

Organizational Provider Credentialing Criteria for Participation and Termination



Regence BlueCross BlueShield of Utah is an Independent
Licensee of the Blue Cross and Blue Shield Association

I. Statement of Purpose

Regence (referred to hereinafter as “the Company”) is firmly committed to developing organizational provider networks that meet our established level of standards and are consistent with the delivery of high quality, cost-effective health care. The Company has established criteria for the evaluation, appointment and reappointment providers to its network panels. Based upon the application of these criteria and the need for additional organizational providers within the network, the Company reserves the right to accept or deny a request for participation, or terminate participation.

All organizational providers requesting participation with the Company, and its subsidiaries must complete an application for participation which has been designed to provide the Company with information necessary to perform a comprehensive review of the organizational provider’s credentials. Once an organizational provider’s application is deemed complete, the Company will commence a review of the organizational provider’s credentials using a variety of national and state data sources. The Company requires all organizational providers to meet the criteria prior to contracting and remain in compliance with the criteria at all times.

The Company will provide notice of material change(s) in criteria 90 days in advance of the effective date of the change(s). The Company reserves the right to exercise discretion in applying *any* criteria and to exclude organizational providers who do not meet the criteria. To remain eligible for participation, organizational providers must continue to satisfy all applicable requirements for participation as stated herein and in all other documentation provided by the Company.

II. Eligible Organizational Providers

The following are organizational providers recognized by the Company for credentialing and recredentialing purposes:

- Ambulatory Surgery Centers
- Hospital Medical Centers
- Home Health Agencies
- Hospice Care Centers
- Skilled Nursing Facilities
- Behavioral Health Care Organizations, including those that provide mental health, chemical dependency, alcohol and drug rehabilitation services
- Child Birthing Centers

All other contracted organizational providers not mentioned above are expected to be in compliance with all criteria.

III. Criteria for all Organizational Providers

To be eligible for participation, organizational providers must meet and maintain the following criteria adopted by the Company:

1. The organizational provider must submit a complete, signed and dated application, and all required documentation. Recredentialing is conducted every three years, at a minimum.

2. At the time of initial application, the organizational provider must not have any of the following sanctions imposed by Medicare, Medicaid, accrediting agencies or other state and federal agencies:
 - a) stop placement status; or
 - b) denial of payment status; or
 - c) temporary management status; or
 - d) pending state charges, actions; or
 - e) loss of accreditation, licensure or certification status.
3. The Company may review and consider the organizational provider's history in making its decision relating to participation and continued participation on our networks, including, but not limited to, the following:
 - a) a suspended or revoked license, certification or registration; or
 - b) actions taken by any state or governmental professional body; or
 - c) sanctions of any nature taken against the organizational provider by any government program, including, but not limited to, Medicare and Medicaid; or
 - d) denial, limitation, suspension or termination of participation by any health care institution or plan; or
 - e) loss of accreditation; or
 - f) prior history with the Company.
4. The organizational provider's state business and operating licenses must be currently free of any restrictions, limitations, conditions or sanctions (formal or informal).
5. Hospital Medical Centers, Ambulatory Surgery Centers, Home Health Agencies, Hospice Care Centers and Skilled Nursing Facilities must be Medicare certified or have accreditation with Medicare deemed status through one of the following accrediting agencies that have approval from the Centers for Medicare and Medicaid (CMS) services for deeming authority of accreditation:
 - a) Accreditation Association for Ambulatory Health Care (AAAHC)
 - b) American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
 - c) Accreditation Commission for Health Care (ACHC)
 - d) Commission on Accreditation of Rehabilitation Facilities (CARF)
 - e) Community Health Accreditation Program (CHAP)
 - f) The Joint Commission
 - g) National Integrated Accreditation for Healthcare Organizations (NIAHO)
 - h) American Osteopathic Association (AOA)
6. Behavioral Health Care Organizations must be licensed or certified through the State Department of Licensing and Certification, and may also have accreditation through The Joint Commission or CARF.
7. Child Birthing Centers must be licensed by the State as a birthing center and have The Joint Commission, AAAHC, or the Commission for the Accreditation of Free Standing Birth Centers accreditation.
8. The organizational provider's liability insurance must be through a commercial carrier or statutory authority, and at a minimum, in the amounts specified below:
 - a) Hospital Medical Centers: \$2 million per occurrence and \$5 million aggregate.
 - b) Ambulatory Surgery Centers: \$1 million per occurrence and \$3 million aggregate.
 - c) Home Health Agencies: \$1 million per occurrence and \$3 million aggregate.
 - d) Hospice Care Centers: \$1 million per occurrence and \$3 million aggregate.
 - e) Skilled Nursing Facilities: \$1 million per occurrence and \$3 million aggregate.
 - f) Behavioral Health Care Organizations: \$1 million per occurrence and \$3 million aggregate.
 - g) Child Birthing Centers: \$1 million per occurrence and \$3 million aggregate.
9. All other organizational providers not mentioned above must have at a minimum \$1 million per occurrence and \$3 million aggregate.

10. The organizational provider must not have what the Company determines to be a pattern of questionable or inadequate treatment, or a pattern of substandard care or mismanagement.
11. The organizational provider must not have made any material misrepresentation or omission to the Company concerning licensure, registration, certification, disciplinary history, or any other material matter covered in the application or credentialing materials.
12. The Company has the right to terminate the organizational provider for any reason, including, but not limited to, those stated in the contract between the Company and the organizational provider, or for any pattern of demonstrated unwillingness to abide by the terms and conditions of the contract.
13. When applicable, the credentialing and recredentialing process incorporates available information from utilization management, case management, quality management, external audit, member complaints, medical record reviews and site visits. The organizational provider must comply with these quality improvement activities. This information will be utilized as a component in determining the organizational provider's acceptability for participation and continued participation.
14. The organizational provider location(s) must meet the Company's site visit standards and requirements.
15. Organizational providers must comply with the Company's requirement for recredentialing. All requests for recredentialing must be submitted in a prompt and timely manner.
16. Organizational providers that have been removed from network participation due to medical records audits or non-compliance with recredentialing requirements, are not eligible to reapply for participation on any network for one (1) year from the end of network participation date.
17. Organizational providers that have been removed from network participation due to quality management findings, are not eligible to reapply for participation on any network for five (5) years from the end of the network participation date.
18. Organizational providers that have been removed from network participation due to external audits findings, are not eligible to reapply for participation on any network.
19. Organizational providers that have been removed from network participation for any reason other than for those set forth in criteria III. 16, 17 and 18 above, are not eligible to reapply for participation on any network for two (2) years from the end of the network participation date.
20. Organizational providers that have been denied initial network participation are not eligible to reapply for participation on any network for one (1) year from the date of the final denial letter.
21. Organizational providers who have been removed from network participation or denied initial network participation more than once are not eligible to reapply for participation on any network.
22. Organizational providers who have been denied initial network participation do not have the right to submit an appeal.
23. The Company has the right to deny or terminate the organizational provider if the Company determines, in good faith and in its sole discretion, that the organizational provider poses a threat or risk of harm to Members.