UNIVERSITY *of* NORTH TEXAS HEALTH SCIENCE CENTER *at Fort Worth*

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Education, Research, Patient Care *and* Service

PROVIDER THIRD PARTY/MCO PARTICIPATION POLICY AND PROCEDURES

MSRDP Operating Procedure Number:	1.010
Effective Date:	September 1, 2003
Prepared By:	MSRDP Business Administration
Purpose:	To define the process and responsibility for the provider Credentialing process.

Approval: _____

1.0 **Policy.** All providers new to UNTHSCFW are required to complete a credentialing packet assembled by Quality Management and distributed by the providers intended department.

2.0 **Purpose.** All providers new to UNTHSCFW are required to complete a credentialing packet assembled by Quality Management and distributed by the providers intended department.

3.0 **Definition.** Not applicable.

4.0 **Procedures.**

4.1 Quality Management distributes the credentialing packet to the requesting department. The packet contains the following forms that must be completed in order to receive provider billing numbers and be accepted to various insurance and managed care plans:

4.1.1 Medicare

4.1.2 Medicaid

4.1.3 BC/BS Par Plan

4.1.4 First Health

4.1.5 Railroad Medicare

4.2 The Managed Care Coordinator processes all insurance and managed care applications for behavioral health providers.

4.3 When the packet is returned to Quality Management, the Managed Care Coordinator is provided with a copy of the Request for Application and thereby notified that there is a new provider to process.

4.4 The Ecare website is accessed to check for the provider's UPIN number. If the provider does not have a UPIN number, it will need to be obtained from Medicare.

4.5 A provider folder is created containing the following documentation:

4.5.1 Texas Standardized Credentialing Application

4.5.2 Copy of current state licenses, Texas Department of Public Safety (DPS) and Drug Enforcement Agency (DEA) certificates

4.5.3 Curriculum Vitae, if applicable

4.5.4 Medicare, Medicaid, Railroad Medicare signature pages

4.5.5 Aetna participation form and signed HCFA 1500 form

4.6 When completed, the Medicare application is sent by certified return receipt mail. While the Medicare application is in progress, the request for a BC/BS Provider Number may be faxed to the carrier. A copy of the temporary state license is submitted if the applicant has no current state license. The BC/BS Provider Number is required so that TIOPA may submit applications to various managed care plans.

4.7 The Aetna participation form is faxed and ten mailed to Aetna Network Management. The signed HCFA 1500 form is forwarded to TIOPA for processing with PacifiCare. The Medicaid, Railroad Medicare and First Health applications are completed and held in the provider folder until the Medicare number has been received.

4.8 When the Medicare and UPIN numbers are received, the Medicare Railroad and First Health applications are processed and TIOPA is notified.

4.9 The Health and Information Systems Analyst is notified to set up a billing number for the new provider. The UPIN and Medicare numbers are provided for entry into the billing system.

4.10 While the above mentioned applications are being processed, the department initiates the form for OMCT privileges. This consists of the Texas Standardized Credentialing Application.

4.11 The department is responsible for initiating the OMCT privileging process and for payment of membership fees to begin the TIOPA credentialing.

4.12 OMCT is responsible for TIOPA credentialing.

4.13 The TIOPA provider representative concurrently works with the managed care contracts to get the new providers on the plans.

4.14 It takes approximately four (4) weeks to obtain the Medicaid and Medicare Railroad billing numbers.

4.15 As each billing number is received, the Health Information Systems Analyst is notified to enter the information into the billing system.

4.16 Clinic management is notified when the billing provider numbers are received.

4.17 A current DEA, DPS, C.V., Board Certification document or official letter from the Board indicating the exam date and an insurance face sheet are required for TIOPA credentialing and direct contract plans.

4.18 The TIOPA credentialing process takes approximately two and one-half (2 ½) to four (4) months to complete. The applications are processed through various credentialing committees. This is dependent upon when the meetings are scheduled and when the application is presented for consideration.

4.19 The current time frame for processing the credentialing applications for all plans is approximately six (6) months after Quality Management receives the complete credentialing package.

5.0 References.

6.0 Follow-Up and Review. Every three (3) years as needed.

7.0 Responsibility. Senior Associate Dean and Chief Medical Officer
Vice President, Practice Operations and Chief Administrative Officer
Sr. Administrative Official in Each Patient Care Department