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# Provider Credentialing

Regence uses its credentialing process to provide members with a selection of physicians and other health care professionals who have demonstrated backgrounds consistent with the delivery of high quality, cost-effective health care. Regence has established criteria that is used to evaluate a provider's credentials. The credentialing criteria serve as the foundation for determining a provider's eligibility and continued eligibility on all Regence networks. Providers are expected to remain in compliance with credentialing criteria at all times.

## Individual Provider Credentialing

### Initial Credentialing

Regence requires that all providers falling within the scope of the Credentialing Program complete the initial credentialing process prior to contracting. Only those applicants licensed in Idaho, Oregon, Utah or Washington (as applicable based on practice location) and in those specialties recognized by Regence will be considered. Providers whose credentialing approval status has lapsed more than 120 days will be required to resubmit an initial application.

Upon receipt of a completed application, the application is reviewed and information is verified before being reviewed for final approval of participation. Incomplete submissions will delay the process.

Providers who have been denied initial participation do not have the right to submit an appeal. Refer to the **participation criteria** for additional information.

### Recredentialing

Regence requires that all providers falling within the scope of the Regence Credentialing Program complete the recredentialing process at least every three years. Providers whose contracting status has lapsed more than 120 days will be required to resubmit an initial application.

The recredentialing process is initiated by the Credentialing Department based on the last credentialing or recredentialing approval date. In order to streamline the process, Regence has developed a recredentialing profile that is populated with information previously submitted to Regence. The recredentialing request is sent six months prior to the recredentialing due date. All providers are expected to respond to the request for recredentialing in a timely manner. Additional information analyzed at the time of recredentialing may include, but is not limited to, member complaints and quality improvement activities. All providers must be recredentialed and approved for continued network participation. After completing the recredentialing process, providers will only be contacted by the

Credentialing Department in the event of an adverse decision or conditional approval status. Providers must agree to these conditions in order for contracts to be maintained.

Providers who have been terminated from network participation have the right to appeal. Refer to the provider contract **termination appeals process** for additional information. Physicians or other health care professionals leaving a delegated entity must notify Regence and are subject to recredentialing guidelines.

## **Delegated Credentialing**

Regence may delegate credentialing activities to contracted provider groups whose membership includes a minimum of 350 providers. Provider groups must demonstrate the ability to meet Regence's performance standards. Credentialing for organizational providers and facilities cannot be delegated. Regence retains the right to approve new physicians, other health care professionals and facilities and to terminate or suspend individual physicians or other health care professionals as necessary and appropriate.

## **Practice Site Visits**

Regence requires that physicians and other health care professionals provide professional services to our members in a setting that meets the Company's site visit standards and requirements.

### **Practice Site Review Standards and Requirements:**

1. Physical Accessibility:
  - a. Must have adequate parking spaces to handle patient load
  - b. Must have no barriers to access
  - c. Must have wheelchair access to office, exam rooms and restrooms
  - d. Must have disabled parking spaces
  - e. Must clearly mark all emergency exits
  
2. Physical Appearance:
  - a. Must be clean and orderly, and the name of the provider must be clearly visible
  
3. Member Rights:
  - a. Exam rooms and/or consulting spaces must provide visual and auditory patient privacy
  - b. Waiting room must have an adequate number of chairs in the to handle patient load

- c. Patient entrance, restroom and exam room must be separate from the provider's living quarters (as applicable)
4. Medical Record Keeping and Confidentiality (HIPAA):
    - a. Medical records must be kept confidential
    - b. Must obtain written authorization for the release of medical records
    - c. Must have a policy in place regarding employee confidentiality
    - d. Must have a written protocol to ensure access and location of medical records are secure at all times
    - e. Must have a written protocol to ensure security and management of medical records stored off-site
    - f. Must have a charting arrangement that shows organized placement of all patient information
    - g. All documents in the medical records must be securely attached within the chart
  5. After Hours / Appointment Accessibility:
    - a. Must have a mechanism to ensure that the provider has coverage available 24 hours a day, 7 days a week (as applicable)
    - b. Wait times for appointments must meet the following:
      1. Emergency = Same day appointments
      2. Urgent = No more than 24 hours for appointments
      3. Routine primary care (symptomatic) = No more than 72 hours for appointments
      4. Preventative (Asymptomatic) = No more than 4 weeks for appointments.

## **Organizational Provider Credentialing**

Facilities are recognized by Regence as organizational providers. These facilities may include but are not limited to:

- Ambulatory Surgery Centers
- Hospital Medical Centers
- Home Health Agencies
- Skilled Nursing Facilities
- Behavioral Health Care Organizations

All contracted organizational providers are expected to be in compliance with all credentialing criteria.

## Initial Credentialing

Regence requires that all organizational providers that fall within the scope of the Credentialing Program complete the credentialing process prior to contracting. Refer to the **credentialing criteria** for a listing of organizational providers that require credentialing. Organizational providers whose credentialing approval status has lapsed more than 120 days will be required to resubmit an initial application.

Organizational providers that have changed ownership and are required to complete the site survey process by the state and Medicare must be initially credentialed under the new ownership. If the state and Medicare allow the acquisition without the application and site survey process, credentialing is not required.

A completed application is reviewed using a variety of national and state data sources before being considered for final approval of participation. Incomplete submissions will delay the process. Organizational providers that have been denied initial participation do not have the right to submit an appeal. Refer to the participation criteria for additional information.

## Recredentialing

Regence requires that all organizational providers that fall within the scope of the Regence Credentialing Program complete the recredentialing process at least every three years. Organizational providers whose contracting status has lapsed more than 120 days will be required to resubmit an initial application.

The recredentialing process is initiated by the Credentialing Department based on the last credentialing or recredentialing approval date. The recredentialing request is generally sent out six months prior to the recredentialing due date. All organizational providers are expected to respond to the request for recredentialing in a timely manner. Upon receipt, the application is reviewed using a variety of national and state data sources. Additional information analyzed at the time of recredentialing may include member complaints. All organizational providers must be recredentialed and approved for continued network participation. After completing the recredentialing process, organizational providers will only be contacted by the Credentialing Department in the case of an adverse decision or conditional approval status. Organizational providers must agree to these conditions in order for contracts to be maintained.

Organizational providers that have been terminated from network participation have the right to appeal. Refer to the provider contract **termination appeals process** for additional information.

## Locum Tenens and Temporary Provider Policy

When a provider is on medical leave or vacation, a *locum tenens* provider is identified and authorized by that provider to treat for his or her patients during the time they are out of the office. Below is Regence BlueShield's policy for assigning and billing for locum tenens providers.

### Locum Tenens Provider Requirements and Process

1. The locum tenens must be identified and authorized by the Regence BlueShield contracted provider.
2. To be considered for locum tenens status, the temporary provider must be one of the following provider types:
  - Doctor of Medicine (MD)
  - Doctor of Osteopathy (DO)
  - Doctor of Podiatry (DPM)
  - Doctor of Chiropractic (DC)
  - Doctor of Optometry (OD)
  - Doctor of Naturopathy (ND)
  - Advanced Registered Nurse Practitioner (ARNP)
  - Physicians Assistant (PA)
3. The locum tenens must be licensed in the State of Washington and only perform services within their scope of license.
4. All procedures performed and billed by the locum tenens must have CPT4 modifier **Q6** *Service furnished by a locum tenens physician* attached to the procedure code. Enter the modifier in box 24D on the *CMS-1500* claim form.
5. The use of a locum tenens provider by a contracted provider is limited to **60** days per 12-month period. However, Regence BlueShield may, within its sole discretion, and under exceptional circumstances, grant an extension.
6. The locum tenens provider should bill Regence BlueShield using the Regence BlueShield tax ID and rider number of the contracted provider for whom they are substituting.
7. Other health care professionals not mentioned in the list above may make their own arrangements for substitute personnel. However, if a Regence BlueShield member sees a non-contracted provider, they may receive reduced or no benefits for the services provided.