability insurance certificate to the Plan, concurrent with expiration.

**Site Inspection
Evaluation (SIE)**

In accordance with Florida Medicaid Managed Care requirements, a site inspection evaluation (SIE) is required for all primary care physicians, obstetrics and gynecology specialists, high-volume behavioral health practitioners and, as applicable, unaccredited facilities at the time of initial contracting as well as periodically in accordance with the re-credentialing cycle.

**Covering
Physicians**

Primary care physicians in solo practice must have a covering physician who also participates or is credentialed with the Plan.

**Allied Health
Professionals**

Allied health professionals (AHP's), both dependent and independent, are credentialed by the Plan.

Dependent AHP's include the following, and are required to provide collaborative practice information to the Plan:

- Advanced registered nurse practitioners (ARNP)
- Certified nurse midwife (CNM)
- Physician assistant (PA)
- Osteopathic assistant (OA)

Independent AHP's include, but are not limited to the following:

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

**Ancillary
Health Care
Delivery
Organizations**

Ancillary and organizational applicants must complete an application and, as applicable, undergo a SIE if unaccredited. The Plan is required to verify accreditation, licensure, regulatory status and liability insurance coverage, prior to accepting the applicant as a Plan provider.

Re-Credentialing

In accordance with regulatory, accreditation and Plan policy and procedure, re-credentialing shall be conducted at least once every three years.

**Updated
Documentation**

Providers must furnish copies of current professional or general liability insurance, license, DEA certificate and accreditation information (as applicable to provider type) to the Plan, prior to or concurrent with expiration.

**Office of Inspector
General
Medicare/Medicaid
Sanctions Report**

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

**Sanction Reports
Pertaining to
Licensure, Hospital
Privileges or Other
Professional
Credentials**

On a regular and ongoing basis, the Plan contacts state licensure agencies to obtain the most current available information on sanctioned providers. This information is cross-checked against the network of Plan providers. If a network provider is identified as being currently under sanction, appropriate action is taken in accordance with Plan policy and procedure. If the sanction imposed is revocation of license, the provider is subject to immediate termination. Notifications of termination are given in accordance with contract and Plan policies and procedures.

In the event a sanction imposes a reprimand or probation, written communication is made to the provider requesting a full explanation, which is then reviewed by the Credentialing/Peer Review Committee. The committee makes a determination as to whether the provider should continue participation or whether termination should be initiated.

**Hearing and
Appellate Review**

The Plan has a defined Hearing and Appellate Review policy and procedure it applies whenever the Plan chooses to alter the conditions of participation of a practitioner based on issues of quality of care, conduct or service. These are reportable to regulatory agencies.

The following recommendations or actions entitle the practitioner affected thereby to a Hearing and Appellate Review:

- Non-renewal of participating practitioner status at time of re-credentialing for reasons associated with clinical care, conduct or service or for such reasons that may require a report to be made to the National Practitioner Data Bank;
- Suspension of participating practitioner status for reasons associated with clinical care, conduct or service, or for such reasons that may require a report to be made to the National Practitioner Data Bank; or
- Revocation of participating practitioner status

for reasons associated with clinical care, conduct or service or for such reasons that may require a report to be made to the National Practitioner Data Bank.

Notification of the adverse 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/her 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 Quality Improvement Committee. Notification of the Plan's final decision will be provided to the practitioner within 30 days.

**Delegated
Entities**

All participating providers or entities delegated for credentialing are to use the same standards as defined in this section. Compliance is monitored on a monthly basis and formal audits are conducted annually.