Title:	Organizational Providers				
Department/Line of Business:	Provider Network Operations / All Lines of Business				
Approver(s):	SWHP/ICSW Credentials Committee				
Location/Region/Division:	SWHP				
Document Number:	SWHP.PNO.018.P				
Effective Date:	04/14/2021	**Last Review/ Revision Date:**	04/14/2021	**Origination Date:**	02/19/1997

SCOPE

This document applies to the following line(s) of business:
All Lines of Business

DEFINITIONS

When used in this document with initial capital letter(s), the following word(s)/phrase(s) have the meaning(s) set forth below unless a different meaning is required by context. Additional defined terms may be found in the BSWH P&P Definitions document.

None.

POLICY

The Scott & White Health Plan (SWHP)/Insurance Company of Scott & White (ICSW) has procedures and criteria for the establishment and monitoring of quality of care and services delivered to SWHP/ICSW members by contracted organizational providers. This includes the initial credentialing process and re-credentialing process at least every three (3) years.

Contracted organizational providers include, but are not limited to: hospitals, skilled nursing facilities, home health agencies, hospice, ambulatory surgery centers, facilities providing mental health and substance abuse services in residential, inpatient, and ambulatory settings, clinic, clinical laboratories, durable medical/home medical equipment suppliers, end-stage renal disease facilities, Federally Qualified Health Centers, freestanding cardiac catheterization labs, home infusion therapy providers, hospice care centers, independent diagnostic testing facilities, kidney/renal dialysis centers, lithotripsy centers, mass immunization providers, orthotics/prosthetics suppliers, portable x-ray suppliers, outpatient diabetes self-management training providers, outpatient physical therapy and speech pathology, radiology and medical imaging centers (freestanding or mobile), rehabilitation facilities, rehabilitation hospitals, residential treatment facilities, rural health centers, and sleep disorder centers and Any willing Local Mental Health Authorities (LMHA) or Local Behavioral Health Authority (LBHA) that meet the credentialing requirements and agree to contracted rates/terms are added to the SWHP/ICSW/RightCare network.

PROCEDURE

During the credentialing/re-credentialing process, the following information is obtained from organizational providers, as applicable:

1. Completed, signed, attested SWHP Facility Application
2. Current, valid state license or certification to practice
3. Medicare/Medicaid program participation eligibility, if applicable

4. Current certifications based on Provider type, if applicable, (e.g., Clinical Laboratory Improvement Amendments certification)
5. Current malpractice coverage/liability insurance that meets or exceeds minimum state requirements
6. Current, valid DEA certificate for applicable Provider type
7. Excluded Providers—searches are conducted using the HHS-OIG LEIE, and the General Services Administration SAM for names of parties disclosed during the credentialing process—parties appearing on any of these databases are denied participation

In addition to the required above-stated verifications and other eligibility criteria, participating Organizational Providers are required to maintain accreditation by a relevant, recognized accrediting body or, in the absence of such accreditation, provide evidence of a successful site survey by pertinent federal or state oversight agencies within the past three years or successfully pass a site visit conducted by SWHP. Failure to adhere may result in denial of network participation.

Site interviews may be conducted with senior management, chiefs of major services, or key personnel in nursing, quality management, and utilization management. The office site visit tool is used (SWHP.PNO.018.A3). Quality improvement policies may be requested from the organization, if needed. Organizational provider must credential their practitioners. A CMS or state review may be substituted for the site visit. SWHP/ICSW obtains a report from the institution that a review has been performed, and the report meets SWHP/ICSW standards. A letter from CMS or applicable state agency, which shows that the facility was reviewed and indicates that it passed inspection is acceptable in lieu of the survey report as SWHP/ICSW accepts CMS criteria, as long as the review is not greater than thirty-six (36) months old. A site assessment is not required if the state or CMS has not conducted a site review of the provider and the provider is in a rural area, as defined by the U.S. Census Bureau.

For Physical Therapy, Occupational Therapy, or Speech Therapy providers undergoing re-credentialing and who are not accredited, a site visit is not required unless a complaint has been raised about the facility during the credentialed period.

SWHP/ICSW maintains copies of licenses and certificates in individual organizational provider files.

SWHP/ICSW maintains a checklist containing validation dates for licensure, accreditation status, CMS or state review, or site visits, if applicable, for each organizational provider. The prior validation checklist is maintained in the credentialing file.

Re-credentialing of organizational providers occurs through a process that updates the same information obtained for initial credentialing.

ATTACHMENTS

Facility Application (SWHP.PNO.018.A1)
Site Visit: Medical Practitioner (SWHP.PNO.018.A2)
Site Visit: Facility Provider (SWHP.PNO.018.A3)

RELATED DOCUMENTS

None.

REFERENCES

National Committee for Quality Assurance (NCQA): CR 7 Standard
Texas Administrative Code, Title 28 Insurance, Part 1, Chapter 11 Health Maintenance Organization Centers for Medicare & Medicaid Services (CMS) – Medicare Managed Care Manual, Chapter 6, Section 70 42 CFR 422.204 – Provider Selection and Credentialing

Attachment Name:	Facility Application		
Attachment Number:	SWHP.PNO.018.A1	Last Review/Revision Date:	02/24/2021

Facility/ancillary/long-term care provider application

Provider identification			
Legal business name:			
Doing business as (if applicable):			
Credentialing Contact:	Credentialing Contact Email:		
Credentialing Contact Phone:	Secure Fax:		
Alternative Contact:	Alternative Contact Phone:		
TIN:	NPI:		
Taxonomy:	EMR:		
API:			
Long-term care vendor number:			
DADS/DARS Contract #:			

Primary office/service address (Please submit Additional Locations Addendum for all other locations.)			
Practice location name:			
Medicaid Number/TPI:	Medicare ID:		
Address line 1:			
Address line 2:			
City:	State:	ZIP+4 (Preferred):	County:
Phone:	Fax:	Primary contact:	
Administrator (full name):			
Does provider bill from this address?	Yes No		

Billing information (if different than above)			
Billing name:			
Address line 1:			
Address line 2:			
City:	State:	ZIP+4 (Optional):	County:

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Facility/ancillary/long-term care provider application

Correspondence Address			
Billing name:			
Address line 1:			
Address line 2:			
City:	State:	ZIP+4 (Optional):	County:

Primary office	Office Hours (AM-PM)
Monday:	
Tuesday:	
Wednesday:	
Thursday:	
Friday:	
Saturday:	
Sunday:	

Age of patients served:

Newborn
Preschool (3 to 5 years)
Children (6-12 years)
Adolescents (13-18 years)
Adults
Geriatrics (65+ years)

Patient program/population served:

Serves intellectual or developmental disability (IDD) population
Services pediatric population

Please indicate any age limitations: _____ **Please indicate any gender limitations:**

Does this office meet American Disabilities Act (ADA) accessibility requirements? Yes No N/A

Check all that apply:

Handicap accessible:	Building	Parking	Restroom
Services for the disabled:	Text telephone	American Sign Language	Mental/physical imp.
Accessible by public transportation:	Bus/Taxi	Subway	Regional train

Do you use Electronic Health Records? Yes, No N/A

If No, when might you start? _____

Electronic Claim Submission? Yes No N/A

Does business have internet access? Yes No N/A

If Yes, please check all that apply: Sign Language TTD/TTY None

Identify any foreign language(s) that are spoken other than English: Arabic Hindi Russian Chinese

Italian Spanish Farsi Japanese Sign Language French Korean Tagalog

German Laotian Vietnamese Hebrew Portuguese Other (specify) _____

Other Information. If entry is not applicable, please enter "N/A" (not applicable).

Do you have Emergency Room Capabilities? Yes No N/A

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Facility/ancillary/long-term care provider application

Average case load per day _____ N/A

Maximum capacity caseloads per day _____ N/A

What is your occupancy rate? _____ N/A

Unique Services you currently offer to your Medicaid patients:

After hours coverage yes/no, If yes:

Answering Service Yes No

Automated Message Yes No

On-Call Staff Yes No

Provider type

Adaptive Aids/Medical Equipment (LTSS)	Congregate Care Facility
Adaptive Assistance Devices	Convalescent Facility
Adult Day Care	County Indigent Health Care Program (CIHCP)
Adult Foster Care	Day Habilitation (LTSS)
Allied Health Professional Group	Dental Group/Practice
Ambulance Service/Transportation Company	Diabetes Education Center
Ambulatory Surgical Center (ASC)-Freestanding/Independent	Diagnostic and Treatment Center
Ambulatory Surgical Center (ASC)-Hospital Based	Dialysis Center
Amputee Center	Dispensing Optical Company
Assisted Living	Drug and Department Stores
Audiology/Hearing Center	Durable Medical Equipment
Biological Products Manufacturer	Early Childhood Intervention (ECI)
Birthing Center	Early Intervention Provider Agency
Blood Bank	Emergency Response Service/System
Cardiac Diagnostic Center	Employment Assistance
Cardiac Rehab Center	End Stage Renal Disease Facility (ESRD)
Case Management	Endoscopy Facility
Certified Registered Nurse Anesthesia (CRNA) Group	Family Counseling and Training
Chiropractic Group/Practice	Family Planning Clinic
Chore Service	Federal Qualified Health Center (FQHC)
Companion Services	Financial Management Service Agency
Comprehensive Care Program (CCP)	Free Standing Emergency Room
Comprehensive Health Center (CHC)	Habilitation (LTSS)
Comprehensive Outpatient Rehab Facility (CORF)	Hearing Aid Equipment

Facility/ancillary/long-term care provider application

Provider type (continued)

- Hemophilia Treatment Center
- Home and Community Support Services
- Home Health Agency
- Home Infusion
- Homemaker Service
- Hospice
- Hospital Long Term, Limited or Specialized Care
- Hospital, Acute Care
- Hospital, Military
- Hospital, Pediatric
- Hospital, Private, Full Care
- Hospital, Rehabilitation
- Independent Lab/Privately Owned Lab
- Infertility Center
- Infusion Therapy Clinic
- Laboratory
- Lithotripsy Center
- Local Health Department
- Magnetic Resonance Imaging (MRI)
- Maternity Service Clinic
- Meals, Home Delivered Meals
- Minor Home Modification
- Mobile X-Ray/Mobile Diagnostic Provider
- Multi-Specialty Group
- Non-Emergent Transportation Services
- Nursing Home
- Nursing/Health Care Staffing Service
- Nutritional Counseling
- Occupational Therapy Group/Clinic
- Optometric Group/Practice
- Oral and Maxillofacial Surgery Clinic
- Organ Procurement Organization
- Orthodontist Group
- Orthotics/Prosthetics
- Oxygen Supplier
- Pediatric Day Health Care
- Personal Assistance Services Agency
- Personal Care Services
- Pest Control
- Pharmacist Group
- Pharmacy
- Pharmacy-Chain
- Pharmacy-Close Operation
- Pharmacy-Home Health IV LTC
- Pharmacy-Hospital Class C
- Pharmacy-Independent
- Pharmacy-Out of State Contracted
- Pharmacy-Out of State Non-contracted
- Pharmacy-Out of State TMHCN
- Physical Therapy Group/Clinic
- Physician Group
- Podiatric Group/Practice
- Prescribed Pediatric Extended Care Centers (PPECC)
- Public Health Agency
- Radiation / Cancer Treatment Centers
- Respiratory Therapy
- Retail Clinic
- Rural Health Clinic-Freestanding/Independent
- Rural Health Clinic-Hospital Based
- Skilled Nursing Facility
- Sleep Medicine Center
- Supported Employment/Employment Assistance
- Transition Assistance Services (LTSS)
- Tuberculosis (TB) Clinic-Group
- Urgent Care Center
- Vehicle Modification (LTSS)

Facility/ancillary/long-term care provider application

Response to these questions is required only if your facility type is listed below

Federally Qualified Health Center (FQHC) centers — Please confirm you currently meet and will continue to meet Medicare conditions of coverage as defined in the Social Security Act §1861(aa)? Yes No
If no, attach an explanation of any deficiencies.

Comprehensive Outpatient Rehabilitation Facility (CORF), End-Stage Renal Dialysis (ESRD) Center, Outpatient Physical Therapy (PT), Outpatient Speech Rehabilitation facility, end-stage renal dialysis center, outpatient physical therapy, outpatient speech athology and Rural Health Center (RHC)rural health centers: Please confirm you currently meet and will continue to comply with all Centers for Medicare & Medicaid Services or state survey requirements. Yes No
If no, attach an explanation of any deficiencies.

STAR Kids Providers Must Answer the Following:

All questions must be answered with a checked "yes" or "no". Do not mark N/A for any questions.

Do you participate in the Medically Dependent Children Program (MDCP)? Yes No

Do you participate in the Community First Choice Program (CFC)? Yes No

Are you a Home and Community Support Service Agency (HCSSA) Provider? Yes No

Are you a Community Living Assistance and Support Services (CLASS) Provider? Yes No

Do you participate in the Deaf, Blind, & Multiple Disabilities (DBMD) Program? Yes No

Are you a Youth Empowerment Services (YES) Provider? Yes No

Are you recognized as a NCQA Patient-Centered Medical Home? Yes No

If yes, what level? _____

Do you offer Telemedicine Services? Yes No

Do you offer Telehealth Services? Yes No

Do you offer Telemonitoring Services? Yes No

Please give a list of where telemedicine services are provided if in addition to services locations

Do you participate in an Electronic Visit Verification Program (EVV)? Yes No

If yes, name of vendor used _____

Do you have experience in treating any of the following:

Children with Post-Traumatic Stress Disorder? Yes No

Children and sexual abuse? Yes No

Children with physical abuse? Yes No

Children with developmental disabilities? Yes No

Children with special needs and disabilities? Yes No

Facility/ancillary/long-term care provider application

Customer Service/Quality Improvement Initiatives

1. Does your organization provide any patient advocacy services? Yes No

Explain: _____

_____

2. Is the facility involved in a Quality Improvement Program (QIP)? Yes No

If YES, name of contact person:

To whom should questions regarding employee complaints, bills, estimates, or potential high cost surgeries, etc. be addressed?

Name:	
Phone:	Email:

Licensure & Certificates (attach a copy of current licensure and Clinical Laboratory Improvements Amendment [CLIA] certification, if applicable)

Type of License: State:	License issuance date:	License number:	Expiration date:
Type of License: State:	License issuance date:	License number:	Expiration date:
Type of License: State:	License issuance date:	License number:	Expiration date:
Radiology Certificate #:		Radiology Expiration Date:	
CLIA Certificate #:		CLIA Expiration Date:	

Accreditation/certification (attach a copy of current accreditation, certificate, or survey)

A.

Accreditation Association of Ambulatory Health Care (AAAHC)
Accreditation Commission for Health Care (ACHC)American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
American Board for Certification in Orthotics & Prosthetics
American College of Radiology (ACR)
American College of Radiology Board of Certification
Center for Improvement in Healthcare Quality
Clinical Laboratory Improvement Amendments (CLIA)
CMS
Commission on Accreditation of Rehabilitation Facilities (CARF)

Note: Continuing Care Accreditation Commission (CCAC) and CARF have merged, so CCAC not included separately
Commission on Office Laboratory Accreditation (COLA)
Community Health Action Partnership (CHAP)
Council on Accreditations (COA)
Det Norske Veritas Healthcare, Inc (DNV)
Healthcare Facility Accreditation Program (HFAP)
Healthcare Quality Association on Accreditation
Intersocietal Accreditation Commission (IAC)
Joint Commission for the Accreditation of HealthCare Organization (TJC or JCAHO)
National Association of Boards of Pharmacy (NABP)

Facility/ancillary/long-term care provider application

Accreditation/certification (continued)

National Board of Accreditation for Orthotic Suppliers

RadSite

Texas Department of Aging and Disability Services (Tx DADS)

The Compliance Team

Utilization Review Accreditation Commission (URAC)

Accrediting Body:	Initial accreditation date (mm/dd/yyyy):	Date of last survey (mm/dd/yyyy):
Accrediting Body:	Initial accreditation date (mm/dd/yyyy):	Date of last survey (mm/dd/yyyy):
Accrediting Body:	Initial accreditation date (mm/dd/yyyy):	Date of last survey (mm/dd/yyyy):

Not accredited — Expected date of accreditation (mm/dd/yyyy):

B. Site Survey — Visit May Be Required

Nonaccredited providers must provide a copy of:

- **Most recent government agency survey (may not be older than 36 months),**
- **Corrective action plan (if deficiencies were cited) and attach the proof from the government agency stating facility is in substantial compliance with most recent survey standards.**

Facilities that don't meet the requirements above require an onsite visit before network status may be granted. Failure to provide documentation or complete the onsite survey may delay your ability to become a participating provider.

Has the provider had an on-site survey by CMS or state agency? Yes No

(YES) Date of most recent full survey _____

(NO) Successful completion of a health plan onsite visit will be required to complete credentialing.

General and professional liability insurance – Please submit a copy of your certificate of insurance.	
General liability coverage	
Current carrier name:	
Policy number:	Coverage type: Occurence-based Claims-based
Effective date:	Expiration date:
Per incident: $	Aggregate: $
Professional/Malpractice liability coverage – Please submit a copy of your certificate of insurance.	
Current carrier name:	
Policy number:	Coverage type: Occurence-based Claims-based
Effective date:	Expiration date:
Per incident: $	Aggregate: $

Facility/ancillary/long-term care provider application

Workers Compensation Insurance – Please submit a copy of your certificate of insurance. (Don't enforce for all types)	
Current carrier name:	
Policy number:	Coverage type: Occurence-based Claims-based
Effective date:	Expiration date:
Per incident: $	Aggregate: $

Automobile Insurance
Are you required to carry automobile insurance? Yes No (If yes, submit a copy of your certificate.)

Advance Directive Policy

Do you have an Advance Directive policy? Yes No

Hospital, nursing homes, home health care agency, and skilled nursing facility: If you responded No, please include a copy of the specific section of your policy/process, which addresses that you do not maintain Advance Directive policies. You do not have to include the complete policy.

Professional Disclosure Questions

Please include an explanation on a separate sheet for any question(s) answered Yes.

1. Has the organization ever been reprimanded, fined by any state agency that disciplines allied health professionals or health organizations? Yes No

Has the organization's license to practice or operate in any jurisdiction (state or county) ever been denied, revoked, suspended, sanctioned or subject to probation or any conditions or limitations? Yes No

2. Have any disciplinary proceedings ever been instituted against the organization by any medical organization or medical institute? Yes No

3. Has the organization ever been convicted of a felony? Yes No

4. Have any malpractice suits, arbitration or other proceeding ever been instituted against the organization (regardless of outcome)? Yes No

5. Has the organization ever been investigated, reprimanded, censured, excluded, suspended or disqualified by Medicare or Medicaid program? Yes No

6. Has the organization's liability insurance policy ever been canceled? Yes No

7. Has the organization ever been denied renewal of the liability insurance policy or had any limitations placed on the scope of coverage? Yes No

Note: This impacts the section called "Enclosures."

Explanation of "Yes" answers to attestation questions Credentialing Questionnaire

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Facility/ancillary/long-term care provider application

Attestation Consent and Release

All information provided in this, or in connection with this application, is complete and accurate to the best of my knowledge, and I shall immediately notify the Plan(s) of any changes thereto. I understand that this application does not entitle me to participation in the Plan(s) network. By applying for appointment as an _____ participating provider, I authorize the Plan(s) plan, its medical director, and appropriate representatives to consult with administrators and members of other institutions where I have been associated, including past and present malpractice carriers who may have information bearing on my professional competence, character, and ethical qualifications. I hereby further consent to the inspection by the Plan(s), and their representatives, its medical director and appropriate representatives, of all records and documents, excluding medical records of nonmembers of _____ plans, that may be material to an evaluation of any professional qualifications and competence to carry out the requested duties, as well as my moral and ethical qualifications for participating provider status with the Plan(s) _____ . I consent and agree that _____ will complete a criminal history background check to determine if I, or any subcontracted providers, have any history of felony convictions, including adjudication withheld on a felony, plea or nolo contendere to a felony or entry into a pretrial for a felony. I agree to obtain any consents or approvals required for my subcontracted providers to undergo such background checks.

I hereby release the Plan(s) and its representatives, including TAHP and Aperture Credentialing, LLC, from any liability for their acts performed in good faith and without malice in connection with evaluating my application, credentials, and qualifications. I hereby release any individuals and organizations from any liability that provide information to the Plan(s) and its representatives or its staff in good faith and without malice concerning my professional competence, ethics, character, and other qualifications, and I hereby consent to the release of such information. By executing this application, I confirm that I am bound by the terms of the ancillary agreement between me or my group and the Plan(s), as such terms may be applicable to me.

I understand that as an applicant for participation in the Plan(s), I have the right to review information obtained from primary verification sources during the credentialing process. I further understand that upon notification from the Plan(s), I have the right to explain any information obtained that may vary substantially from that provided by me and correct any erroneous information submitted by another party. This shall be accomplished by my submission of a written explanation or by appearance before the credentialing committee, if they so request. I further understand that I may appeal the committee's decision either in writing or by appearance before the credentialing committee, if they so request.

By signing below, I attest that I have reviewed and understand all terms and conditions contained in this Attestation/Consent & Release. I agree that my electronic signature is equivalent to my hand-written signature.

Type or Print Name_____

Title _____

Signature_____

Date

Enclosures

Please submit all applicable documents from the list below with your completed and signed application. Failure to provide this information will prohibit completion of your credentialing and/or contracting process. Please submit enclosures for each location.

Copy of all federal, state and/or local licenses required to operate as a health care facility (by location) Copy of

accreditation certificate or letter

Copy of most recent CMS or state survey, including your corrective action plan if deficiencies were cited or cover letter from CMS/state agency stating facility is in substantial compliance

Copy of CLIA certificate for each location, as applicable

Copy of current DEA certificate (if applicable);

Current TDH Radiology certificate for each location (if applicable);

Evidence of Texas Mental Health and Mental Retardation certification (REQUIRED for community mental health centers)

Evidence of Medicare certification (REQUIRED for institutional centers)

Professional/Malpractice liability/Workers Compensation Certificate of Insurance (AS REQUIRED ABOVE);

Copy of TMHP Medicaid Letter (when applicable)

Facility/ancillary/long-term care provider application

Enclosures (continued)

Evidence of an Agreement with HHSC [REQUIRED for CORF providers]

Facility Organizational Chart

Medical Director's or Administrator's Curriculum Vitae/ Resume

Medical Staff / Allied Health Professional Roster

Explanation of "Yes" answers to attestation questions

Company brochure (if available)

Current Signed W-9

Auto (professional/general/WC/ Auto) Insurance

Attachment B - Hospital Facilities

Hospital - part of multi-hospital system? Yes No

Are you considered an Essential Community Provider as defined by CMS? Yes No

Hospital Services/Treatment Levels:

Adult acute care	Level 4 trauma
Level 1 trauma	Children's Hospital — [CMS Designated
Level 2 trauma	Designated Childrens Unit/Wing
Level 3 trauma	Specializes in Pediatric Services

Are you a member of the American Hospital Association? Yes No

Number of Certified Beds _____

NICU Level Certification Date

Medicare - Certified Acute Inpatient Facility Information

Medicare Certified Bed Count: _____ ICU Bed Count(excluding Neonatology): _____

Acute Inpatient Rehab Services	Skilled Nursing Unit
Cardiac Catheterization Services	Durable Medical Equipment
Outpatient Occupational Therapy	Surgical Services (Outpatient or ASC)
Cardiac Surgery Program	Inpatient Psychiatric Facility Services
Outpatient Physical Therapy	Mammography
Critical Care Services– Intensive Care Unit (ICU)	Orthotics and Prosthetics
Outpatient Speech Therapy	Outpatient Dialysis
Diagnostic Radiology	Outpatient Infusion/Chemotherapy

Medicare-Approved Transplant Programs

Heart/Lung	Liver
Heart	Lung
	Pancreas
Intestinal	Other

Facility/ancillary/long-term care provider application

Attachment C - Texas Long-Term Services and Supports

Provider type Services Details			
Personal assistance service direct: Consumer-directed block grant model Consumer-directed service (CDS) model Consumer-delegated agency model Financial management/ CDS Rate enhancement program Department of Aging and Disability Services (DADS) participant contract number: List level:	Day activity/health services: Rate enhancement program Department of Aging and Disability Services (DADS) participant contract number: List level:	Residential care/assisted living facility: Rate enhancement program Department of Aging and Disability Services (DADS) participant contract number: List level:	Transition/relocation services

Long-term Care Provider Knowledge of state requirements:

The rendering service practitioner must be knowledgeable of the following:

a.Acts that constitute abuse, neglect, or exploitation of a member, as defined in 40 TAC Chapter 705, Subchapter A

b.Reports suspected abuse, neglect, or exploitation, as instructed

Adheres to applicable state laws when providing transportation

May not be a spouse, legally responsible for person or employment supervisor of the member who receives the service

FOR SUPERIOR HEALTH PLAN AND COMMUNITY FIRST ONLY

Counties Served: Please select the ones in which services can be provided or check here ☐ STATEWIDE [servicing all counties]

Andrews	Aransas	Archer	Armstrong	Atascosa
Austin	Bailey	Bandera	Bastrop	Baylor
Bee	Bell	Bexar	Blanco	Borden
Bosque	Brazoria	Brazos	Brewster	Briscoe
Brooks	Brown	Burleson	Burnet	Caldwell
Calhoun	Callahan	Cameron	Carson	Castro
Chambers	Childress	Clay	Cochran	Coke
Coleman	Collin	Collingsworth	Colorado	Comal
Comanche	Concho	Coryell	Cottle	Crane
Crockett	Crosby	Culberson	Dallam	Dallas
Dawson	Deaf Smith	Denton	DeWitt	Dickens
Dimmit	Donley	Duval	Eastland	Ector

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Facility/ancillary/long-term care provider application

Counties Served (continued)

Edwards	El Paso	Ellis	Falls	Fayette
Fisher	Floyd	Foard	Fort Bend	Freestone
Frio	Gaines	Galveston	Garza	Gillespie
Glasscock	Goliad	Gonzales	Gray	Grimes
Guadalupe	Hale	Hall	Hamilton	Hansford
Hardeman	Hardin	Harris	Hartley	Haskell
Hays	Hemphill	Hidalgo	Hill	Hockley
Hood	Howard	Hudspeth	Hunt	Hutchinson
Irion	Jack	Jackson	Jasper	Jeff Davis
Jefferson	Jim Hogg	Jim Wells	Johnson	Jones
Karnes	Kaufman	Kendall	Kenedy	Kent
Kerr	Kimble	King	Kinney	Kleberg
Knox	La Salle	Lamb	Lampasas	Lavaca
Lee	Leon	Liberty	Limestone	Lipscomb
Live Oak	Llano	Loving	Lubbock	Lynn
Madison	Martin	Mason	Matagorda	Maverick
McCulloch	McLennan	McMullen	Medina	Menard
Midland	Milam	Mills	Mitchell	Montgomery
Moore	Motley	Navarro	Newton	Nolan
Nueces	Ochiltree	Oldham	Orange	Palo
Parker	Parmer	Pecos	Pinto	Polk
Potter	Presidio	Randall	Reagan	Real
Reeves	Refugio	Roberts	Robertson	Rockwall
Runnels	San Saba	San Jacinto	San Patricio	Schleicher
Scurry	Shackelford	Sherman	Somervell	Starr
Stephens	Sterling	Stonewall	Sutton	Swisher
Tarrant	Taylor	Terrell	Terry	Throckmorton
Tom Green	Travis	Tyler	Upton	Uvalde
Val Verde	Victoria	Walker	Waller	Ward
Washington	Webb	Wharton	Wheeler	Wichita
Wilbarger	Willacy	Williamson	Wilson	Winkler
Wise	Yoakum	Young	Zapata	Zavala

Facility/ancillary/long-term care provider application

Attachment D - Behavioral Health Facilities/Providers

Specialty Service Identified (examples ECT, Eating Disorders, Ambulatory Detox....)

Place of service location for each program/service _____

Secure fax number for each place of service address _____

Bed Counts for inpatient Mental Health or Substance Use Disorder _____

Behavioral health (BH):

Behavioral Health (MH) Rehabilitation

Behavioral Health Facility

Behavioral Health Intensive Outpatient

Behavioral Health Partial Hospitalization

Behavioral Health Residential Treatment

Behavioral Health Unit

Chemical Dependency Intensive Outpatient

Chemical Dependency Partial Hospitalization

Develop/Behavioral Pediatric

Hospital, Behavioral Health

Local Behavioral Health Authority (LMHA)

Mental Retardation Diagnostic Services (MRDA)

Outpatient Behavioral Health

OUTPATIENT DIAG/TREATMENT CTR

Physiological-Independent Diagnostic Testing Facilities (IDTF)

Psychiatric Clinic

Psychology Group

Residential Treatment Facility/Program

Residential-Based Supported Community Living Services

Substance Abuse Treatment Center

Adolescent & Children Behavioral Health

DUI/DWI Education Program

Intensive Family Intervention Adult Living Facility

Rehabilitative Behavioral Health Services (RBHS) Assisted Long-Term Care Facility

Statewide Inpatient Psychiatric Program

Psychiatric Residential Treatment Facility

Facility/ancillary/long-term care provider application

Identify specialty services offered	Available[Not]	Available	Location(s)	Comments/Descriptions
Eating Disorder Treatment — Inpatient				
Eating Disorder Treatment – Outpatient				
Electro-convulsive Therapy (ECT) - Inpatient	☐	☐		
Electro-convulsive Therapy (ECT) – Outpatient				
Dual Diagnosis Services				
Continuing Day Treatment				
LBGT services				
Domiciliary Services in an IOP or PHP setting (program must be formally approved by UBH)	☐	☐		
Chronically Mentally Ill Services (CMI)/ Severely Mentally Ill Services (SMI)	☐	☐		
Respite Care Services	☐	☐		
Emergency Room Services (assessment only)	☐	☐		
Twenty-three (23) Hour Crisis Observation				
Mobile Crisis Stabilization				
MHSA Outpatient Clinics in a hospital				
Ambulatory Detox - Drug				
Ambulatory Detox - Alcohol				
Medication Assisted Treatment (MAT) - in an Detox, IOP or PHP setting Methadone Suboxone Buprenorphine Naltrexone (i.e. vivitrol)	☐	☐		
	☐	☐		
Sober Living/Supervised Living				
Halfway House				
Group Home				
Therapeutic Foster Care				
ASAM Residential Services				3.1 3.3 3.5 3.7
Bridge on Discharge (aftercare planning immediately post IP discharge)				Geriatric Adol. Adult Child

Facility Type:

Hospital

Intensive Family Intervention Adult Living Facility

Home Health Agency

Rehabilitation Center

Rehabilitative Behavioral Health Services (RBHS) Assisted Long-Term Care Facility

Substance Use Treatment Facility

Statewide Inpatient Psychiatric Program

Psychiatric Residential Treatment Facility

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Facility/ancillary/long-term care provider application

Facility Practice Locations and Levels of Care per location														
		Mental Heatlh							Substance Abuse					
Location #1														
Address:	Child													
	Adol.													
Phone:	Adult													
Secure Fax:	Geriatric													
NPI:		ECT	I/P				O/P		Methadone			Suboxone		
Taxonomy:	# of I/P Beds (MH):		# of Medicare I/P Beds (MH):					# of I/P Beds (SA):						
Location #2														
Address:	Child													
	Adol.													
Phone:	Adult													
Secure Fax:	Geriatric													
NPI:		ECT	I/P				O/P		Methadone			Suboxone		
Taxonomy:	# of I/P Beds (MH):		# of Medicare I/P Beds (MH):					# of I/P Beds (SA):						
Location #3														
Address:	Child													
	Adol.													
Phone:	Adult													
Secure Fax:	Geriatric													
NPI:		ECT	I/P				O/P		Methadone			Suboxone		
Taxonomy:	# of I/P Beds (MH):		# of Medicare I/P Beds (MH):					# of I/P Beds (SA):						
Location #4														
Address:	Child													
	Adol.													
Phone:	Adult													
Secure Fax:	Geriatric													
NPI:		ECT	I/P				O/P		Methadone			Suboxone		
Taxonomy:	# of I/P Beds (MH):		# of Medicare I/P Beds (MH):					# of I/P Beds (SA):						
Location #5														
Address:	Child													
	Adol.													
Phone:	Adult													
Secure Fax:	Geriatric													
NPI:		ECT	I/P				O/P		Methadone			Suboxone		
Taxonomy:	# of I/P Beds (MH):		# of Medicare I/P Beds (MH):					# of I/P Beds (SA):						

Facility/ancillary/long-term care provider application

Abuse, Neglect, and Exploitation Attestation

Provider must be knowledgeable of acts that constitute Abuse or Neglect and Abuse, Neglect, or Exploitation of a Member. The Department of Family and Protective Services oversee Child Protective Services (CPS) and Adult Protective Services (APS).

Abuse is defined as "the negligent or willful infliction of injury, unreasonable confinement, intimidation, or cruel punishment with resulting physical or emotional harm or pain by the person's caretaker, family member, or other individual who has an ongoing relationship with the person" and includes, but is not limited to:

- Scratches, cuts, bruises, and burns
- Welts, scalp injury, and gag marks
- Sprains, punctures, broken bones, and bedsores
- Confinement
- Rape and other forms of sexual abuse
- Verbal and psychological abuse

Neglect is defined as "the failure to provide for one's self the goods or services, including medical services, which are necessary to avoid physical or emotional harm or pain, or the failure of a caretaker to provide such goods or services" and includes, but is not limited to:

- Malnourishment and dehydration
- Too much or too little medication
- Lack of heat, running water, or electricity
- Unsanitary living conditions
- Lack of medical care
- Lack of personal hygiene or clothes

Exploitation is defined as "the illegal or improper act or process of a caretaker, family member, or other individual who has an ongoing relationship with an elderly or disabled person that involves using, or attempting to use, the resources of the elderly or disabled person, including the person's social security number or other identifying information, for monetary or personal benefit, profit, or gain without the informed consent of the elderly or disabled person" and includes, but is not limited to:

- Taking Social Security or Supplemental Security Income (SSI) checks
- Abusing joint checking accounts
- Taking property and other resources

To Report Abuse for APS or CPS contact them at the following:

- By Phone: 1-800-252-5400
- Online: https://www.dfps.state.tx.us/Contact_Us/report_abuse.asp

The Abuse Hotline toll-free 24 hours a day, 7 days a week, nationwide, or report with our secure website and get a response within 24 hours.

By my signature below, I attest that the Provider represents and warrants they are knowledgeable of acts that constitute Abuse or Neglect (CPS) and Abuse, Neglect, or Exploitation (APS) of a Member. Provider

Type or Print Name_____

Title _____

Signature_____

Date

Attachment Name:	Site Visit: Medical Practitioner		
Attachment Number:	SWHP.PNO.018.A2	**Last Review/Revision Date:**	02/24/2021

Scott & White Health Plan/Insurance Company of Scott & White Site Visit:

Medical Practitioner

Provider Name: _____ Address: _____

Office Contact: _____ Phone: _____

Deficiencies are corrected within 6 months. When major construction is involved, consideration may be given for an extension. Deficiencies are monitored until all elements are brought into compliance. A second site visit may be scheduled within six months, focusing on areas where submitted evidence of improvement has not been accepted as satisfactory.

Scoring _____

Physical Accessibility TDI, NCQA Threshold: 100 %	No	Yes	N/A
Handicap access is noted to be in accordance with state mandates as applicable			
1. Hallway/doorway access is a minimum of 2'10" wide.			
2. Patient has access to lavatory with safety bars.			
3. Entrance has ramp or single low step.			
4. Exam room allows space for wheel chair			
Appearance TDI, NCQA Threshold: 80 %			
1. Exterior of building is presentable			
2. Office waiting room is clean and well lit			
3. Furniture coverings are in good repair			
4. Exam rooms are clean			
5. Furniture and exam tables are in good repair			
Adequacy of Waiting Room TDI, NCQA Threshold: 100 %			
6. Exam rooms have adequate space			
7. Waiting room provides adequate seating. The number of chairs available reflects the number of patients that can be seen in an hour (i.e. 6 patients in an hour, there are at a minimum 6 chairs).			
8. Adequate number of exam rooms. The number of exam rooms reflects the number of practitioners actively seeing patients in a time period. (i.e. 4 physicians have 4 exam rooms)			
Appointment Availability TDI, NCQA Threshold: 100 %			
5. There is evidence that appointments are scheduled according to level of need.			
Urgent Care appointments are available within 24 hours			
Routine Care appointments are available within 5 days. Behavioral Health appointments are available within 10 days.			
Preventive Care appointments are available within 6 weeks. Next available appointment is _____ weeks. (Behavioral Health – NA)			
Adequacy of Treatment Record Keeping TDI, NCQA Threshold: 100 %			
6. Medical records are secure and confidential.			
7. Medical Record is orderly with legible file markers. Office prepares a proposed record of new patient for reviewer. Record has designated places for: Patient identification (e.g. Patient Name/Date of Birth/Medical record number), allergy notation, problem list, Immunizations, as applicable, past medical history, substance abuse (i.e., tobacco, alcohol, and/or other substances), ancillary studies requested (e.g. Lab/X-Ray/Psychometric tests), consult notes, correspondence/records from outside providers, (History/Progress notes acceptable for Newborns/Pediatrics).			
9. Record availability: Medical records are organized and stored in a manner that allows easy retrieval			
Certificate/License for radiology services are current: Admin exp: Tech exp:			

Total points possible:	**Total points:**	**Total %:**	
Texas Department of Insurance Complaint Process Posted.		**No**	**Yes**

Comments and/or recommendations to provider:
Provider feedback/comments:

Reviewer: **Clinic Office Contact:** **Date:**

Attachment Name:	Site Visit: Facility Provider		
Attachment Number:	SWHP.PNO.018.A3	**Last Review/Revision Date:**	02/24/2021

Site Visit: Facility Provider

Site: _____

A practitioner must meet a minimum threshold of 90% to be credentialed as an approved provider. Deficiencies are corrected within 30 days. When major construction is involved, consideration are given for an extension. For sites who meet the threshold, but have deficiencies, a second site review may be done within six (6) months for those areas where submitted evidence of improvements have not been satisfactory.

Second Site Visit Scheduled Date (when applicable):

ELEMENT	YES	NO	N/A	Comments
Adequacy of Facility: Medical Safety and Environment				
Clearly marked office sign (external)				
Facility accessible to persons with disabilities				
Fire alarms/sprinklers				
Fire extinguishers visible and accessible				
Facility clean, neat, well-lit and well-maintained				
Waiting/exam rooms adequate for patient volume (adequate seating)				
Corridors clear				
Exits clearly marked				
Mechanism to inform patients of hours of operation				
Exam rooms designed to assure privacy of patients				
Exam rooms equipped with supplies				
Biohazard disposal				
Sharps container				
Equipment/instruments sterilized/disposable				
TDI complaint process/800 number is displayed				
Provisions for patients who do not speak English or are visually/ hearing impaired				
Written Policies for the Following:				
OSHA guidelines				
Patient confidentiality				
Triage of patients/emergencies				
Handling narcotics				
Inspection of emergency equipment				
Laboratory Area/Services: If Performed in Office				
Current CLIA certification or waiver posted Date:				
Area clean and organized				
Radiology Area/Services: If Performed in Office				
Certificate of registration Bureau of Radiation Control (current in past 3 yrs) , Radiology Date: Technology Date:				
Area clean and organized				
Medical Record Keeping:				
Medical records are available during office hours				
Medical records protected from public access/inadvertent exposure				
Medical records are individualized by patient name or ID				
Consults, labs, x-rays are contained in medical record				
Medical records secured/system for organization of file				

ELEMENT	YES	NO	N/A	Comments
Medical records released only in accordance with Federal and state laws, court orders or subpoenas, including release request by member.				
Each chart has a sample problem list.				
Electronic medical records (secure system used)				
TOTALS:				%

Provider feedback/comments:

Reviewer: _____ Clinic Office Contact: _____ Date: