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Overview

Credentialing is the process used by the Plan to evaluate the qualifications and credentials of providers, i.e., 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 is responsible for gathering all relevant information and documentation through a formal application process. Primary source verifications are obtained in accordance with federal, state and accreditation agency requirements and Plan policy and procedure. 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 primary care physicians (PCPs) and Obstetrics and Gynecology specialist physicians' offices and high volume behavioral health providers. 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 evaluates and establishes that the entity clearly meets all regulatory requirements and is able to perform credentialing consistent with the Plan's 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, documents and files.

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Applicants Right to be Informed of Credentialing Application Status

An applicant has the right to be informed of the status of credentialing. Upon receipt of a written request, the Plan will provide written information to the applicant of the status of the credentialing application, generally within 15 business days. The information provided will advise of items still needing to be verified, any non-response in obtaining verifications, and any discrepancies in verification information received compared to information provided by the applicant.

Applicants Right to Review and Correct Erroneous Credentialing Information

In the event the credentials verification process reveals information submitted by the applicant that differs from the verification information obtained by the Plan.

The Plan's notification to the applicant 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 receiving the correction information from the applicant; and
- The Plan's review process.

The applicant may review certain documentation submitted by him/her in support of the 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 applicant may not review peer review information obtained by the Plan.

The Plan, or its designee will review corrected information and explanation at the time of considering

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the applicants credentials for provider network participation.

Baseline Criteria

Baseline criteria for applicants to enter the credentialing process:

License to Practice

Practitioners must have a current valid unrestricted license to practice;

Drug Enforcement Agency Certificate

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

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). PCP's 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 WellCare 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

Practitioners are not eligible to become participating providers with the Plan if they have opted-out of

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Medicare. The Plan at the time of initial credentialing reviews the State-specific Opt-out Listing maintained on the designated State Carrier's website, to determine whether a practitioner has opted-out of Medicare. Ongoing monthly/quarterly monitoring of the State specific Opt-Out website is performed by the Plan.

Professional Liability Insurance

Plan providers (all disciplines) are required to carry and continue to maintain professional liability insurance in the industry standard limits as defined by the state of practice.

Covering Physicians

Primary Care Physicians in solo practice must have a Plan-participating covering physician willing to care for their members in their absence.

Allied Health Practitioners

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

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

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

Independent AHPs 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 Facility/Health Care Delivery Organizations must complete a credentialing application and provide information on accreditation, license, regulatory status, claims history, liability insurance coverage and rating. In addition, depending on accreditation and/or Medicare/Medicaid status, a site-inspection evaluation may be required as part of the credentialing process.

Re-Credentialing

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

**Updated
Documentation**

Providers must provide evidence of current Professional Liability Insurance, and maintain License, and DEA Certification, (as applicable to provider type) prior to or concurrent with expiration.

**Office of
Inspector General
Medicare
Sanctions Report**

On a regular and ongoing basis, the Plan accesses the listings of the Health and Human Services Office of Inspector General Medicare Sanctions (exclusions and reinstatements) Report, and the State's list of excluded providers. This information is crosschecked against the network of Plan providers. If providers are identified as being currently sanctioned, such providers are subject to immediate termination. 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 consistent with the following:

- 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

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the date of the termination recommendation.

- The practitioner shall have a period of 30 calendar days in which to file a written request for a hearing and appellate review. The request shall be sent via certified return receipt mail.
- Upon timely receipt of the request, the Plan 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 personal appearance of the practitioner requesting the hearing and appellate review shall be required. A practitioner who fails, without good cause, to appear and proceed at such hearing shall be deemed to have waived rights to a hearing and appellate review.
- 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. Notification of the Plan's final decision will be provided to the practitioner within 30 days of appeal request.

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