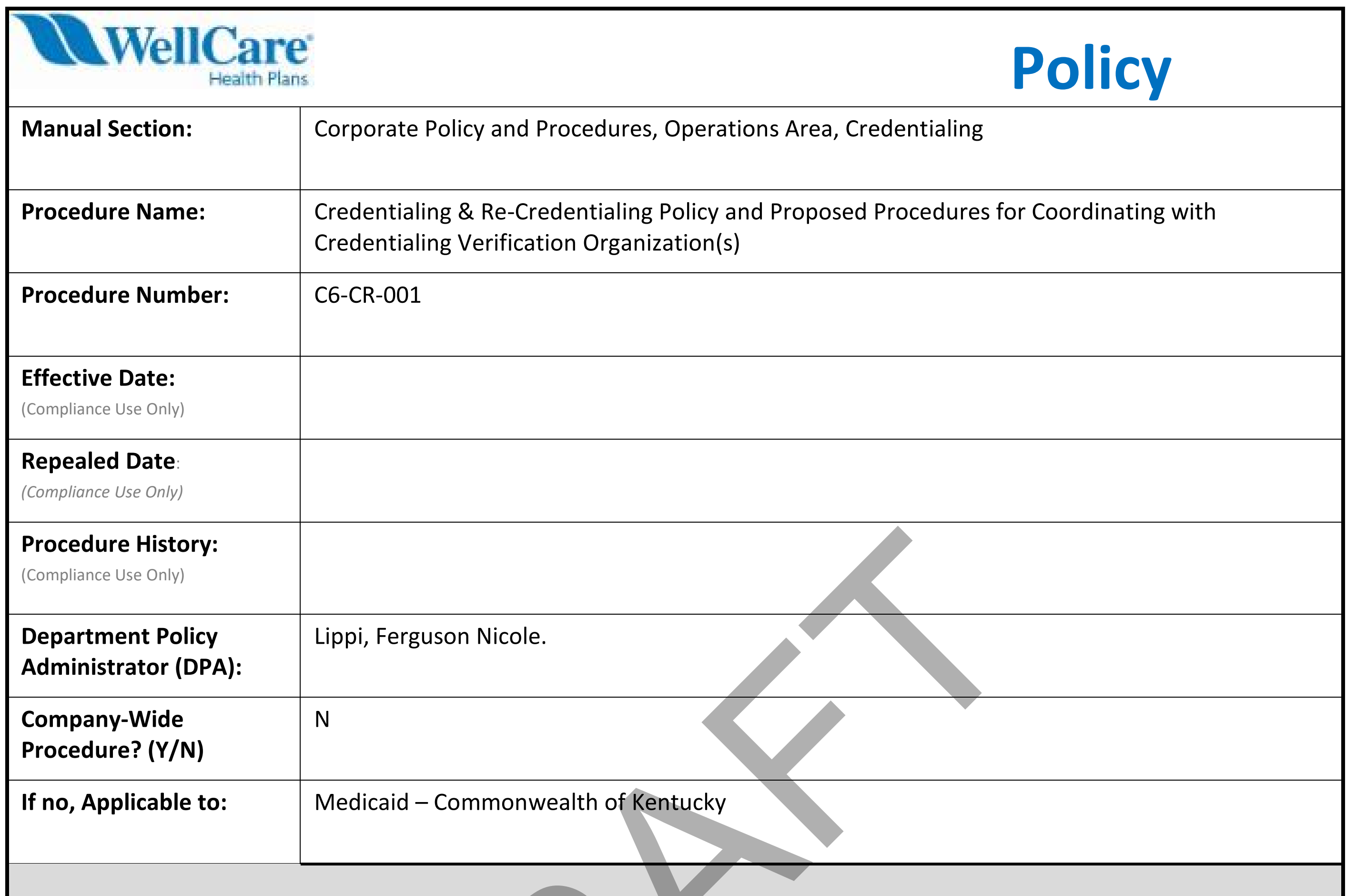

WellCare Health Plans

Policy

Manual Section:	Corporate Policy and Procedures, Operations Area, Credentialing
Procedure Name:	Credentialing & Re-Credentialing Policy and Proposed Procedures for Coordinating with Credentialing Verification Organization(s)
Procedure Number:	C6-CR-001
Effective Date: (Compliance Use Only)	
Repealed Date: *(Compliance Use Only)*	
Procedure History: (Compliance Use Only)	
Department Policy Administrator (DPA):	Lippi, Ferguson Nicole.
Company-Wide Procedure? (Y/N)	N
If no, Applicable to:	Medicaid – Commonwealth of Kentucky

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Procedure:

1. Establishment and Review of Credentialing Policies and Procedures

The Plan maintains documented policies and procedures for Credentialing, Re-credentialing and between-cycle monitoring and maintenance of providers. The Credentialing designee, on an ongoing basis (but at least annually), reviews credentialing policies and procedures in order to make any changes necessary to maintain compliance with the Company's iCare Compliance Program and Code of Conduct and Business Ethics, National Committee for Quality Assurance (NCQA), and with applicable State and Federal Accreditation requirements.

2. Practitioners to Credential and Re-credential

The Plan defines the types of practitioners who are credentialed and re-credentialed as those listed below in this section:

- Practitioners who have an independent relationship with the Plan. An independent relationship exists when the Plan selects and directs its members to see a specific practitioner or group of practitioners, including all practitioners whom members can select as primary care practitioners (PCPs). An independent relationship is not synonymous with an independent contract. The Plan does not credential some practitioners with whom it holds independent contracts; however if a provider is listed in a Plan provider directory, the provider must be credentialed;
- Practitioners who see members outside the inpatient hospital setting or outside freestanding ambulatory facilities;

- Practitioners who are hospital based but who see the Plan members as a result of their independent relationship with the Plan: Anesthesiologists who have Pain Management practices, University faculty who are hospital based but who also have private practices;
- Oral Surgeons who provide care under the Organization's medical benefits.
- Dentists who provide care under the Plan medical or dental benefits;
- Non-physician practitioners who have an independent relationship with the Plan as defined above, and who provide care under the Plan medical benefits;
- Non-physician dependent practitioners working in collaborative practice with a contracted physician.
- Telemedicine Practitioners who do not have an independent relationship with the Organization and who provide treatment services under the organization's medical benefit.

Behavioral Health Practitioners

- Psychiatrists and physicians who are certified in addiction medicine;
- Addiction medicine specialist;
- Doctoral or master's level psychologists who are state certified or state licensed;
- Master's level clinical social workers who are state certified or state licensed;
- Master's level clinical nurse specialists or psychiatric nurse practitioners who are nationally or state certified or state licensed;
- Other behavioral healthcare specialists, who are licensed, certified or registered by the state to practice independently such as, but not limited to: Licensed Marriage and Family Therapists, Licensed Mental Health Counselors, Licensed Psychoanalysts, and Licensed Professional Counselors.

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The following list identifies by discipline the practitioner types that fall under the Plan scope of credentialing & re-credentialing. The lists below are not all inclusive. Providers must complete the credentialing review process prior to becoming effective as a participating provider. Examples of the provider types the Plan assesses using the criteria identified in this procedure are listed below:

Doctorate Level Practitioners

- Medical Doctors (MD)
- Osteopathic Doctors (DO)
- Chiropractors (DC)
- Podiatrists (DPM)
- Oral Surgeons (DDS/DMD)
- Optometrists (OD)
- Psychologists (PsyD/PhD)

- Pharmacists (PharmD)

Dental Practitioners

- Dentists (DDS/DMD)

Allied Health Professionals - Independent

- Acupuncturists
- Audiologists
- Diabetes Educators - Outpatient
- Dietitians
- Massage Therapists
- Nutritionists
- Occupational Therapists
- Physical Therapists
- Speech Therapists/Language Pathologists
- Psychologists
- Clinical Social Workers
- Clinical Nurse Specialists
- Licensed Marriage and Family Therapists
- Licensed Mental Health Counselors
- Licensed Psychoanalysts
- Licensed Professional Counselors
- Pharmacists
- Nurse Practitioners, as applicable

Allied Health Professionals - Dependent

- Nurse Practitioners
- Certified Nurse Midwives

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- Physician Assistants

Employed Medical Directors and Licensed Independent Behavioral Health Employees

The Plan credentials employed Medical Directors and certain licensed independent behavioral health employees in accordance with this policy. The credentialing process for employees is identified in **Employee Credentialing – Medical Directors and Behavioral Health Licensed Independent Practitioners** - **Attachment A**.

3. Practitioners Who Are Not Credentialed or Re-credentialed

The Plan defines the types of practitioners who are ***not*** credentialed, and therefore not re-credentialed, as those listed below in this section:

Practitioners who do not have an independent relationship with the Plan, and meet any of the following criteria:

- Practitioners who practice exclusively within the inpatient setting and who provide care for Plan members only as a result of members being directed to the hospital or another inpatient setting;
- Practitioners who practice exclusively within free standing facilities and who provide care to Plan members only as a result of members being directed to the facility;
- Pharmacists who work in conjunction with a pharmacy benefit management (PBM) organization;
- Covering practitioners (e.g. locum tenens); Locum tenens who do not have an independent relationship with the Organization
- Practitioners who do not provide care for members in a treatment setting (e.g. board certified consultants).

Hospital Based Practitioners (including, but not limited to):

- Anesthesiologists
- Emergency Room Physicians
- Hospitalists
- Pathologists
- Radiologists
- Neonatologists

Non-inpatient facilities in which practitioners may practice exclusively and provide care for members only as a result of members being directed to the facility may include but are not limited to:

- Mammography Centers
- Urgent Care Centers

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- Surgery Centers
- Ambulatory Behavioral Healthcare Facilities
- Psychiatric and Addiction Disorder Clinics

School Based Practitioners

- Nurses

4. Criteria for Credentialing & Re-credentialing

Doctorate Level Practitioners - MD/DO/DPM/DDS/DMD/DC/OD/PsyD/PhD/PharmD

- Hold and continue to hold a current unrestricted license, in good standing, issued by the State of practice;
- Hold a valid NPI as verified through the CMS National Plan and Provider Enumeration System;
- Hold a valid Social Security Number and Birthdate as verified through the Social Security Death Master;
- Hold and continue to hold a current DEA, and if applicable to the state where services are performed, a current CDS or CSR certificate (applicable for MD/DO/DPM/DDS/DMD), bearing the current address in the State of practice, with schedules consistent with prescribing practices. (It is acknowledged that practitioners in certain specialties do not maintain DEA/CDS/CSR certificates – such practitioners will be reviewed on a case by case basis);
- Carry and continue to carry professional liability insurance or coverage consistent with the Plan's requirements, **See state specific listing of professional liability insurance requirements - Attachment B;**
- Hold and continue to hold board certification (applicable to MD/DO/DPM/DDS/DMD) or have verifiable education/training in the specialty requested.
- Hold and continue to hold current hospital privileges or privileges at an ambulatory surgery center (MD/DO) as applicable to specialty. Privileges are not a requirement for many specialties such as: Allergy, Dermatology, Endocrinology, Genetics, Hospice and Palliative Care, Neurology, Occupational Medicine, Ophthalmology, Pain Management, Pathology, Physical Medicine and Rehabilitation (PMR), Podiatry, Preventive Medicine, Psychiatry, Radiology, and Rheumatology. Based on the practice setting, the hospital privileges requirement may be waived for practitioners in specialties not listed above. Primary care physicians (PCPs) who do not have hospital admitting privileges must have a formal arrangement with a participating Plan physician for hospitalization of Plan members;
- PCPs, Obstetrics and Gynecology and other specialist physicians in solo practice have documented covering/admitting physician arrangements for times when they may be absent from their practice;
- Be and continue to be eligible for participation in Medicare and/or Medicaid with no evidence of any investigation under Medicare or Medicaid or other government entity;
- Not have current sanctions listed under the Office of Inspector General Medicaid/Medicare Sanctions report;

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- **Medicare requirement** - Not have opted-out of Medicare if participation is for the Medicare line of business (not applicable for DC's);

Allied Health Professional Practitioners

- Hold and continue to hold a current unrestricted license, in good standing, issued by the State of practice;
- Hold a valid NPI as verified through the CMS National Plan and Provider Enumeration System;
- Hold a valid Social Security Number and Birthdate as verified through the Social Security Death Master;
- Carry and continue to carry professional liability insurance or coverage consistent with the Plan's requirements, **See state specific listing of professional liability insurance requirements – Attachment B;**
- Be and continue to be eligible for participation in Medicare and/or Medicaid with no evidence of any investigation under Medicare or Medicaid or other governmental entity;
- Not have current sanctions listed under the Office of Inspector General Medicaid/Medicare Sanctions report;
- Not have opted-out of Medicare if participation is for the Medicare line of business;

5. Credentialing & Re-credentialing Application and Attestation

Credentialing

Practitioners are required to complete an application for Credentialing. The Plan uses the Council for Affordable Quality Health Care (CAQH) Universal Provider Data source as a part of provider Credentialing and Recredentialing process. The database may contain the most accurate and up-to-date information. The most recent attestation date can be reviewed by locating the top left corner of page 1 of the application. The actual signed "attestation" document included within CAQH, for the most part, would be outdated. Use of attestation page 1 of the CAQH application is an acceptable NCQA and industry credentialing standard. The application includes demographic information and the collection of the following information under a current, signed and dated attestation of correctness and completeness. The age of credentials verifications must not exceed 180 days prior to the Credentialing decision date (Medicare) (NCQA). Because credentialing applications vary from state to state, and some applications are state mandated, the language in the questionnaire section of the applications may vary. The wording, however, must meet the intent of the following wording content and contain the following history of actions against the applicant.

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Re-Credentialing

Re-credentialing information is collected under a current, signed and dated attestation of correctness and completeness. The re-credentialing verification time limit must not exceed 180 days from the date of re-application signature to the re-credentialing decision date. Because re-credentialing applications vary from state to state, and some re-applications are state mandated, the language in the questionnaire section of the re-application may vary. The wording, however, must meet the intent of the following wording content and contain the following history of actions against the applicant.

The Credentialing and Re-credentialing application questionnaire language must meet the following wording content:

- Reasons for any inability to perform the essential functions of the position, with or without accommodation;
- Lack of present illegal drug use;

- History of loss of license and felony convictions;
- History of all past and present issues regarding loss or limitation of clinical privileges or disciplinary action at all facilities or organizations with which the practitioner has had privileges;
- Current malpractice insurance coverage – the application shall include the dates and amount of the current insurance coverage even if the amount is $0. If the application form does not include specific questions regarding the dates and amount, a signed addendum may be obtained from the practitioner containing this information, or a copy of the insurance face sheet may be provided;
- An attestation to the correctness and completeness of the application.

The Credentialing Application Questionnaire Addresses:

- Do you have any physical or mental health problems or limitations in ability that may affect your ability to practice and provide health care with reasonable skill and safety?
- Do you have any history of chemical dependency/substance abuse?
- Have you been the subject of an investigation, or have proceedings ever been initiated to have your license to practice limited, suspended, revoked, denied, sanctioned or subject to probationary conditions, or have you voluntarily or involuntarily relinquished your license in this or any other state?
- Has your narcotics registration certificate ever been voluntarily or involuntarily relinquished, limited, suspended, sanctioned or revoked?
- Have you been the subject of an investigation, or have you ever been suspended, sanctioned or otherwise restricted from participating in any private, state or federal health insurance program, for example Medicaid or Medicare?
- Have you ever been named a defendant in a criminal proceeding?
- Has your medical staff membership, employment, or medical staff status at any health care institution ever been rejected, limited, suspended, revoked, not renewed or subject to probationary conditions, or have you been the subject of an investigation, or relinquished medical staff membership or clinical privileges while under investigation or disciplinary action?
- In the last five years, have you been a defendant in a malpractice/professional liability suit, or are there currently any pending or potential suits against you, or have any judgments been made or settlements paid on your behalf?
- Have you opted out of Medicare?
- Have you ever been denied professional liability Insurance coverage or had your professional liability insurance coverage cancelled by your carrier?
- Have you *failed* to meet the State Licensure requirements for continuing education?

The Re-credentialing Application Questionnaire Addresses:

- Do you have any physical or mental health problems or limitations in ability that may affect your ability to practice and provide health care with reasonable skill and safety?

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- In the last three years have you had a history of chemical dependency/substance abuse?
- In the last three years have you been the subject of an investigation, or have proceedings been initiated to have your license to practice limited, suspended, revoked, denied, sanctioned or subject to probationary conditions, or have you voluntarily or involuntarily relinquished your license in this or any other state?
- In the last three years has your narcotics registration certificate been voluntarily or involuntarily relinquished, limited, suspended, sanctioned or revoked?
- In the last three years have you been the subject of an investigation, or have you been suspended, sanctioned or otherwise restricted from participating in any private, state or federal health insurance program, for example Medicaid or Medicare?
- In the last three years have you been named a defendant in a criminal proceeding?
- In the last three years has your medical staff membership, employment, or medical staff status at any health care institution been rejected, limited, suspended, revoked, not renewed or subject to probationary conditions, or have you been the subject of an investigation or relinquished medical staff membership or clinical privileges while under investigation or disciplinary action?
- In the last three years, have you been a defendant in a malpractice/professional liability suit, or are there currently any pending or potential suits against you, or have any judgments been made or settlements paid on your behalf?
- In the last three years have you opted out of Medicare?
- In the last three years have you been denied professional liability Insurance coverage or had your professional liability insurance coverage cancelled by your carrier?
- In the last three years have you *failed* to meet the State Licensure requirements for continuing education?

The Credentialing and Re-Credentialing Application Contains:

- A current signed and dated attestation statement as to the correctness and completeness of the application; faxed, digital, electronic, scanned or photocopied signatures are acceptable forms of signature. Signature stamps are not acceptable.

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By Submitting a Completed Credentialing Application the Applicant is:

- attesting to the correctness and completeness of the information provided;
- authorizing Plan representatives to consult with others who have been associated with him/her, who may have information bearing on his/her competence and qualifications;
- consenting to the inspection by Plan representatives of all records and documents that may be material to an evaluation of his/her professional qualifications and ability to carry out the patient care responsibilities he/she requests, as well as his/her professional ethical qualifications in relation to participating provider status;
- releasing from liability all Plan representatives for acts performed in good faith in connection with evaluating the practitioner and his/her credentials/re-credentials;

- releasing from liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to Plan representatives in good faith concerning the applicant's ability, professional ethics, character, current ability to safely provide care and other qualifications for participating provider status.

The term "Plan representative" includes the Board of Directors, the CEO, the Medical Director, the Director of Quality Improvement, the Credentialing designee, all Peer Review Committee Members and others that may have responsibility for collecting or evaluating the applicant's credentials or acting upon his/her application/re-application, and any authorized representative of any of the foregoing.

New Applicant's Burden of Proof

The applicant has the burden of producing adequate information for a proper evaluation of his/her credentialing application – i.e. experience, background, education, training, work history, demonstrated ability and competence, current ability to safely provide care – and resolving any doubts about these or any of the other basic qualifications specified in the policy section of this Policy and Procedure. Action on an individual's application for credentialing is withheld until such information is made available and is verified. The applicant shall promptly be notified of any non-success in collection or verification efforts.

Complete Application

In order to begin the credentialing process, a complete application must be received. An application is considered complete and processable when:

- The application is fully completed with *all* requested information. A response indicating "see CV" is not acceptable;
- The application is signed and dated by the applicant. A stamped signature is not acceptable;
- An applicant in solo practice provides covering physician information;
- An applicant provides information on the primary hospital(s) where admissions are made or ambulatory surgery center(s) where procedures are performed, together with all requested supporting information;
- A PCP without hospital privileges provides a Hospital Admitting Attestation form documenting his/her admitting arrangements with a participating provider;
- A full explanation is provided for any answer in the questionnaire section of the application that requires an explanation;
- The Medicaid Number is provided (if contract is for Medicaid);
- The Medicare number is provided (if contract is for Medicare);
- The National Provider Identification (NPI) number is provided;
- Five year work history is provided either in the application or enclosed with the application in the form of curriculum vitae (CV). Month and year dates must be identified. If a CV is enclosed it must contain the most current address/affiliation and this should be the same as the address/affiliation on the application;

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- Professional liability insurance face/declarations sheet in the state required limits, with the applicant's name listed as covered insured as provided.

6. Practitioner Rights

Review of Information

Practitioners have the right to review information obtained from outside sources submitted in support of their Credentialing or Recredentialing Application. This may include information such as data from malpractice insurance carriers or state licensing boards. Any Peer-Review Protected information obtained is excluded.

Correction of erroneous information from other sources & time frames

Practitioners have the right to correct erroneous information obtained from outside sources in support of their Credentialing or Recredentialing Application.

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 is allowed to submit corrections for the erroneous information. The Plan shall notify the practitioner of the discrepancy and request a written explanation within 15 business days. The corrections are to be submitted to the requestor at the address listed on the discrepant letter.

The Plan's notification to the practitioner shall include:

- Nature of the discrepant information;
- Process for correcting erroneous information submitted by another source;
- Format for submitting corrections;
- Time frame for submitting the corrections;
- Addressee to whom corrections must be sent;
- Plan's documentation process for receipt of the corrected information from the applicant; and
- Plan's review process and decision notification time frame

The Plan is not required to reveal the source of the erroneous information.

Application Status

Practitioners have the right to be informed of the status of their Credentialing or Recredentialing Application, upon request.

Practitioners may contact their Provider Relations Representative for status or they can reach the Credentialing Department at .credentialinginquires@wellcare.com.

7. Verification - Primary and Secondary Sources

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Primary source verification is documented verification by an entity that conferred or issued a credential, such as a medical school, a residency program or a licensing board, indicating that an individual's statement of possession of a credential is true.

Secondary source verification is documented verification of a credential obtained from a verification report from an entity listed as an acceptable secondary source, on the basis of a statement from that entity that it has performed the primary source verification. Information received through any secondary verification source must meet the same transmission and documentation requirements as outlined for primary source verification.

Documents, diplomas, certificates or transcripts provided directly by the applicant are not acceptable as primary or secondary source verified documentation. Primary and/or secondary source verifications may be accomplished by mail, fax, telephone, or electronically. The means by which primary or secondary source verifications are obtained shall be documented. The intent is to ensure that no interference from outside parties occurs in the obtaining and transmission of the verified credentialing information. The lists of acceptable credentialing verification sources used to verify credentialing information together with applicable verification time frames are identified in Section 10 Credentialing Verification Procedures and Timeframes.

The following verifications must be primary source verified (PSV) only:

- Current valid license to practice;
- Education and Training;
- Board Certification (PSV of Board Certification is acceptable for verification of education and training.

8. Appropriate Methods of Documenting Verifications

The Plan may use oral or verbal telephonic, written and internet data to verify credentialing information. The various methods of verification used must meet the following requirements.

Verbal Telephonic Verification

- The credentialing associate who performs the verification of the credential must date, sign and obtain the name of the person verifying the documented information to be placed in the credentialing file.

Written Verification

- Written verification in the form of a letter or cumulative report must be the date of the official document, (date on the letter or document, not the receipt date) to assess performance against timeliness requirements. The credentialing associate who verified the credentials must sign or initial the verification. Where applicable, the latest cumulative reports and periodic updates released by the approved sources must be used. The date of the report query and volume must be noted in the practitioner's file.

Internet and Electronic Verification

- The date generated by the source must be used to determine timeliness for information that is retrieved through internet/electronic verification.

9. Timeliness of Verifications

Many of the credentialing elements have time-sensitive factors, which are required by various standards and guidelines. The Plan is responsible for ensuring and documenting that none of the time-sensitive credentialing

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factors are more than 180 calendar-days old, as appropriate, at the time of the credentialing decision.

10. Credentialing/Re-credentialing Verification Procedures and Time Frames

This section identifies the verifications that are required as part of the credentialing/re-credentialing processes, the acceptable sources and methods of verification, the verification time limits and the applicable practitioner types. **Credentialing/Re-credentialing Application** (MD/DO/DPM/DC/DDS/DMD/OD/PsyD/PhD/PharmD/Allied Health Professional)

Verification time limit: 180 calendar days per NCQA standards. State specific requirements must be followed.

Required at the time of initial credentialing/re-credentialing.

Primary source verification of the application is not required.

Verification must include:

- review to ensure the application is fully completed and is appropriately signed and dated.

Upon receipt of a completed application, Credentialing, in a timely fashion, seeks to verify the information provided from primary and/or secondary sources.

- **Work History** (MD/DO/DPM/DC/DDS/DMD/OD/PsyD/PhD/Allied Health Professional)

  Verification time limit: 180 calendar days.

  Required at the time of initial credentialing.

  Primary source verification is not required.

  Verification must include:

  - A minimum of five years relevant work history, which may be contained in the practitioner's application or curriculum vitae. If the practitioner has practiced fewer than five years from the date of verification of work history, it starts at the time of initial licensure. Experience practicing as a non-physician health professional (i.e., registered nurse, nurse practitioner, clinical social worker) within the five years should be included;
  - The beginning and ending month and year dates for each position;
  - A gap exceeding six months is clarified either verbally or in writing;
  - A gap exceeding one year must be clarified in writing;
  - If a practitioner has had continuous employment for five years or more, then there is no gap and no need to provide the month and year; providing the year meets the intent.

- **Current Valid State License** (including applicable state specific provisional licenses)
- (MD/DO/DPM/DC/DDS/DMD/OD/PsyD/PhD/PharmD/Allied Health Professional)

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Verification time limit: 180 calendar days.

Required at the time of initial credentialing, re-credentialing and between cycle monitoring.

License must be in effect at the time of the credentialing decision.

Verification must come from the state licensure agency through the following method:

- Evidence of dated electronic verification of the practitioners' current licensure obtained from the licensure website.

- **Current Valid DEA/CDS/CSR** (if applicable) (MD/DO/DPM/DDS/DMD/NP/PA)

  Verification time limit: None.

  Required at the time of initial credentialing, re-credentialing and between cycle monitoring.

  For practitioners who prescribe medications, the certificate must be in effect at the time of the credentialing/re-credentialing decision. Verification is obtained through one of the following methods:

  - Copy of current certificate;
  - Documented visual inspection of the original certificate;
  - Documented telephone confirmation with the DEA or CDS or CSR Agency;
  - Evidence of dated electronic verification through the National Technical Information Service NTIS database;
  - American Medical Association (AMA) Physician Master File;
  - Documented confirmation with the state pharmaceutical licensing agency.

- **Current Professional Liability Insurance**
- (MD/DO/DPM/DC/DDS/DMD/OD/PsyD/PhD/PharmD/Allied Health Professional)

  Verification time limit: None.

  Required at the time of initial credentialing and re-credentialing.

  The certificate must be in effect at the time of the credentialing/re-credentialing decision. Verification is obtained through one of the following methods:

  - The application shall include the dates and amount of the current insurance coverage even if the amount is $0. A signed addendum may be obtained from the practitioner that contains liability insurance information. ;
  - A copy of the insurance face/declaration sheet, which must includes the practitioner name, expiration date, and liability covered, may be provided. If the practitioner name is not on the sheet, a list must be attached on the Insurance Carrier's official stationery.

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- **Education and Training, including Board Certification, if indicated on the application**

  Required at the time of Initial Credentialing.

  Verification must include the highest of three levels of education and training obtained by the practitioner:

  - Graduation from medical or professional school;
  - Residency;
  - Board Certification – must be verified at time of credentialing and re-credentialing;

  Verification of board certification is required only if the practitioner states on the application that he/she is board certified.

  Because medical specialty boards verify education and training, verification of board certification fully meets the requirement for verification of education and training, unless otherwise stated below.

- **Education and Training**

  Verification time limit: None.

  Required at the time of initial credentialing.

  Graduation from medical school - Physicians (MD/DO)

  Education verification is obtained through one of the following methods:

  - Confirmation from medical school;
  - AMA Physician Master File profile;
  - AOA Physician Master File profile;
  - Confirmation from a state licensing agency if the state agency performs primary-source verification of education and residency training. At least annually the Plan must obtain written confirmation from the state licensing agency that it performs primary source verification. Written confirmation from the licensing board is not required if there is a state statute that requires the licensing board to obtain verification of education and training directly from the institution. A copy of the state statute must be included in the credentialing document library.

  Completion of AMA's Fifth Pathway Program - Physicians (MD's)

  Verification time limit: None.

  Required at the time of initial credentialing

  If a physician states that training was completed through the AMA's Fifth Pathway program, verification is obtained through the following method:

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- The American Medical Association (AMA) Physician Master File profile.

Completion of the ECFMG - Physicians (MD's)

Verification time limit: None.

Required at the time of initial credentialing

If a physician states that an ECFMG was completed, verification is obtained through one of the following methods:

- Confirmation from ECFMG;
- AMA Physician Master File profile.

Completion of residency training – Physicians (MD's, DO's)

Verification time limit: None.

Required at the time of initial credentialing

Training verification is obtained through one of the following methods:

- Confirmation from residency training program;
- AMA Physician Master File profile;
- AOA Physician Master File profile;
- Confirmation from a state licensing agency if the state agency performs primary-source verification of residency training. At least annually the Plan must obtain written confirmation from the state licensing agency that it performs primary source verification. Written confirmation from the licensing board is not required if there is a state statute that requires the licensing board to obtain verification of education and training directly from the institution. A copy of the state statute must be included in the credentialing document library.

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Graduation from Chiropractic College – Chiropractors (DC's)

Verification time limit: None.

Required at the time of initial credentialing

Education verification is obtained through one of the following methods:

- Confirmation from a chiropractic college whose graduates are recognized as candidates for licensure by the regulatory authority issuing a license;

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- Confirmation from a state licensing agency if the state agency performs primary-source verification. At least annually the Plan must obtain written confirmation from the state licensing agency that it performs primary source verification.

Graduation from dental school – Dentists (DMD's, DDS's)

Verification time limit: None.

Required at the time of initial credentialing

Education verification is obtained through one of the following methods:

- Confirmation from the dental school;
- Confirmation from the appropriate specialty program of residency training;
- Confirmation from the dental board if the board performs primary-source verification of education and training. At least annually the Plan must obtain written confirmation from the dental board that it performs primary source verification;
- Confirmation from a state licensing agency if the state agency performs primary-source verification of residency training. At least annually the Plan must obtain written confirmation from the state licensing agency that it performs primary source verification.

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Graduation from podiatry school – Podiatrists (DPM's)

Verification time limit: None.

Required at the time of initial credentialing

Education verification is obtained through one of the following methods:

- Confirmation from the podiatry school;
- Podiatry specialty board master file, if the organization provides documentation that the specialty board performs primary source verification of podiatry school graduation. At least annually the Plan must obtain written confirmation from the podiatry board that it performs primary source verification;
- Confirmation from a state licensing agency if the state agency performs primary-source verification. At least annually the Plan must obtain written confirmation from the state licensing agency that it performs primary source verification.

Completion of residency training – Podiatrists (DPM's)

Verification time limit: None.

Required at the time of initial credentialing

Training verification is obtained through one of the following methods:

- Confirmation from the residency training program;
- Confirmation from the state licensing agency if the state agency performs primary-source verification of residency training. At least annually the Plan must obtain written confirmation from the state licensing agency that it performs primary source verification.

Non-physician allied and behavioral healthcare professionals

Verification time limit: None.

Required at the time of initial credentialing

Education verification is obtained through one of the following methods:

- Confirmation from the professional school;
- Confirmation from the state licensing agency if the state agency performs primary-source verification of education. At least annually the Plan must obtain written confirmation from the state licensing agency that it performs primary source verification;
- Confirmation from a specialty board or registry, if the Plan provides documentation that the board or registry performs primary-source verification of education and training. At least annually the Plan must obtain written confirmation from the specialty board or registry that it performs primary source verification.

- **Board Certification –** Physicians (MD's, DO's) (as applicable)

Verification time limit: 180 calendar days for the Initial Verification..

Required at the time of initial credentialing, re-credentialing and between cycle monitoring.

Board Certification verification is obtained through one of the following methods:

- Confirmation from the ABMS, its member boards or through an official ABMS Display Agent where a dated certificate of primary source authenticity has been provided;
- AOA Official Osteopathic Physician Profile Report or AOA Physician Master File;
- Confirmation from the appropriate specialty board;
- The AMA Physician Master File profile;
- Confirmation from the state licensing agency if the state agency performs primary-source verification of board status. At least annually the Plan must obtain written confirmation from the state licensing agency that it performs primary source verification;

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- For foreign board certification, confirmation from the appropriate specialty board.

- **Board Certification –** Dentists (DMD/DDS) (as applicable)

  Verification time limit: 180 calendar days for the Initial Verification..

  Required at the time of initial credentialing, re-credentialing and between cycle monitoring.

  Board Certification verification is obtained through the following method:

  - Confirmation from the American Board of Oral and Maxillofacial Surgery
  - Lifetime Board Certifications do not expire and do not need to be re-verified during subsequent credentialing cycles

- **Board Certification –** Podiatrists (DPM's) (as applicable)

  Verification time limit: 180 calendar days for the Initial Verification..

  Required at the time of initial credentialing, re-credentialing and between cycle monitoring.

  Board Certification verification is obtained through one of the following methods:

  - Confirmation from the American Board of Podiatric Surgery
  - Confirmation from the American Board of Podiatric Orthopedics and Primary Podiatric Medicine;
  - Confirmation from the state licensing agency if the state agency performs primary-source verification of board status. At least annually the Plan must obtain written confirmation from the state licensing agency that it performs primary source verification.
  - Lifetime Board Certifications do not expire and do not need to be re-verified during subsequent credentialing cycles

- **Hospital Privileges** (MD/DO/DPM/DDS/DMD) (as applicable)

  Verification time limit: 180 calendar days.

  Required at the time of initial credentialing and re-credentialing.

  Hospital Privileges verification is obtained through one of the following methods:

  - The application includes the name of the facility, dates of affiliation and specialty of the hospital privileges held; the practitioner's attestation shall suffice as verification of hospital privileges;

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  - A copy of a letter may be provided from the practitioner which contains the hospital affiliation information;
  - A copy of the electronic screen print of the hospital website;
  - Written validation from the hospital of practitioner's hospital privileges.

- **Malpractice History** (MD/DO/DPM/DC/DDS/DMD/OD/PsyD/PhD/PharmD/Allied Health Professional)

  Verification time limit: 180 calendar days.

  Required at the time of initial credentialing and re-credentialing.

  Verification must include the last five years of history of malpractice settlements.

  Malpractice History verification is obtained through one of the following methods:

  - malpractice insurance carrier;
  - the National Practitioner Data Bank.

- **National Practitioner Data Bank (NPDB)**

  (MD/DO/DPM/DC/DDS/DMD/OD/PsyD/PhD/PharmD/Allied Health Professional)

  Verification time limit: 180 calendar days.

  The NPDB is accessed via a secure Internet website. The site is password protected and accessible only to authorized users. Credentialing Specialists are provided individual passwords to access the website for the purpose of making the required queries.

  A query shall be made to the National Practitioner Data Bank

  - at the time of initial credentialing;
  - at the time of re-credentialing;
  - as part of any between cycle professional/quality of care peer review

  Verification is evidenced by:

  - printout of the response to information disclosure request from the NPDB.

- **State specific Medicare Opt-out listing**

  Physicians: MD/DO/DPM/DDS/DMD/OD

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Practitioner: PA/ARNP/APRN/CNS/CRNA/CNM/Psychologist/CSW

Verification time limit: 180 calendar days.

Required at the time of initial credentialing, re-credentialing and between cycle monitoring.

Practitioners that sign a contract with the Plan for the provision of Medicare services will be reviewed against the State Carrier's listing of Medicare Opt-Out practitioners. Practitioners who appear on the list as having opted out are not eligible to become or remain as participating providers and will be informed accordingly.

Verification is evidenced by:

- Medicare Opt-Out verification form;
- log indicating review of the most recent Opt-Out listing information

- **Sanction Information – Medicare/Medicaid**

(MD/DO/DPM/DC/DDS/DMD/OD/PsyD/PhD/Allied Health Professional)

Verification time limit: 180 calendar days.

Initial verification for Medicare and Medicaid sanctions must cover the most recent five year period available through the data source. If a practitioner was licensed in more than one state in the most recent five-year period, the query must include all states in which the practitioner worked.

Verification is undertaken:

- at the time of initial credentialing;
- at the time of re-credentialing;
- as part of between cycle monitoring.

Verification is evidenced by one of the following:

- printout of the response to information disclosure request from the NPDB
- response from the appropriate state licensure agency;
- response from the Federation of State Medical Boards (FSMB);
- signed and dated Medicare/Medicaid Sanctions verification form indicating review of the Office of Inspector General's (OIG) Medicare/Medicaid Sanctions website report;
- log indicating review of the most recent OIG Sanctions information signed and dated by the Credentialing Specialist.

Satisfactory verification sources for Medicare/Medicaid sanctions:

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- List of Excluded Individuals and Entities (LEIE) maintained by the Office of Inspector General (OIG);
- NPDB;
- FSMB;
- American Medical Association (AMA) Physician Master File entry;
- State Medicaid Agency or intermediary and the Medicare intermediary.

- **Sanction Information – Licensure or Limitation on Scope of Practice**
  (MD/DO/DPM/DC/DDS/DMD/OD/PsyD/PhD/PharmD/Allied Health Professional)

  Verification time limit: 180 calendar days.

  Initial verification of state sanctions/restrictions on licensure and/or limitations on scope of practice is undertaken and must cover the most recent five year period available through the data source. If a practitioner was licensed in more than one state in the most recent five-year period, the query must include all states in which the practitioner worked. Verification is undertaken:

  - at the time of initial credentialing;
  - at the time of re-credentialing;
  - as part of between cycle monitoring.

  Verification is evidenced by one of the following:

  - printout of the response to information disclosure request from the NPDB
  - printout of the query response from the Federation of State Medical Boards (FSMB);
  - verification response from the appropriate state licensure agency;
  - log indicating review of the most recent state specific listing of state sanctions, restrictions on licensure and or limitations on scope of practice.

  Satisfactory verification sources for sanctions imposing limitations on licensure or hospital/clinical privileges:

  Physicians

  - Appropriate state regulatory agency
  - NPDB;
  - FSMB.

  Chiropractors

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- State Board of Chiropractic Examiners;
- NPDB.

Dentists

- State Board of Dental Examiners;
- NPDB.

Podiatrists

- State Board of Podiatric Examiners;
- Federation of Podiatric Medical Boards;

Non-physician - behavioral healthcare professionals – allied health professionals

- Appropriate state regulatory agency;
- State licensure or certification board;

- **Site Inspection Evaluations**
  SIE's are performed in conjunction with the member complaint monitoring process when the member complaints threshold is met or exceeded.
  The Plan has a process to ensure that the offices of providers meet office site standards. (Re-credentialing Site Inspections are performed in accordance with the State contract requirements.) The office site evaluation includes standards for:

  - Accessibility/Environment/Adequacy Privacy of Waiting and Examination Room Space;
  - Safety;
  - Medication Storage;
  - Available Services;
  - Office Protocols and Appointment Availability;
  - Confidentiality and HIPAA Compliance;
  - Adequacy of treatment record keeping.

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11. Confidentiality

Information and documentation obtained in the credentialing/re-credentialing process is confidential. Employees of the Plan are required to sign a confidentiality statement at the time of employment and all employees are required to participate in the WellCare Health Plans, Inc., Corporate Ethics and Compliance Program – Code of Conduct and Business Ethics, which incorporates HIPAA and general confidentiality and security awareness

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training. Paper credentialing documentation is kept in individual credentialing files which are housed in locked file rooms. Access to the credentialing file rooms is available to only those credentialing individuals whose security access badges have been programmed to allow entry. Electronic credentialing information and documentation is maintained in Plan databases. Input of and access to electronic credentialing information and documentation is undertaken by appropriate individuals via individual login and individually determined password. Access is restricted to those associates or other authorized Plan representatives who have been issued an appropriate login and established a password. Only employees of the Plan or persons with authority to act in the peer review/approval process, or agents of the Plan performing in a legal capacity, or agents of Accreditation, Federal or State Regulatory Agencies, acting in the capacity of reviewers of the Plan, or others as provided by law, may have access to credentialing files.

12. Application Processing Time Frames

The time frame for processing initial credentialing applications will be performed in accordance with respective state specific regulatory requirements:

- Kentucky 45 days

13. Respective Authority of the Corporate Medical Director, State Medical Director or Other Designated Physician and the Credentialing Committee

The State Medical Director has oversight responsibility and accountability for the clinical aspects of the credentialing program at State level and he/she or his/her designee acts as Chairperson of the Credentialing/Peer Review Committee. In accordance with policies and procedures, The Corporate Medical Director is delegated the authority to approve and sign-off on credentialing files that are determined to be “clean files.” The sign-off date for clean files is the "credentialing decision date." A list of approved new provider "clean files" is brought by the State Medical Director to the Credentialing Committee at the next available Credentialing/Peer Review Committee meeting for information.

Files that do not meet the Plan’s established “clean file” criteria are brought to the Credentialing/Peer Review Committee by the State Medical Director for review and decision by the Committee. The State Medical Director has the authority to appoint a clinical peer as an ad hoc member of the Credentialing/Peer Review Committee. In such cases, the clinical peer may attend the meeting or may have his or her opinion presented by the State Medical Director or another member of the committee. The Credentialing Committee has the authority to approve or disapprove provider participation.

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14. Non-discriminatory Credentialing and Re-credentialing

The Plan does not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional, who is acting within the scope of his or her license or certification under state law, solely on the basis of the license or certification.

The Plan does not make credentialing and re-credentialing decisions based solely on an applicant’s race, ethnic/national identity, gender, age, sexual orientation or the type of procedure or patient (i.e., Medicaid) in which the practitioner specializes. This does not preclude the Plan from including in its network practitioners who meet certain demographic or specialty needs, for example, cultural needs of members.

The Plan does not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatments. To assure there is no discrimination in the making of credentialing decisions, the Plan maintains a heterogeneous credentialing committee membership and those responsible for making credentialing

decisions affirm they will not discriminate when making credentialing decisions. In addition, the Plan has established participation requirements and has set criteria to assist in decision making. A report is maintained of all committee reviews and monitored to demonstrate nondiscriminatory credentialing and re-credentialing decisions. The report includes, but is not limited to: Specialty, County, Age and Gender.

15. Decision Making Criteria

The Plan has established participation requirements for the network practitioners identified in Section 4, and has defined the process and set the criteria used to reach credentialing/re-credentialing decisions. Credentialing/Re-credentialing decisions are based on assessment of a practitioner's verified credentials and ability to provide reasonable standards of care.

Managing Files that meet the Plan's established criteria

Practitioners who meet the Plan's established "clean file" criteria are reviewed and approved by the Medical Director. Clean files are presented in list format at each meeting of the Credentialing/Peer Review Committee. Files that do not meet the Plan's established criteria for a "clean file" are reviewed by the Credentialing/Peer Review Committee at the next available meeting.

"Clean File" assignment - Category 1 file

Applications where the following is identified:

- No malpractice claims with a closure date in the last five (5) years for new applicants and three (3) years for re-applicants;
- No reports of disciplinary action, licensure restriction or any type of investigation for new applicants; and
- No reports of disciplinary action, licensure restriction or any type of investigation within the last three years for re-applicants.

"Clean File" assignment - Category 2 file

Applications where the following is identified:

Any file where Category 1 "clean file" requirements are met as well as meeting the following criteria:

PCP's (Internal Medicine/Geriatrics, Family Practice, Pediatrics, General Practice):

- Multiple malpractice settlements/judgments totaling collectively $750,000 or under, or one malpractice settlement/judgment equal to or under $500,000;

Specialists and Obstetricians/Gynecologists:

- Multiple malpractice settlements/judgments totaling collectively $1,000,000 or under, or one malpractice settlement/judgment equal to or under $500,000;
- State licensure board report with a final date over five years old and unrelated to patient care.

The Medical Director reviews and validates all Category 2 "clean file" assignments prior to approval. The

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Medical Director may assign a file that meets Category 2 criteria for review by the Credentialing/Peer Review Committee for the approval decision. Such file will be reassigned to Category 3.

Credentialing/Peer Review Committee - Category 3 file Mandatory Review

Applications where one or more of the following is identified:

- Malpractice claims history in the last five (5) years for new applicants and three (3) years for re-applicants:

  PCP's (Internal Medicine/Geriatrics, Family Practice, Pediatrics, General Practice):

  - Two (2) or more malpractice settlements/judgments totaling in excess of $750,000;
  - One (1) or more individual malpractice settlement/judgment in excess of $500,000;

  Specialists and Obstetricians/Gynecologists:

  - Three (3) or more malpractice settlements/judgments totaling in excess of $1,000,000;
  - One (1) or more individual malpractice settlement/judgment in excess of $500,000;
- Clinical privileges limited, revoked, or otherwise altered by another health care organization, for new applicants
- Clinical privileges limited, revoked, or otherwise altered by another health care organization, within the last three years for re-applicants
- Any loss or limitation of license or any adverse state licensure board action or county/professional/medical association censure (patient care related), for new applicants
- Any loss or limitation of license or any adverse state licensure board action or county/professional/medical association censure (patient care related), within the last three years for re-applicants
- Disciplinary action taken by a Federal Organization, for new applicants
- Disciplinary action taken by a Federal Organization, within the last three years for re-applicants
- Criminal action, for new applicants
- Criminal action, within the last three years for re-applicants
- Files that meet Category 2 criteria but are re-assigned by the Medical Director to Category 3.

The Credentialing Committee is the peer review body that has authority to approve or disapprove providers for participation. In particular, the Credentialing Committee performs peer review of those applicants where credentialing has identified issues that may have a bearing on the standard of care the applicant may provide to members.

16. Notification of Decisions in a Timely Manner

Following credentialing or re-credentialing approval, a letter is forwarded to the provider within a specified time

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frame. Unless otherwise specified by the State regulation, NCQA notification guidelines shall be followed, sending the notification letter to providers within 60 days of the approval decision. The letter advises of approval (one, two, or a three-year period subject to state/contractual requirements and subsequent re-credentialing, and advises of the specialty/scope of clinical practice or services that were approved.

In the event a denial decision is recommended, the provider is notified of the Committee's determination and is provided the reasons for the denial decision and, as applicable, is offered the right to appeal.

Initial providers denied participation by the Credentialing Committee are not eligible to reapply for a period of at least one year.

17. Provider Directories and other member materials are consistent with credentialing data

Provider directories are extracted from the Plan's mainframe database. Validated credentialing information on approved providers is extracted by the Department responsible for loading the mainframe database after receiving notification of an approval decision. So as to ensure data entered is consistent with credentialing data, including education, training, certification and specialty, the Plan's Internal Audit Department validates all new or amended provider contract loads, testing the accuracy of the configuration for financial and clerical errors. After the provider information has been loaded, the originator in Provider Relations is notified to perform the final quality review to ensure consistency of data between the mainframe database and the credentialing database. Provider Relations then closes out the tracking as complete.

Provider Relations has a Policy and Procedure that identifies the process for ensuring that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification and specialty.

18. Delegation

The Plan has documented policies and procedures for the delegation of credentialing and re-credentialing, including what may be delegated and how the Plan decides to delegate.

19. Assessment of Organizational Providers

The Plan has a documented policy and procedure for the credentialing and assessment of organizational providers, which includes the provider types, the assessment criteria, and the need to be re-credentialed every three years.

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Verification Process

The verification process includes obtaining verifications in accordance with Section 10 Credentialing Verification Procedures and Time Frames

An application for credentialing is deemed complete and ready for review at such time as all information has been verified and all required responses are received back. At that time verification of information is entered into the appropriate credentialing database screens.

The applicant is notified of any nonsuccess in completing the documentation collection or verification process. The applicant is also notified if the verification process reveals information submitted by the applicant differs from information obtained in the verification process. Notification is made in accordance with Section 6 Practitioner Rights.

When collection and verification is complete, and all information/documentation is received, the file is assigned to a review category based on criteria outlined in Section 15 Decision Making Criteria and submitted to the Corporate

Medical Director for review.

Review Process

Upon receipt of the completed application, the Corporate Medical Director reviews the application and supporting documentation. The Corporate Medical Director has delegated authority to determine that a file is "clean" and able to be signed off as complete, clean and approved.

The Corporate Medical Director may take one of the following courses of action:

- after determining that an application is "clean" grant immediate provider participation. In such event, the applicant's name is submitted in the form of a list to the next meeting of the Credentialing/Peer Review Committee for information;

  Or

- refer the application to the Credentialing/Peer Review Committee for review and approval or disapproval. All applications assigned to Category 3, based on the criteria in Section 16 Managing Files that meet the Plan's Established Criteria, are referred to the State Medical Director and the Credentialing Committee for approval or disapproval.

Credentialing Committee Action

The Credentialing/Peer Review Committee reviews all Category 3 applications and makes a determination.

Approval Determination

- When the determination of the Credentialing/Peer Review Committee is favorable to the applicant, the approval determination is forwarded to the Quality Improvement Committee.

Adverse Determination

- When the Credentialing/Peer Review Committee determination is adverse to the applicant, the State Medical Director or designee in a timely manner informs the applicant by special notice that he/she is entitled to appeal the decision. In the event the adverse recommendation arises as a result of the practitioner's failure to meet the credentialing criteria established by the Plan, the practitioner is not entitled to appeal. The applicant may apply again when credentialing criteria is met and provided the application is made after a one-year period.

- When the Credentialing/Peer Review Committee determination is adverse to the re-applicant, the State Medical Director or designee, in a timely manner informs the re-applicant by special notice that he/she is entitled to the appeal rights.

Credentialing department shall refer any suspected provider fraud, waste, and/or abuse cases to the Plan's Special Investigations Unit (SIU). Any disclosures or notifications to HHS, OIG, and/or the respective agency will be handled by the SIU.

Quality Improvement Committee

The Quality Improvement Committee (QIC) receives the minutes of the Credentialing/Peer Review Committee and forwards a report to the Board of Directors.

Board of Directors

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The Board of Directors receives the minutes and report of the QIC containing the decisions of the Medical Director and Credentialing/Peer Review Committee.

Credentialing Database Update

The credentialing database is updated with the approval status of the provider, and the three year re-credentialing due date, which is used to facilitate the future re-credentialing cycle of the provider.

Notification for loading of New Provider Approvals

Following notification of new provider approvals, the mainframe database is updated accordingly.

Information entered into the mainframe database is taken from the credentialing database, so as to ensure data entered is consistent with credentialing data, including education, training, certification and specialty. The Plan's Internal Audit Department validates all new or amended provider contract loads, testing the accuracy of the configuration for financial and clerical errors. After the provider information is loaded into the mainframe database, the originator in Provider Relations reviews for final quality review to ensure consistency of data between the mainframe database and the credentialing database.

Letter to Practitioner Notifying of Credentialing/Re-credentialing Approval

Based on the approval date of the practitioner, a letter is sent to the practitioner advising that his/her credentialing has been approved. The letter includes the specialty/scope of services the practitioner has been approved for, and advises of the requirement for re-credentialing every three years. Notification of the decision is provided to the practitioner within applicable state required notification timeframes identified in **Section 16 Notification of Decisions in a Timely Manner** of this policy.

Quality Audit of Credentialing Files

A Credentialing Quality Auditor performs credentialing audits of a random sample of files per month to verify for accuracy and consistency. Audit results are maintained in the Credentialing Department.

Attachments

- A – Employee Credentialing - Medical Directors and Behavioral Health Licensed Independent Practitioners
- B - Insurance Limits by State

Addendum:

- A - Kentucky Credentialing Requirements

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Attachment A

Employee Credentialing – Medical Directors and Behavioral Health Licensed Independent Practitioners.

WellCare Health Plans, Inc. (the Company) has responsibility for meeting State, Federal and Accreditation Agency requirements in connection with employee recruitment and retention. The Human Resources Department is responsible for the overall recruitment and employment process of qualified personnel. As a requirement of some state and accreditation agencies, the Company must also maintain a credentialing file on certain employed licensed independent practitioners. The purpose of this attachment to the Credentialing policy is to identify the disciplines that need to be credentialed in conjunction with the employment process, and to document the collaborative processes between the Human Resources and Credentialing Departments.

The licensed independent practitioner disciplines listed below are subject to the initial credentialing process in conjunction with the employment process:

Medical Doctor	MD
Doctor of Osteopathy	DO
Doctor of Philosophy	PhD
Doctor of Psychology	PsyD
Licensed Mental Health Counselor	LMHC
Licensed Marriage and Family Therapist	LMFT
Licensed Clinical Social Worker	LCSW
Nurse Practitioner – Psychiatry	ARNP

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1. Human Resources Recruiter (HRR) will provide credentialing application to candidate, and request application completion and return to Credentialing Department usually within 48 hours of receipt.
2. HRR will notify Credentialing Department to expect completed application from the candidate. Notification will include candidate's full name, license number, clinical specialty and telephone number.
3. In the event the application is not received within five business days of HRR's notification, Credentialing:
    a. contacts the candidate to request the application;
    b. notifies HRR of non-receipt of the application.
4. When the completed application is received, credentialing will processes the application.
5. Application processing includes the following steps:
    a. create an electronic file in Credentialing database to maintain credentials and timeframe for ongoing credentialing maintenance activity;
    b. create a paper credentialing file;
    c. review work history;
    d. perform primary source verifications as applicable for:
        i. all current active state licenses;

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ii. training;
iii. board certification (Medical Director);
iv. NPDB
v. follow-up on negative findings (if any) revealed through data banks;

e. obtain Corporate Medical Director's review and signature.

6. Credentialing will notify HRR credentialing is complete.
7. Credentialing will:
   a. Update the Credentialing database with credentialed date (all disciplines);
   b. Submit the application through appropriate Credentialing Committee(s) (all disciplines);
   c. notify Risk Management to add Medical Directors only to the Officers liability insurance policy;
   d. notify Configuration to add Medical Directors only into Peradigm (Xcelys);

8. Employees subject to the initial credentialing process are not subject to the re-credentialing process, as performance is evaluated through the annual evaluation process conducted by Human Resources.
9. Credentialing performs ongoing maintenance and validation of Board Certification and State Licenses of Medical Directors annually to ensure current valid information is maintained. Credentialing also performs ongoing review of licensure and OIG sanction websites on a regular monthly or quarterly basis. Any negative information identified in connection with an employed Medical Director is forwarded to Human Resources for evaluation in conjunction with the employment process.

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Attachment B

Insurance Limits by State

Kentucky

The Company's health plan(s) operating in the State of Kentucky require individual providers to meet professional liability insurance in the minimum limits of:

$1,000,000 per occurrence $3,000,000 aggregate.

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State Addenda A:	Kentucky Medicaid
Procedure Name:	Credentialing and Re-Credentialing Procedure
Procedure Number:	C6-CR-001-PR-001
State Approval Date:	Pending Approval – Proposed CVO Process

Pursuant to Kentucky MCO contract section 27.7, "Provider Credentialing and Recredentialing", WellCare shall conduct Credentialing and Recredentialing in compliance with National Committee for Quality Assurance standards (NCQA), KRS 205.560(12), 907 KAR 1:672 or other applicable state regulations and federal law until such time that the Department contracts with a Credentialing Verification Organization (CVO) to perform such services. WellCare shall document the procedure it will implement, which shall comply with the Department's current policies and procedures, for credentialing and recredentialing of providers with whom it contracts or employs to treat Enrollees. Detailed documentation and scope of the Credentialing and Recredentialing process is contained in **Appendix J "Credentialing Process."**

WellCare shall complete the Credentialing or Recredentialing of a Provider within forty-five (45) Days of receipt of all relative information from the Provider. The status of pending requests for credentialing or recredentialing shall be submitted as required in **Appendix J** "**Credentialing Process.**"

If WellCare accepts the Medicaid enrollment application on behalf of the provider, WellCare shall use the format provided in **Appendix J "Credentialing Process"** to transmit the listed provider enrollment data elements to the Department. WellCare shall generate and electronically submit a Provider Enrollment Coversheet for each provider to the Department.

WellCare shall establish ongoing monitoring of provider sanctions, complaints and quality issues between recredentialing cycles, and take appropriate action.

WellCare shall provide a credentialing process whereby the Provider is only required to complete one credentialing process that applies to WellCare and any or all of its Subcontractors, if one credentialing process meets NCQA requirements.

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Transition to a Credentialing Verification Organization (CVO)

In compliance with KRS 205.532, the Department will contract with one or more CVOs to conduct enrollment, credentialing, and recredentialing services for the Medicaid managed care program. This section sets forth requirements WellCare must meet at such time that the CVO contract(s) are effective and operational.

Each provider seeking to be enrolled in Medicaid and credentialed with the Department and WellCare shall submit a single credentialing application to the designated CVO or organization meeting the requirements of KRS 205.532(1)(c)2, if applicable. WellCare shall comply with and take all necessary actions to implement the requirements of 2018 Ky.Acts Ch. 69 and all other applicable Federal and State laws.
WellCare shall work with any identified CVO designated by the Department. WellCare shall have a documented process that addresses the following at a minimum:

A. Referral of providers to the CVO to complete credentialing prior to contracting with WellCare, and to provide information to Network Providers about the re-credentialing process.
B. Methods for receiving verified credentialing packets from the CVO;
C. Determining whether WellCare will contract with the provider within thirty (30) Days of receipt of the verified credentialing packet from the CVO;
D. Within ten (10) Days of an executed contract with a provider, ensuring that any of WellCare's internal processing systems are updated to include the accepted provider contractor and the provider as a participating provider;
E. Notifying the provider if additional time beyond the required ten (10) Days is needed to load and configure the provider contract, which time shall not exceed an additional fifteen (15) Days;
F. Working with the CVO as needed when a re-evaluation of provider documentation is determined as necessary to maintain participation status.
G. Meeting with the Department and/or the CVO monthly during implementation activities, quarterly during ongoing operations, or at a different frequency as requested by the Department, Contractor, or CVO about the credentialing process.

WellCare shall accept provider credentialing and verified information from the Department, or the Department's contracted CVO, and shall not request a provider to submit additional credentialing information without the Department's written prior approval. WellCare is not prohibited from collecting additional information to inform WellCare's contracting process.

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Nothing in this section requires WellCare to contract with a provider if WellCare and provider do not agree on the terms and conditions for participation.

A provider's Claims become eligible for payment as of the date of the provider's Credentialing Application Date. WellCare shall not require a provider to Appeal or resubmit any Clean Claim submitted during the time period between the provider's Credentialing Application Date and WellCare's completion of its credentialing process.

A university hospital, as defined in KRS 205.639, may perform the activities of a CVO for its employed physicians, residents, and mid-level practitioners where such activities are delineated in the hospital's contract with WellCare. The provisions of KRS 205.532 (3), (4), (5), and (6) with regard to payment and timely action on a credentialing application shall apply to a credentialing application that has been verified through a university hospital.

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Appendix J CREDENTIALING PROCESS

Credentialing and Recredentialing Requirements

This documentation shall include, but not be limited to, defining the scope of providers covered, the criteria and the primary source verification of information used to meet the criteria, the process used to make decisions and the extent of delegated credentialing and recredentialing arrangements. WellCare shall have a process for receiving input from participating providers regarding credentialing and recredentialing of providers. Those providers accountable to a formal governing body for review of credentials shall include physicians, dentists, advanced registered nurse practitioners, audiologist, CRNA, optometrist, podiatrist, chiropractor, physician assistant and other licensed or certified practitioners. Providers required to be recredentialed by WellCare per Department policy are physicians, audiologists, certified registered nurse anesthetists, advanced registered nurse practitioners, podiatrists, chiropractors and physician assistants. However, if any of these providers are hospital-based, credentialing will be performed by the Department. WellCare shall be responsible for the ongoing review of provider performance and credentialing as specified below:

A. WellCare shall verify that its enrolled network Providers to whom Members may be referred are properly licensed in accordance with all applicable Commonwealth law and regulations and have in effect such current policies of malpractice insurance as may be required by WellCare.
B. The process for verification of Provider credentials and insurance, and any additional facts for further verification and periodic review of Provider performance, shall be embodied in written policies and procedures, approved in writing by the
C. Department.
D. WellCare shall maintain a file for each Provider containing a copy of the Provider's current license issued by the Commonwealth and such additional information as may be specified by the Department.
E. The process for verification of Provider credentials and insurance shall be in conformance with the Department's policies and procedures. WellCare shall meet requirements under KRS 205.560(12) related to credentialing. WellCare's enrolled providers shall complete a credentialing application in accordance with the Department's policies and procedures.

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The process for verification of Provider credentials and insurance shall include the following:

A. Written policies and procedures that include WellCare's initial process for credentialing as well as its re-credentialing process that must occur, at a minimum, every three (3) years;
B. A governing body, or the groups or individuals to whom the governing body has formally delegated the credentialing function;
C. A review of the credentialing policies and procedures by the formal body;
D. A credentialing committee which makes recommendations regarding credentialing;
E. Written procedures, if WellCare delegates the credentialing function, as well as evidence that the effectiveness is monitored;
F. Written procedures for the termination or suspension of Providers; and
G. Written procedures for, and implementation of, reporting to the appropriate authorities serious quality deficiencies resulting in suspension or termination of a provider.

WellCare shall meet requirements under KRS 205.560(12) related to credentialing. Verification of Provider's credentials shall include the following:

A. A current valid license or certificate to practice in the Commonwealth of Kentucky;
B. A Drug Enforcement Administration (DEA) certificate and number, if applicable;
C. Primary source of graduation from medical school and completion of an appropriate residency, or accredited nursing, dental, physician assistant or vision program as applicable; if provider is not board certified.

D. Board certification if the practitioner states on the application that the practitioner is board certified in a specialty;
E. Professional board certification, eligibility for certification, or graduation from a training program to serve children with special health care needs under twenty-one (21) years of age;
F. Previous five (5) years' work history;
G. Professional liability claims history;
H. Clinical privileges and performance in good standing at the hospital designated by the Provider as the primary admitting facility, for all providers whose practice requires access to a hospital, as verified through attestation;
I. Current, adequate malpractice insurance, as verified through attestation;
J. Documentation of revocation, suspension or probation of a state license or DEA/BNDD number;
K. Documentation of curtailment or suspension of medical staff privileges;
L. Documentation of sanctions or penalties imposed by Medicare or Medicaid;
M. Documentation of censure by the State or County professional association; and
N. Most recent information available from the National Practitioner Data Bank.
O. Health and Human Services Office of Inspector General (HHS OIG)
P. System for Award Management (SAM)

The provider shall complete a credentialing application that includes a statement by the applicant regarding:
A. The ability to perform the essential functions of the positions, with or without accommodation;
B. Lack of present illegal drug use;
C. History of loss of license and felony convictions;
D. History of loss or limitation of privileges or disciplinary activity;
E. Sanctions, suspensions or terminations imposed by Medicare or Medicaid; and
F. Applicants attest to the correctness and completeness of the application.

Before a practitioner is credentialed, WellCare shall verify information from the following organizations and shall include the information in the credentialing files:
A. National practitioner data bank, if applicable;
B. Information about sanctions or limitations on licensure from the appropriate state boards applicable to the practitioner type; and
C. Other recognized monitoring organizations appropriate to the practitioner's discipline.

At the time of credentialing, WellCare shall perform an initial visit to providers as it deems necessary and as required by law. (See 42 CFR Part 455 Subpart E.). WellCare shall document a structured review to evaluate the site against WellCares organizational standards and those specified by this contract. WellCare shall document an evaluation of the medical record documentation and keeping practices at each site for conformity with WellCares organizational standards and this contract.

WellCare shall have formalized recredentialing procedures. WellCare shall formally recredential its providers at least every three (3) years. WellCare shall comply with the Department's recredentialing policies and procedures. There shall be evidence that before making a recredentialing decision, WellCare has verified information about sanctions or limitations on practitioner from:
A. A current license to practice;
B. The status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility;
C. A valid DEA number, if applicable;
D. Board certification, if the practitioner was due to be recertified or become board certified since last credentialed or recredentialed;

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E. Five (5) year history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the practitioner; and
F. A current signed attestation statement by the applicant regarding:
   1. The ability to perform the essential functions of the position, with or without accommodation;
   2. The lack of current illegal drug use;
   3. A history of loss, limitation of privileges or any disciplinary action; and
   4. Current malpractice insurance.
   5. Health and Human Services Office of Inspector General (HHS OIG)
   6. System for Award Management (SAM)

There shall be evidence that before making a recredentialing decision, WellCare has verified information about sanctions or limitations on practitioner from:

A. The national practitioner data bank;
B. Medicare and Medicaid;
C. State boards of practice, as applicable; and
D. Other recognized monitoring organizations appropriate to the practitioner's specialty.

WellCare shall have written policies and procedures for the initial and on-going assessment of organizational providers with whom it intends to contract or which it is contracted. Providers include, but are not limited to, hospitals, home health agencies, free-standing surgical centers, residential treatment centers, and clinics. At least every three (3) years, WellCare shall confirm that the provider is in good standing with state and federal regulatory bodies, including the Department, and, has been accredited or certified by the appropriate accrediting body and state certification agency or has met standards of participation required by WellCare.

WellCare shall have policies and procedures for altering conditions of the practitioners participation with WellCare based on issues of quality of care and services. WellCare shall have procedures for reporting to the appropriate authorities, including the Department, serious quality deficiencies that could result in a practitioner's suspension or termination.

If a provider requires review by WellCare's credentialing Committee, based on WellCare's quality criteria, WellCare will notify the Department regarding the facts and outcomes of the review in support of the State Medicaid credentialing process.
WellCare shall use the provider type summaries listed at
http://chfs.ky.gov/dms/provEnr/Provider+Type+Summaries.htm

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