
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- or secondary-source verifications are obtained in accordance with federal, state and accreditation agency requirements and Plan policies and procedures. An appropriate professional review body of the Plan evaluates the background, education, training, board certification, experience, work history and demonstrated ability, patient-admitting capabilities, licensure, regulatory compliance and health status, and accreditation status as applicable to non-individuals.

Satisfactory site inspection evaluations are made at the primary care, 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 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, procedures, credentialing forms, documents and files.

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

A practitioner 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 practitioner 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 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 credential-verification process reveals information submitted by the practitioner that differs from the verification information obtained by the Plan, the practitioner shall be notified in writing by the Plan within 15 business days and shall be allowed to submit a correction for the erroneous information. The Plan will provide written notification to the practitioner of the discrepant information.

The Plan's notification to the practitioner includes:

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

The practitioner may review certain documentation submitted by him/her 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.

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 provider 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 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.

Professional Liability Insurance

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

Covering Physicians

Primary-care physicians (PCPs) in a solo practice must have a Plan-participating covering physician willing to care for their members in their absence.

Allied Health Professionals

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 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 Facility/ Health Care Delivery Organizations

Ancillary facilities and health care delivery organizations must complete a credentialing application and provide information on accreditation, licensure, regulatory status and liability insurance coverage. 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 regulatory 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 Medicaid Sanctions Report	On a regular and ongoing basis, the Plan accesses the listings of 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. This information is crosschecked against the network of Plan providers. If providers are identified as being currently sanctioned, such providers are subject to immediate suspension and termination. Notifications of termination of contract are given in accordance with Plan policies and procedures.
Hearing and Appellate Review	<p>The Plan has a clearly defined hearing and appellate review policy and procedure that 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, which are reportable to regulatory agencies.</p> <p>The Plan makes available the hearing and appellate review process to practitioners whenever the plan chooses to alter a practitioner's conditions of participation based on issues of quality of care, conduct or service provided.</p> <p>The following recommendations or actions entitle the practitioner affected thereby to a hearing and appellate review:</p> <ul style="list-style-type: none">• 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;
- 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.

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 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 mailed via certified return-receipt mail.

Upon timely receipt of the request, the chief executive officer or a 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 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. 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 QI Committee. Notification of the Plan's final decision will be provided to the practitioner within 30 days.

