
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, surgery centers, home health agencies, skilled nursing facilities and other ancillary facilities/health care delivery organizations.

This includes (as applicable to provider type):

- Background;
- Education;
- Postgraduate training;
- Certification;
- 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, a timely notification of the credentialing decision is forwarded to the provider.

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 e-mailed 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 unrestricted license to practice.

Drug Enforcement Administration Certificate

Practitioners must have a current valid DEA Certificate (as applicable to practitioner specialty).

Board Certification

Physicians (M.D., D.O., D.P.M.) must maintain Board Certification in the specialty being practiced as a provider for the Plan; or must have 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.

Ability to Participate in Medicaid and Medicare

Providers must have the ability to participate in Medicaid and Medicare. Any individual or entity excluded from participation in any government program is not eligible for participation in any Company Plan. Existing providers who are sanctioned and thereby restricted from participation in any government program are subject to immediate termination in accordance with Plan policy and procedure.

Practitioners that Opt-Out of Medicare

A practitioner who opts-out of Medicare is not eligible to become a participating provider. An existing provider who opts-out of Medicare is not eligible to remain as a participating provider for the Plan.

At the time of initial credentialing, the Plan reviews the

State-specific opt-out listing maintained on the designated State Carrier's Web site to determine whether a practitioner has opted out of Medicare. Ongoing/quarterly monitoring of the opt-out Web site is performed by the Plan.

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 and obstetrics and gynecology specialists, 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, Medicare certification (as applicable), 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 is required 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.

**Participating
Provider Appeal
through the
Dispute Resolution
Peer Review
Process**

The Plan may immediately suspend, pending investigation, the participation status of a participating provider who in the opinion of the Medical Director is engaged in behavior or who is practicing in a manner that appears to pose a significant risk to the health, welfare, or safety of members. In such instances, the Medical Director investigates on an expedited basis.

The Plan has a Participating Provider Dispute Resolution Peer Review Panel process for whenever the Plan chooses to alter the conditions of participation of a practitioner based on issues of quality of care, conduct or service, and if such process is implemented, may result in reporting to regulatory agencies.

The Provider Dispute Resolution Peer Review process has two levels. All disputes in connection with the actions listed below are referred to a first level Peer Review Panel consisting of at least three qualified individuals of which at least one is a participating provider and a clinical peer of the practitioner that filed the dispute.

The practitioner also has the right to consideration by a second level Peer Review Panel consisting of at least three qualified individuals of which at least one is a participating provider and a clinical peer of the practitioner that filed the dispute, and the second level panel is comprised of individuals who were not involved in earlier decisions.

The following actions by the Plan entitle the practitioner affected thereby to the Provider Dispute Resolution Peer Review Panel Process.

- Suspension of participating practitioner status for reasons associated with clinical care, conduct or service; or
- Revocation of participating practitioner status for reasons associated with clinical care, conduct or service; or
- Non-renewal of participating practitioner status

at time of re-credentialing for reasons associated with clinical care, conduct; service or excessive claims and/ or sanction history;

Notification of the adverse recommendation, together with reasons for the action, and the practitioners rights and process for obtaining the first and or second level Dispute Resolution Peer Review Panel processes, are provided to the practitioner Notification to the practitioner will be mailed by overnight recorded or certified return-receipt mail.

The practitioner has a period of up to 30 days in which to file a written request via recorded or certified return receipt mail to access the Dispute Resolution Peer Review Panel process, .

Upon timely receipt of the request, the Medical Director or his/her designee shall notify the practitioner of the date, time and telephone access number for the Panel hearing. The Plan then notifies the provider of the schedule for the Review Panel hearing.

The practitioner and the Plan are 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 Dispute Resolution Peer Review Panel shall consider and decide the case objectively and in good faith. The Medical Director, within five business days after final adjournment of the Dispute Resolution Peer Review Panel hearing, shall notify the practitioner of the results of the first level Panel hearing. In the event the findings are positive for the practitioner, the second level review shall be waived.

In the event the findings of the first level Panel hearing are adverse to the practitioner, the practitioner may access the second level Peer Review Panel by following the notice information contained in the letter notifying the practitioner of the adverse determination

of the first level Peer Review Panel.

Upon timely receipt of the request for a second level Peer Review Panel hearing, the Medical Director or his/her designee shall notify the practitioner of the date, time and access number for the second level Peer Review Panel hearing.

The second level Dispute Resolution Peer Review Panel shall consider and decide the case objectively and in good faith. The Medical Director, within 5 business days after final adjournment of the second level Dispute Resolution Peer Review Panel hearing, shall notify the practitioner of the results of the second level Panel hearing via certified or overnight recorded delivery mail. In the event the findings of the second level Peer Review Panel result in an adverse determination for the provider, the findings of the second level Peer Review Panel shall be final.

A practitioner who fails to request the Provider Dispute Resolution Peer Review Process within the time and in the manner specified waives any right to such Review to which he/she might otherwise have been entitled. The Plan may proceed to implement the termination and make the appropriate report to the National Practitioner Data Bank and State Licensing Agency as appropriate and if applicable.

**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/quarterly basis and formal audits are conducted annually.