APS Healthcare Puerto Rico

Participating Provider Manual
A Guide for Contracted Providers and Facilities

2020

INDEX

I. INTRODUCTION

Welcome to APS Healthcare Puerto Rico Provider Network

As a Participating Provider, you join a select network of facilities and treatment programs that works with an innovative managed behavioral health organization. APS has developed a network of providers to help increase the effectiveness and promote the rational use of mental health and chemical dependency resources. In close collaboration with our participating providers, we ensure that processes like case management, quality assurance and utilization review, are safeguarding quality while properly managing costs.

This Provider's Manual was developed to answer your questions, make recommendations and to serve as a reference source for your office staff.

It might be necessary to update this Manual, to comply with contractual or business changes. You will receive replacement sections with explanations of changes, additions or deletions. Periodically you will also receive APS Healthcare informational communications and Provider Newsletters.

APS provides a partnership with you, which offers referrals and prompt reimbursement for your services. The information contained herein is applicable to all network providers; however, authorization and claims submission procedures vary by customer. Please refer to the member's identification card to determine authorization and claims payment procedures.

Remember that this document does not replace the Provider contract that you currently have with APS Healthcare Puerto Rico.

QUESTIONS OR COMMENTS

Specific policy or procedural questions that may arise shall be directed to the Provider Relations Department of APS Healthcare Inc., using the following address or by contacting the Provider Service Line:

APS Healthcare, Inc.
Provider Relations Department
P.O. Box 71474
San Juan, P.R. 00936-8574
Phone: (787) 641-0773

II. APS HEALTHCARE PUERTO RICO, INC.

As a Managed Behavioral Healthcare Organization (MBHO), APS has the expertise to provide: administrative, consultative and case management services to our providers and members.

APS offers twenty-four (24) hour on call service for Members and Providers by trained and experienced professionals. Assessment and referral services are provided to the most appropriate and available level of care. Psychiatric nurses (RN), master's level social workers (MSW), or psychologists conduct patient interviews telephonically and review treatments for providers delivering clinical services. Psychiatrists are on staff and available for consultation whenever necessary. Treatment planning with our clinical care managers is coordinated with our providers from initial assessment and throughout treatment.

We believe that the relationship between treatment standards and clinical judgment is one of assistance and collaboration rather than one of control. The intent of treatment standards is to inform clinical judgment, not to overrule the clinician's professional experience.

APS requires that utilization management (UM) determinations are based upon evidence based medical necessity criteria which are evaluated by appropriate clinicians with current knowledge relevant to the criteria under review and approved by the VP of Medical Affairs, annually. To obtain a set of the APS Healthcare Puerto Rico, Inc. clinical criteria, please send an email to: clinicalcriteria@apspuertorico.com

III. MEMBER RIGHTS AND RESPONSABILITIES

APS providers should be familiar with the APS Members Rights and Responsibilities Statement. A copy of these should either be displayed in your office or given to the member prior to render any service.

A. Member Rights

1. Members have the right to receive provided care and treatment with dignity and respect; as individuals who have personal needs, feelings, preferences and requirements.

2. Members have the right to impartial services and access to treatment, regardless of race, religion, gender, ethnicity, age, or disability.

3. Members have the right to privacy in their treatment, in their care and in fulfillment of their personal needs.

4. Members have the right to be treated by staff/providers who communicate in a language/format they understand.

5. Members have the right to be fully informed of all services available, any charges for or limitations to those services and available alternative treatment.

6. Members have the right to be provided an individualized treatment plan and to participate in decision making regarding their treatment planning.

7. Members have the right to be fully informed, in a language/format they understand, of their rights as clients and of all rules and regulations governing their conduct as clients in this program.

8. Members have the right to be fully informed of all diagnostic and/or treatment procedures, medication treatments, including the benefits and risks, any research projects involving their treatment through APS and to receive information necessary to give informed consent prior to the start of any procedures, treatment or research project.

9. Members have the right to a candid discussion of appropriate or medically necessary treatment options for their conditions. Members have the right to know treatment options regardless of the cost and whether they are covered services.

10. Members have the right to refuse treatment without compromising their access to the organization's services to the extent permitted by law, and to be informed of the consequences of this refusal. However, the provider reserves the right to discontinue treatment should the extent of their refusal make reasonable and responsible treatment possible.

11. Members have the right to continuity of care. As long as they remain eligible for services through APS, members will not be discharged or transferred except for therapeutic reasons, for their personal welfare, or for the welfare of others. Should their transfer or discharge become necessary, members will be given the reasons and plan, as well as reasonable advance notice, unless an emergency situation exists.

12. Members have the right to voice opinions, recommendations, complaints, or appeals in relation to APS policies, members' rights and responsibilities or the care provided without fear of restraint, interference, coercion, discrimination, or reprisal.

13. Members have the right to be free from physical, chemical and mental abuse.

14. Members have the right to confidentiality management of their medical records as established by HIPAA Law.

15. Members have the right to refuse to perform any services for the program, or for other clients, unless they are a part of their therapeutic plan of treatment, which they have approved.

16. Members have the right to be informed in advance of any non-staff visitors to a facility/office and the right to privacy if they do not wish to see visitors, or participate in activities while visitors are present.

17. Members have the right to receive information necessary to give informed consent prior to being involved in activities, which include the use of tape recorders, video tape equipment, one-way observation mirrors, photography, or any other techniques.

18. Members have the right to receive information regarding the authorization and certification /non-certification processes, benefit plan services included and excluded; co-payments; the provider network available for their care at the time they seek to access care; clinical guidelines, members rights and responsibilities; and how to file a claim.

19. Members have the right to file an appeal for review by an individual uninvolved in the original determination.

B. Member Responsibilities

1. Members have the responsibility to provide, to the extent possible, information that APS and its providers need in order to care for them.

2. Members have a responsibility to follow the plans and instructions for care that they have agreed upon with their provider(s).

3. Members have the responsibility to follow administrative guidelines and codes of conduct in the provider facility.

4. Members have the responsibility to attend appointments free from the influence of alcohol and illegal substances.

5. Members have a responsibility to participate, to the degree possible, in understanding their behavioral health problems and developing mutually agreed-upon treatment goals.

6. Members have a responsibility to follow APS policies and processes as described in their handbook/packet regarding authorization and certification/non-certification; benefit plan eligibility; benefit plan services included and excluded; co-payments; the provider network available to them and how to file a claim.

IV. PROVIDER OPERATIONS

The Provider Operations Area, operating through its Provider Relations Department, acts as a liaison between all mental health providers, and the departments within the organization.

The Provider Relations Department is responsible for Credentialing, Re-Credentialing, Contracting and servicing processes and is dedicated to assist APS providers with the following:

* Orientation of new APS providers and their staff
* Education of APS providers regarding policies and procedures
* Conducting Site Visits
* Producing and distributing provider newsletters
* Resolving problems for providers
* Contracting providers
* Network development
* Recruitment of specialized providers

A. Provider Service Line

APS maintains a team to answer provider questions through a direct number. The phone lines are open from 7:00 a.m. - 5:00 p.m. Monday - Friday. The phone number is (787) 641-0781. Also, providers can be oriented in person at APS Central Office by previous appointment.

B. Changes in Provider Information

Any change of a provider's name, address, phone number, facsimile number, or tax identification number shall be submitted in writing to the attention of the Provider Relations Department. The request should be signed and dated by the provider and will be accepted by mail or facsimile. To ensure timely claims processing, APS is to be notified as soon as a change occurs. If a requested change requires re-contracting or amending a provider's current agreement, the agreement or amendment must be executed before the change becomes effective. For example, if a provider resigns from one APS practice group and then joins another, both APS practice group agreements will be amended. If a provider resigns from an APS practice group to establish an independent practice, the provider will no longer be considered active unless accepted into the network as an independent practitioner.

C. Provider Access

When APS contacts a provider with a referral or a member in ongoing treatment calls a provider to schedule an appointment, it is expected that the provider will be able to offer an appointment to the member within APS standards of accessibility.

The following scheduling standards supersede all lesser standards in the provider agreement:

1. **Emergent Care**

When a member presents with a life-threatening emergency they should be seen immediately. Members who present with a non-life-threatening emergency should be offered an appointment within six (6) hours of contact.

Life-threatening Emergent Care is required when a member has made a suicide attempt or is in immediate danger of committing a suicide or homicide attempt. It might be appropriate for the member to be treated in the Emergency Room of a hospital on those occasions. Non-life threatening Emergent Care applies to those situations when the patient is markedly distressed, has limited resources, and when there is a strong potential for rapid stabilization.

2. **Urgent Care**

Urgent care is required when a member is markedly distressed but has the resources to avoid imminent stabilization. When a member requires **urgent care** an appointment should be offered within twenty four (24) hours of contact.

3. **Routine Care**

An appointment must be offered within ten (10) business days of the initial referral for routine care. For members being discharged from the inpatient, partial day hospital, or intensive outpatient levels of care, an appointment must be offered within five (5) business days.

When accepting referrals, providers should be able to schedule ongoing appointments in a timely manner. Every attempt should be made to accommodate members within these access standards. It is important that the provider document the first appointment offered, especially when the member fits either the emergent or urgent criteria or refuses appointments that fall within the APS access standards. If a provider is unable to meet these standards, the provider shall notify APS so that alternative arrangements can be made. Any provider who is consistently unable to schedule appointments within the time frames described above, will be presented to APS's Credentialing Committee for review and corresponding action.

When a member contacts his or her provider by telephone for any reason, it is expected that the provider or an office administrator will return the member's call promptly. Emergent phone calls are to be returned within thirty (30) minutes. Urgent calls are to be returned within one (1) hour. Routine calls are to be returned by the next business day.

APS network providers are responsible for the ongoing care of any member for whom a referral has been accepted. **It is expected that answering machine messages and**

answering services provide patients with a number to contact the provider in the case of an emergency. A message that states that the patient should go to the Emergency Room of a hospital is not acceptable. If on-call responsibilities are rotated in a group practice or with clinicians who do not participate with APS, it is the responsibility of the primary clinician to see that APS's referral and authorization procedures are followed.

4. New Patients/Clients

A) Please remember that you must accept new referrals from APS on the same basis as you are accepting non-APS members; without regard to race, religion, gender, color, sexual orientation, place of residence, national origin, age or physical or mental health status.

B) The only times you may refuse an APS referral are:

- *The patient requires treatment that is outside the scope of your clinical licensure or expertise.*
- *Your panel is closed to all new patients.*

Note: If you decide to stop accepting any new patients, you must provide APS a writing notice 30 days in advance.

5. Preferential Turns

As an APS provider you are expected to establish a system of preferential turns - regardless of your specialty- that include residents of the island municipalities of Vieques and Culebra. A system of preferential turns refers to a policy that you as a provider must establish, in order to give priority in treating enrollees from the islands of Vieques and Culebra, so they are able to be seen by a provider within a reasonable time after arriving to the Provider's office. The priority in turns given to these enrollees is necessary due to their remote place of residence and the increased length of time required in getting back to those places. All providers must be aware that this is a requirement established by Articles 1-4 of the Law No. 86 of August 16, 1997 and Articles 1-5 of Law No. 200 of August 5, 2004.

6. Report Requirements

Provider must comply with reporting requirements as established by APS, and particularly with the requirements to submit Encounter Data, Claims Data, UM Data, for all services provided, and to report all instances of suspected Fraud and Abuse among others. All reports submitted by you as a Provider to APS, have to be labeled with the Provider's NPI. Other reports might be required by APS as needed according to the terms of the provider contract or the contract between APS and ASES.

D. FACILITY STANDARDS

Our facilities standards refer to the inpatient and outpatient sites where members receive care services. These standards address the appearance, safety and licensure, if applicable, of the office or facility. The following standards are required of APS facility providers:

- Visible signs clearly identify the facility;
- The exterior of the building is clean and well maintained;
- The area surrounding the facility is safe when exiting at night;
- The waiting room has adequate seating for patients;
- The facility is clean and in good repair (this includes the waiting room, admission area, patient rooms and halls, offices, kitchen, dining area, restrooms and common areas);
- The facility meets the requirements of the Americans with Disabilities Act (ADA);
- Emergency phone numbers (police, fire, ambulance) are posted in common staff areas;
- Fire extinguishers are readily available;
- Smoking is restricted to an outdoor location or a separately ventilated room;
- Medications are protected from public access;
- All hospital units and inpatient/outpatient programs are licensed by the state;
- If eligible, the hospital or facility is accredited by the Joint Commission for the Accreditation of Health Care Organizations (JCAHO);
- If sanctioned by JCAHO, the provider has submitted an acceptable corrective action plan;
- If eligible, the provider is Medicare approved;
- If eligible, the provider is Medicaid approved.

E. SERVICE STANDARDS

1. The following service standards apply to all providers:

- There is at least one staff member available for patient intake during business hours;
- Routine phone calls from patients are returned by the next business day;
- Urgent calls from patients are returned within one (1) hour;
- Emergent calls from patients are returned within thirty (30) minutes;
- The provider informs all patients on how the provider is to be contacted during and after business hours in an urgent or emergent situation;
- Routine initial outpatient appointments are scheduled within ten (10) business days;
- For members being discharged from the inpatient, partial day hospital, or intensive outpatient levels of care, an appointment must be offered within five (5) business days.

- Urgent outpatient appointments are scheduled within twenty four (24) hours of the referral or contact from a member in ongoing treatment;
- Emergency services are scheduled immediately if the patient has a life-threatening emergency or within six (6) hours of the referral or contact from a member in non-life-threatening emergencies;
- Providers are required to be certified in de-escalation techniques;
- Providers are required to accept and distribute APS educational materials;
- Providers are required to follow APS's utilization management program protocols;
- Providers must share their clinical information with the member's Primary Care Physician (PCP);
- Member Rights and Responsibilities statement is displayed or distributed to the member prior to rendering service.

2. **The following service standards apply only to those providers contracted with APS to provide inpatient, residential, partial hospitalization, intensive outpatient services or twenty-three (23) hours evaluation and observation services:**

- Visitors are required to sign a confidentiality statement prior to entering patient areas;
- Provider adheres to written admission criteria;
- If services are not provided in a general hospital, arrangements are in place for transporting patients in the case of a medical emergency;
- Examination rooms are available to perform the case history and physical examination of patients;
- Adequate clinical staff to patient ratio;
- Staff is trained annually in de-escalation techniques;
- Treatment is individually tailored to meet the needs of each patient;
- Adult and adolescent patients are separated by units or by patient rooms;
- Adolescent and child patients are separated by units or by patient rooms;
- The Initial Treatment Plan is completed within twenty-four (24) hours of admission, as instructed by Puerto Rico Law 408;
- The case history and physical examination of the patients are completed within twenty-four (24) hours of admission;
- The Psychosocial Assessment is completed within twenty-four (24) hours of admission;
- The Initial Psychiatric Assessment including Mental Status Exam and DSM-V diagnosis is completed within twenty-four (24) hours of admission;

- Discharge planning begins upon admission and includes scheduling a post-discharge outpatient appointment within forty-eight (48) hours of discharge.
- Admissions are accepted twenty-four (24) hours per day, seven (7) days per week;
- Acute units are locked;
- All hallways can be monitored from the nursing station(s) directly or with the use of video equipment;
- *For inpatient facilities, the following will also apply:*
- Patients do not have access to potentially harmful objects;
- Shower heads are recessed or do not bear weight (suicide-proof);
- Patient rooms are free from any weight-bearing objects;
- Patient rooms are free of electrical cords that are twelve (12) inches or longer in length;
- Medically complex patients who are at-risk for suicide and are in rooms that require electrical cords are monitored at least every fifteen (15) minutes;
- Light fixtures are recessed or are protected by a non-breakable device;
- Windows and mirrors are shatterproof or protected by a non-breakable device;
- All objects within the seclusion room are secured;
- One piece toilet seats are used in the seclusion area restroom;
- Patients in seclusion and in the adjacent bathroom can be viewed by staff at all times;
- Staff is trained annually in the use of de-escalation techniques to avoid the use of seclusion unless absolutely necessary.

3. The following service standards apply to only those hospitals and programs who provide substance abuse services:

- Patients are seen at least once within any 24 hour period.
- If provided, admissions for medical detoxification are accepted twenty-four (24) hours per day, seven (7) days per week;
- Beds dedicated to patients admitted for detoxification are nearest to the nursing station;
- Staff includes providers with substance abuse certification;
- Urine/drug screens are conducted routinely;
- An aftercare program is offered to all patients.

F. ON-CALL COVERAGE

1. Covering Providers

If a provider is temporarily unavailable to members who are in active treatment, the provider is responsible for arranging adequate emergency coverage during his/her absence. APS must be notified of all coverage arrangements. Covering providers must adhere to all APS's administrative requirements, including, but not limited to: authorization procedures, accessibility standards and co-payment collection. The covering provider must be of equivalent licensure level and must accept APS's fee schedule allowance.

When arranging emergency coverage, network providers are not required to work with a participating APS provider but it is suggested. If the provider who is covering is not participating with APS, the APS provider is responsible for obtaining authorization for coverage from APS. All claims generated by the covering provider should include the authorization number and should indicate the provider for whom services are being covered. Payment for claims submitted without this documentation will be denied.

2. Suspending Referrals

When a provider is temporarily unable to schedule initial appointments within ten (10) business days or if the provider is unable to accept new referrals due to a leave of absence, vacation or any other reason, the provider shall notify APS in writing. A letter stating the reason for the provider's inability to accept referrals and the time frame during which referrals are to be suspended, should be submitted to the attention of the Provider Relations Department.

G. CREDENTIALING/RECREDENTIALING

1. Initial Credentialing

All prospective providers undergo an evaluation of their professional credentials and experience. The purpose of the credentialing process is to ensure that all APS providers meet the criteria established by the APS Credentialing Committee. The credentialing process also ensures compliance with the guidelines established by the National Committee for Quality Assurance (NCQA), URAC and Center for Medicare and Medicaid Services (CMS).

The credentialing process is initiated with the submission of a signed agreement and a complete application to APS. The application is carefully reviewed for completeness and adherence to the APS credentialing criteria. Accepted applications with supporting documents are submitted for primary source verification and then forwarded to the APS Credentialing Committee for peer review and disposition. All applicants are informed in writing of acceptance or rejection from the APS network.

The Credentialing Committee is chaired by the VP of Medical Affairs and also includes network providers in order to obtain peer review.

2. Primary Source Verification

Choosing the practitioners who will work well in the delivery system is the responsibility of APS. Well-defined policies and procedures describe the requirements and the process used to evaluate practitioners.

(a) Application reviewed for completeness. Any application more than one hundred and eighty (**180**) days beyond the signature date requires a current signature to confirm that all the information remains accurate and correct.

(b) License verification through the appropriate state licensing board is written.

(c) Copy of the Puerto Rico Medicaid Program (PRMP) enrollment; must be active in order to comply with Federal regulations 42 CFR 431.107 (b) and 455.410 (b) require that the State Medicaid Agency, the PRMP under the Puerto Rico Department of Health, to enroll providers participating in the Medicaid program, including all the providers that order, prescribe, refer, provide and bill services to the Government Health Plan only apply to Vital and Platino Plans. (https://www.medicaid.pr.gov/Home/PEP/)

(d) Liability Insurance; Must be active and meet minimum coverage required 1 million/3 million for Hospitals, Programs, Agencies, while M.D. and D.O. Ph.D. and MSW level requires 100,000/300,000 coverage. Additional verification is required only if there is a positive history in the past five (5) years of claims or sanctions.

(e) Positive history of claims requires written explanation from the provider to be reviewed by the Credentialing Committee.

(f) Hospital Privileges: Verified in writing through Privilege Verification Form (Required for MD and DO).

(g) Board Certification: Copy of entry into ABMS compendium.

(h) If not Board Certified, residency must be verified in writing with verification of residency form or clearing house.

(i) Education verified at highest level, attained with the University in writing or clearing house. For MD and DO this is not required if Board Certified or if the residency is verified.

(j) A copy of a valid DEA or CDS certificate (if applicable).

(k) National Provider Data Bank (NPDB) inquiry queried for all providers. If there are any loss of privileges, malpractice history or other sanctions found, they will be reviewed on a case by case basis by the Area Credentialing Committee.

(l) Provider is reviewed by the APS Credentialing Committee for final approval.

(m)Educational Commission for Foreign Medical Graduates (ECFMG) must be included for Foreign Graduates.

(n) Curriculum Vitae: The last five years must be documented and explained, if any GAP is identified.

The credentialing specialist will notify the applicant of missing data elements and secure the required information. If the credentialing specialist is unable to secure the required information within a predetermined time, the credentialing process will cease and the applicant will be notified in writing of the action with cause.

Confirmation of primary source verification is expected to be submitted to the Credentialing Committee in sixty (60) days for US educated/trained providers and ninety (90) days for foreign educated/trained providers following receipt of a completed application and supporting documents. A portfolio with copies of the supporting documents of each applicant will be submitted to APS Credentialing Committee.

3. Re-credentialing

As a participating provider, you will undergo a triennial (every 3 years) re-examination of your credentials. The process will be initiated six months (6) prior to the anniversary date of the contract or employment. The re-examination of your credentials will be combined with an objective evaluation of your history with APS related to:

(a) Delivery of Quality Care that is congruent with APS' philosophy and treatment protocols.
(b) Participation in Quality Improvement activities
(c) Utilization Management (compliance and track record)
(d) Patient Satisfaction (survey results and complaint tracking)
(e) Medical Records (meeting objective criteria for completeness and legibility)
(f) Results of office site visits
(g) Quality of Care Issues
(h) Complaints and Grievances history

All of the above described information will be reviewed by the Credentialing Committee who will decide whether participation in the APS network will be continued. You will be notified in writing of the decisions of the committee. If the re-credentialing process is not completed within 3 years, you will be terminated from the network and will need to apply to APS as a new provider.

4. Credentialing Committee

Reports to: APS Quality Improvement Committee
Reporting Process: Submission of written minutes approved by the committee chair. Verbal and written presentation of recommendations for credentialing and re-credentialing decisions for network participation to the HP QIC.

Meeting Frequency: At least monthly
Membership:

- VP Medical Affairs (Chair)
- Network Practitioner: Psychiatrist
- Network Practitioner: Psychologist
- Network Practitioner: Child and Adolescent Practitioner
- Network Practitioner: Social Worker/Other Masters-level
- Network Practitioner: Substance Abuse Counselor
- Network Practitioner: Inpatient Practitioner
- Providers Network Manager (non-voting member)

Roles and Functions of Committee: The functions of this committee include the following:

- Oversee and conduct the credentialing and recredentialing of practitioners and providers, and conduct peer review and approval of credentialing status to network practitioners and providers.
- Credential provider entities, such as inpatient facilities.
- Make recommendations on content of credentialing policies and procedures for practitioners and providers.
- Review quality of care issues related to individual practitioners or providers and make recommendations as appropriate.
- Review and approve oversight activities related to delegated credentialing arrangements.

5. Quality Reviews

In addition to the normal re-credentialing cycle, providers may be reviewed between cycles when quality performance monitors indicate the need for such a review. APS monitors the quality of provider services by tracking complaints received from members, clients, organizations or APS staff. Complaints are weighted according to the seriousness of the complaint or by the number of less serious complaints received. In all cases, a Provider Relations staff member will contact provider to gain additional information about the content of the complaint before a weight is assigned.

In most instances, APS will work with the provider to either educate them in cases where lack of knowledge on the part of the provider led to the complaints, or to develop an Action Plan with the provider to bring them into compliance.

In certain instances when, either because of the number of complaints or the seriousness of the complaint, the provider file will be reviewed by the Credentialing Committee who will make recommendations regarding the network status of the provider as well as regarding actions to be taken by APS. A provider may be suspended or terminated from the network as a result of the review of the Credentialing Committee. Possible actions which can be taken by APS include, but are not limited to a Site Visit of the practitioner, a Treatment Record review of APS members in treatment with practitioner, contact by the

APS VP Medical Affairs or or his/her delegate to further discuss the issues, suspension or termination from the network.

6. Additional Events Causing Early Termination or Suspension:

Notwithstanding any other provision in the Provider Service Agreement, The Credentialing Committee may terminate a provider's credentialing status at any time upon notice to the Physician of the occurrence of any of the following events;

(a) Provider's conviction of a felony or misdemeanor or involving moral turpitude.

(b) Professional incompetence of Provider, or non-performance of professional responsibility.

(c) Provider's failure to comply with quality improvement and utilization review procedures and standards, as established by APS, including, but not limited to, appointment availability, billing practices, utilization, provision of services, cost effective use of inpatient services unless adequately justified as determined by APS surveys or outcome studies and failure to meet timeline requirements of the credentialing program.

(d) Provider's physical disability resulting from alcohol or drug abuse, which impairs physician's ability to practice his or her profession in a competent manner; or loss or suspension of the licenses required to fulfill the Agreement.

(e) Provider's failure to maintain membership on the Medical Staff of his/her primary admitting facility or failure to maintain adequate malpractice or general liability insurance.

(f) Provider's failure to provide satisfactory personal and professional references and credentials, or to provide verifiable information regarding past employment, training, hospital affiliation, or professional licensing for him/herself or any paraprofessional under his/her supervision.

(g) Provider being a party to or having been a party to malpractice or other litigation or arbitration that has resulted in material judgments, settlements or awards against Physician.

(h) Provider's solicitation of Member's during the initial and any succeeding term of the Agreement, or knowingly or directly advising any APS Member to become enrolled with any other Health Maintenance Organization, Physician Organization, or any other similar hospitalization or medical payment plan or insurance program.

(i) APS's inability to maintain agreements with hospitals, physicians, and ancillary service providers who collectively constitute a service delivery system, or the loss of business in the provider's service area.

APS reserves the right to suspend or terminate a provider immediately. In all cases, APS will notify the provider in writing that these actions have or are about to occur and inform them of the reasons for these decisions, and offer the provider the right to appeal the decision and review APS documentation.

H. Provider Appeal Rights

1. Appeals Process

To assure providers the right to appeal decisions made by APS, an appeals policy and procedure was implemented for situations in which a credentialing or re-credentialing determination or a review of quality of care or service issues result in alteration of provider privileges. The policy also indicates that as part of its responsibility to safe-guard client members, APS will notify the appropriate authorities when a provider is terminated due to a serious quality deficiency.

SEND APPEALS TO:

APS HEALTHCARE PUERTO RICO, INC.
PROVIDER RELATIONS DEPT.
P.O. Box 71474
San Juan, PR 00936-8574

The final determination, made within twenty days of the appeal, may be to uphold, modify or reverse the original determination. In any case, provider notification by the Provider Appeals Sub Committee must be made within five business days of the final determination. If circumstances beyond the committee's control occur, the Provider Appeals Sub Committee may be given an additional ten days to provide the determination. The provider notification letter contains the final determination and the reasons behind any delay.

The Provider Appeals Sub Committee maintains a provider appeals log to track and trend the data and information. This aggregated data and information is submitted to the Network Committee on a quarterly basis for review and incorporation into the network quality improvement report submitted to the APS Quality Improvement Committee.

2. Practitioner Appeals Committee

Reports to: APS Quality Improvement Committee
Reporting Process: Submission of written minutes approved by the committee chair. Verbal and written presentation of recommendations related to appeal outcome.
Meeting Frequency: As needed basis
Membership:

- VP medical Affairs, (Chair, non-voting member)
- At least 3 clinical professionals who are not in direct economic competition with the practitioner under review. For review of physician practitioners all members will be licensed physicians. For review of non-physician practitioners at least one member

will be a physician and at least one member will be in the discipline of the practitioner under review.
- Chief Clinical Officer (non-voting staff)
- Provider Director (non-voting staff)
- Credentialing Supervisor (non-voting staff)
- APS Legal Counsel (non-voting staff)
- Quality Improvement Director (non-voting staff)

Roles and Functions of Committee: The functions of this committee include the following:
- Complete review of all materials relevant to practitioner appeals related to APS' modification or termination of network participation.
- Determine appeal outcome to overturn, overturn with conditions or uphold prior Credentialing Committee decision on practitioners network participation.

3. Reporting of Termination Decisions

In accordance with Federal Law, the National Practitioner Data Bank and the State Licensing Agency shall be informed of APS's decision to terminate a provider:

APS will report to the National Practitioner Data Bank and the appropriate licensing agencies all providers who have been suspended or terminated for quality of care issues.

The provider is apprised during the sanctioning process that a report may be sent to the licensing agencies and boards. The provider will then be granted with the opportunity to further clarify issues and provide additional relevant information. In all cases, providers will be given the right to appeal any credentialing or re-credentialing decision to the APS Provider Appeals Subcommittee.

I. Provider Education

1. Provider Orientation Program

The purpose of this program is to orient new providers to APS's clinical philosophy, operational policies and administrative procedures. The APS Provider Manual is reviewed and providers are briefed on APS's relationships with local clients. The Provider Orientation Program is APS's first step in the development of long lasting partnerships with providers. The Provider Orientation Program allows for the solicitation of valuable input and feedback from network providers.

2. Provider Satisfaction Survey

In our effort to persistently improve our business practices and our relationships with providers, APS will contract a company to conduct a survey to network providers annually,

to determine their level of satisfaction with APS. Providers are contractually obligated to participate in these surveys as well as any other Quality Improvement Activities. The APS Quality Improvement Committee will distribute the results of these surveys in the aggregate to each of APS's customers as well as to the network providers, via the Provider Newsletter. Corrective actions might be taken by APS to address problems that have surfaced through the surveys in order to enhance the relationship between providers and APS.

3. Provider Newsletter

APS distributes a Provider Network Newsletter to all network providers. The newsletters update providers on APS's products and operational procedures. It provides a forum for sharing information about managed behavioral health care conferences and resources, changes and or procedure orientation.

J. Onsite Review Process

In accordance with the APS Provider standards and the guidelines set forth by NCQA, URAC, an Onsite Evaluation will be completed with selected hospitals, programs, individual practitioners and practice groups. As part of the credentialing process, an onsite evaluation may be conducted for these providers prior to acceptance to the network, every three years thereafter as part of the re-credentialing process, or earlier if quality concerns are identified by the Credentialing Committee.

A Provider Operations staff member will meet with the provider to discuss the role of the provider and of APS in the provision of behavioral healthcare services to our members. APS policies and procedures will be reviewed and the provider's adherence to APS standards will be evaluated.

The evaluation will consist of a review of the provider accessibility to APS members, the provider's medical record keeping standards, and the provider's office site appearance. Records **must be kept in locked files** maintained in an area that protects the confidentiality of the patient, and are not accessible to the general public. At the conclusion of the evaluation, the provider will be informed of any deficiencies and given the opportunity to submit a corrective action plan to address those areas. The corrective action plan must be submitted to the Credentialing Committee in writing within thirty (30) days of the site visit.

K. Treatment Record Review

In addition to Onsite Evaluations, APS may also conduct reviews of Provider's treatment records in accordance with Law 408, HIPPA and national standards such as NCQA, URAC and AMA. The providers included in the annual treatment record review sample are determined based upon the volume of work done for APS.

Treatment records may be reviewed on site in the providers office or APS may request that the records be copied and forwarded by mail to APS for review. In any case, the records should be blinded as the identity of the member and will be treated confidentially by APS. Please see below for the Treatment Record documentation standards that are congruent to those of NCQA.

1. **Treatment Documentation Guidelines**

    a. Initial Session/Admission date noted.

    b. Each page in treatment record contains the patient's name and ID number (e.g.DOB,SS)

    c. Socio-demographic information updated

    d. Emergency contacts noted.

    e. Consent for Treatment Forms signed. By the patient or legal guardian.

    f. All entries include responsible clinician's name and professional degree.

    g. All entries are dated.

    h. Treatment record are in a safe, private and lock area.

    i. Treatment record is legible and in ink or typed.

    j. Informed consent for medication is documented and the patient understanding of the treatment plan is documented.

    k. Complete developmental history is documented (physical, psychological, social, academic and work related).

    l. Relevant Medical conditions are listed, prominently identified and revised, if applicable.

    m. Presenting problems, along with relevant psychological and social conditions affecting the patient's medical and psychiatric status are documented.

    n. Assessment of severity and imminence of potential harm to self or others is completed and documented.

o. Patients who become homicidal, suicidal or unable to conduct activities of daily living are promptly referred to the appropriate level of care, if applicable.

p. Each record indicates what medications have prescribed, the dosages of each and the dates of initial prescription or refills.

q. Allergies and adverse reactions are clearly documented, if applicable. If the patient has no know allergies, history of adverse reactions or relevant medical conditions, this is prominently noted.

r. Initial Psychiatric Evaluation is documented

s. Psychiatric history is documented to include previous treatment dates, provider identification, therapeutic interventions and responses, sources of clinical data, relevant family information, results of laboratory tests and consultation.

t. Treatment record documents screenings tools such as PHQ-9, MCHAT, among others.

u. Substance abuse evaluation is documented in members with primary mental health diagnosis, if applicable.

v. Mental health evaluation is documented in members with primary substance abuse diagnosis, if applicable.

w. Mental status exam is completed that includes assessment and documentation of the patient's affect, speech, mood, thought content, judgment, insight, attention or concentration, memory and impulse control.

x. DSM V diagnosis (Axis I) is documented, consistent with the presenting problems, history, mental status exam and /or other assessment data.

y. Treatment plan is consistent with diagnosis and has objective, measurable goals.

z. Treatment plan has estimated time frames for goal attainment or resolution and/or discharge plan.

aa. Focus of treatment interventions are consistent with treatment plan goals and objectives.

bb. Treatment record documents that STAT psychiatric consults were facilitated by appointment, if applicable.

cc. The treatment record documents preventive services, as appropriate (e.g., relapse prevention, stress management, wellness programs, lifestyle changes and referrals to community resources).

dd. Treatment records provides evidence of disclosure notice to communicate with other behavioral health care providers or practitioners when appropriate.

ee. Treatment record provides evidence of communication and coordination of care with other behavioral healthcare providers or practitioners if they exist.

ff. Discharge Plan

gg. The treatment record documents dates of follow-up appointments or, as appropriate.

hh. Schizophrenia and Psychotic Disorders

- AIM Test completed every six months
- Medical Records documented that the clinician did a formal screening of the member for substance use, abuse or dependence, using a formal assessment tool such as CAGE, MAST or other screening process.
- Medical record documented that the clinician involved the patient or the patient's family in the treatment planning process.
- Psychiatric history is documented to include previous treatment dates, provider identification, therapeutic interventions and responses, sources of clinical data, relevant family information, results of laboratory tests and consultation.

ii. Major Depressive Disorders 296.2x or 296.3x

- Completed risk assessment for every visit.
- Patient has 3 follow up visits in a period of 84 days
- Patient was treated with antidepressive medications for an uninterrupted period of 180 days.
- Co-morbid problems are assessed upon initial evaluation.
- The use of psychosocial treatment approaches, including problem-solving treatment, group psychoeducation, and cognitive behavioral psychotherapy.

jj. ADHD 314.00, 314.01 and 314.9

- Family or caretakers involvement in the treatment noted in the record.
- Co-morbid problems are assessed upon initial evaluation and review every 6 months.
- Parent and child psychoeducation about ADHD and its various treatment options.
- Assessment of the continued need for treatment noted on record.

kk. Bipolar Disorder - 296.0x, 296.40, 296.4x, 296.5x, 296.6x series

- Completed risk assessment for every visit.
- Co-morbid problems are assessed upon initial evaluation and review every 6 months.
- The record reflects monitoring of medication levels in the blood.
- Substance abuse evaluation is documented in members with primary mental health diagnosis, if applicable.

APS reviews a random sample of treatment records. Records are selected from APS enrollees that have started treatment with the practitioner during the prior year. To ensure the confidentiality of patient information, APS reviewers or vendors use the following procedures:

- Reviewers are licensed healthcare professionals with a contractual and professional obligation to maintain confidentiality;
- The provider is given advanced notice of the review.
- The provider is requested to blind all patient-identifying information.
- The records remain at the provider's office throughout on-site review.

Treatment records are reviewed at each individual practitioner site. Providers shall receive written notification of their results within 30 days of the review with their completed tool along with the record keeping toolkit. Compliance with the standards requires an overall score of 80%. Providers who fall below the acceptable threshold (above) are referred to the Provider Quality Monitoring Committee for further review and follow-up. Results of the provider treatment record review are documented in the provider file and reviewed at the time of re-credentialing.

V. **UTILIZATION MANAGEMENT**

APS was founded upon the belief that quality and successful outcomes in behavioral healthcare are achieved by *providing access to the most appropriate care, at the right time and in the least restrictive setting*. Our clinicians bring to APS significant mental health and substance abuse (MH/SA) inpatient and outpatient experience gained in the field, together with a successful history of managing the utilization of behavioral healthcare services for our 8 million members.

The APS Utilization Management (UM) process begins with a comprehensive clinical intake including risk assessment. Fulfilling more than the traditional role of determining medical necessity, we design our systems to serve as a resource to patients, families and providers. Further, our clinical staff is always looking for opportunities to develop and implement alternatives to the more typical adversarial utilization review.

The APS Clinical Triage Tool system provides active, next day follow-up for all members who have been identified through triage as *"Urgent"* or *"Emergent".* Using our *Utilization Management Guidelines*, written medical necessity criteria consistent with national practice standards, our care managers work pro-actively with both the patient and the provider to build consensus around the appropriate level of care, treatment plan and goal.

Utilizing a full continuum of care consisting of network providers who have been credentialed to National Committee for Quality Assurance (NCQA) standards, our care managers monitor the quality of care and provide ongoing clinical review of a member's treatment in collaboration with our provider partners throughout the entire process. In addition, care managers maintain linkage with the PCP in order to ensure effective coordination of care. In those instances where care managers and providers have difficulty determining the proper diagnosis, course of treatment or proper level of care, our physician advisors are available to offer assistance.

Another critical tool that aids APS care managers in tracking and coordinating ongoing care is our award-winning information system. The APS clinical staff uses this system to verify and track eligibility and benefits, document complaints about APS clinical or service issues, authorize services, document the electronic medical record, generate certifications, initiate provider searches and document appeals. This system also assists in tracking communications with primary care physicians and other service agencies.

A. Clinical Procedures

1. Referral and Authorization Procedures

APS maintains a twenty-four (24) hours, toll free phone number through which members, their families, primary care physicians and providers may request referrals for behavioral health care services. Members are not required to obtain a referral from a PCP to access behavioral health services.

2. Member Service Line

An Information Service to respond to questions, concerns, inquiries, and Complaints regarding insurance coverage from the Enrollee, Enrollee's family, or Enrollee's Authorized Representative; and a Medical Advice Service to advise Enrollees about how to resolve non-emergency medical or Behavioral Health concerns.

An APS Member Referral Coordinator processes member requests for routine referrals during business hours. An APS Member Referral Coordinator verifies eligibility, updates

demographic information, and educates members regarding their benefits. In most instances, these calls are received from the member actually seeking treatment. However, APS will work with a PCPs or family member with the permission of the beneficiary seeking treatment.

The Member Referral Coordinator conducts a very brief, objective screening to ensure that the member's situation is non-urgent. (Any suspected urgent situation is transferred to a Care Manager for proper call handling.) Once this is established, the Member Referral Coordinator searches the network for a provider who offers services that best match the member's clinical needs. The member is given the name and telephone number of a geographically accessible network provider. The member is then instructed to contact the provider to schedule an appointment. If a member is referred to a practice group, APS reminds the member to ask for an APS credentialed provider within the group at the time the appointment is requested.

Member Service Line is available Monday through Friday from 7:00 a.m. to 7:00 p.m. E.S.T. The primary function of the Line is assisting members to interact with APS and participating physicians and providers. Member Service Line can be reached at the back of each member's card.

3. High Risk Indicators

APS Care Managers closely monitor all members identified as *at risk* due to the following conditions, characteristics or past treatment histories:

4. Case Management Program

APS designed a model of care that assigns enrollees to an appropriate level of care management and an appropriate team of providers to treat and manage the identified health condition. The model of care includes transition of care planning when the enrollee presents at a facility for Emergency Services or post-discharge following an inpatient stay. The model includes linkages and interventions related to social determinants of health to treat the holistic needs of the enrollee.

5. Pre-Authorization Process

When a member demonstrates a need for admission to a partial hospitalization program, an intensive outpatient program, a call to APS must be made to request authorization for services or to schedule an evaluation to determine the most appropriate level of care.

B. Retrospective Review

Retrospective reviews are defined as a review conducted after services have been provided to the patient. These reviews are conducted when a patient has received treatment without authorization, or when the pre-certification by a contracted provider or facility was not feasible, the provider is not contract by APS (this happens mostly when the

services are furnished out of the services area). In order to appropriately evaluate the patient's medical necessity, the provider should send completed record copies and claims.

C. Prospective Review

All service requests subject to prospective utilization review for urgent and non-urgent services, will be sent to APS for an evaluation of medical necessity criteria by a UM Clinical Reviewer or a Physician Advisor (PA), to ensure that members receive proper behavioral healthcare services based on their needs, as specified by CMS, URAC standards, Local Medicaid and Law 408 requirements. All prospective reviews will have an organization determination issued in the following time frame:

- All urgent care requests shall be processed as soon as possible based on the clinical situation, but in no case later than 72 hours of the receipt of the request for a utilization management determination.
- Non-urgent care requests shall be processed within 14 calendar days for Medicare Advantage/Medicaid and 72 hours for local Medicaid accounts.

This is the maximum time allotted to APS-PR to process service requests. However, APS-PR will process requests for urgent services, as expeditiously as the member's health condition requires.

Government Health Plan (VITAL) Timeliness of Prior Authorization

- The decision to grant or deny a Prior Authorization must not exceed seventy-two (72) hours from the time of the Enrollee's Service Authorization Request for all Covered Services; except that, where the Contractor or the Enrollee's Provider determines that the Enrollee's life or health could be endangered by a delay in accessing services, the Prior Authorization must be provided as expeditiously as the Enrollee's health requires, and no later than twenty-four (24) hours from the Service Authorization Request.

- An extension of the time allowed for Prior Authorization decisions for up to fourteen (14) Calendar Days, where:
    - The Enrollee, or the Provider, requests the extension; or
    - An extension in order to collect additional Information, such that the extension is in the Enrollee's best interest

D. Concurrent Review

1. The Utilization Clinical Reviewer is responsible for the concurrent review of all to determine appropriateness, intensity, severity,

expected length of stay, and the adequacy of the discharge plan.

- inpatient
- partial hospitalization
- IOP admissions
- ECT treatments

2. All Concurrent Reviews are based on necessity criteria according
   - CMS' National Coverage Determinations (NCD)
   - CMS' Local Coverage Determinations (LCD)
   - APS's adopted clinical guidelines/MCG
   - Law 408 (Puerto Rico Mental Health Law)
   - Local applicable legislation
   - Shall follow the processes established by the APS Utilization Management Department.
3. Concurrent reviews may result in APS determinations as established in policy UM 01 APS Determinations.

APS, when conducting routine concurrent reviews, accepts information from any reasonably reliable source such as the member, member authorized representative, provider facility, attending physician that will assist in the certification process, collects only the information necessary to certify the admission, procedure or treatment, length of stay, or frequency or duration of services, does not routinely require hospitals, physicians, and other providers to numerically code diagnoses or procedures to be considered for certification, but may request such codes, if available, requires only the section(s) of the medical record necessary in that specific case to certify medical necessity or appropriateness of the admission or extension of stay, frequency or duration of service, or length of anticipated inability to return to work; and administers a process to share all clinical and demographic information on individual patients among its various clinical and administrative departments that have a need to know, to avoid duplicate requests for information from members or providers.

As a decision to extend the treatment or stay is granted, the rendering facility is responsible of notifying the patient of such authorization.

E. Emergency Services

In accepting a referral from APS, network providers accept the responsibility of providing twenty-four (24) hour urgent and emergency services for our members. Patients in active treatment should be given instructions on how to contact their provider or a covering provider in the case of an emergency.

Members who have behavioral health care benefits that are managed by APS are instructed to go to an emergency room when the member, believes that an emergency condition exists. As stated previously, it is expected that answering machine messages and/or answering services provide patients with a number to contact the provider in an

emergency. A message that states that the patient should go to the emergency room is not acceptable.

Emergency services are delivered by a provider in cases where the provider has conducted a clinical diagnostic interview sufficient to determine that the member is harmful to self or others and in need of immediate intervention to foster member safety. Intervention may include safe transport if medical necessity applies, and any of the following: inpatient evaluation, a 23-hour observation bed, inpatient admission, or inpatient detoxification.

The member's behavioral health care provider is expected to triage all other urgent and emergency situations. APS Care Managers are available through our 800 number twenty-four (24) hours a day to assist providers with emergency cases. Contact a Care Manager whenever a member requires emergency attention.

APS Healthcare must be notified by the hospital, admitting physician and/or patient of an emergency admission.

F. Discharge Planning

Discharge planning begins at the initiation of all hospital and program services. It includes preparing the patient and the family for the next level of care and arranging for placement or provision of additional services. APS Care Managers will work with hospitals and programs to assure a smooth transition and the use of participating providers for follow-up care within 5 days of discharge.

G. Electroconvulsive Therapy (ECT)

APS follows guidelines consistent with national standards on electroconvulsive therapy (ECT) as promulgated by the American Psychiatric Association's task force on electroconvulsive therapy. When covered under a member's Group Medical Agreement, outpatient and inpatient electroconvulsive therapy may be authorized by an APS Physician Advisor. Inpatient and outpatient ECT must be conducted at a network facility by a network psychiatrist who is an ECT sub-specialist. Inpatient ECT must be conducted during an authorized inpatient stay. An APS Physician Advisor will authorize a specific number of inpatient or outpatient ECT sessions based on medical necessity.

H. Neuropsychological Testing

The task of neuropsychological testing is to understand the behavioral, cognitive or emotional difficulties of adults and children brought forth by cerebral dysfunction. Neuropsychological testing is used predominantly for medical-surgical or comorbid conditions.

APS will consider authorizing neuropsychological testing for psychiatric conditions only after a neurological assessment and a psychiatric assessment have been conducted.

Approval of neuropsychological testing will be based on the necessity to refine or differentiate a psychiatric diagnosis resulting in a modification and/or enhancement of the treatment plan. An expert neuropsychology consultant or a physician advisor who is board certified in neurology is used to make decisions in this area. Requests for neurological testing when a definitive organic condition is present will be referred to the members Health Plan or PCP.

I. Adverse Determination and Appeals Process

When appropriate APS UM criteria is not met for the requested level of care, or during a concurrent review, the physician advisor reviews the potential adverse determination. Appeals in all cases will be performed by a reviewer (physician advisor) not involved in the initial determination. Attending physicians/providers requesting the services may be contacted by the physician advisor for additional information. If upon reviewing the additional clinical information obtained, the Physician Advisor agrees that the requested level of care does not meet APS UM criteria, a non-certification will be completed. In all cases, the provider is offered an alternative treatment option and provided the clinical rationale for the adverse determination. Notification is provided by phone and in writing to the provider or facility, and the member. The adverse determination notifications include the principle reason(s) for the determination, instructions on how to request an appeal of the determination and the alternative treatment option recommended.
When the attending physician, ordering provider, or facility rendering services request information related to the clinical rationale used for non-certification APS will document the request and the physician advisor involved in the determination or its alternate will be available for a peer discussion regarding the clinical rationale within one business day from the call or presented request.
In cases where the patient is in active treatment in any intensive level of care, an expedited appeal completed within 72 hours of receiving all clinical information, will be offered.

Facilities Appeals

It is the policy of APS Healthcare that participating facilities –as providers- acting on their own behalf will have **one (1) level of appeal** in instances where the facility has fully complied with all the required steps to present and handling of the case. If the hospital is deemed not to have complied with an administrative process requirement (Example; getting a pre-authorization of psychiatric inpatient services), payment for such services may be denied and any appeals received related to the determination will be classified as an administrative appeal, not subject to revision. This appeal level is granted to facilities as an administrative process that is treated independently from the beneficiary's appeal rights and process.

It is the expectation of APS Healthcare, that facilities adhere to the UM and clinical standards stated in this manual and provide the highest level of quality, patient safety and efficiency necessary.

Facilities requesting that appeals be expedited must send APS Healthcare all the corresponding case documentation at the time of the appeal, so that a psychiatrist revision may take place.

J. Reporting Adverse Occurrences

Adverse occurrences are defined as suicides, attempted suicides, homicides, attempted homicides, physical or sexual abuse. If a APS member experiences such an occurrence, the provider is to report the incident to APS immediately. APS will supply the provider with a risk management protocol to assist the provider in an intervention. Notification of APS does not substitute for nor take precedence over state or federally mandated reporting requirements for abuse, neglect or danger to self or others.

APS HEALTHCARE PUERTO RICO, INC.
Attn: Quality Department
P.O. Box 71474
San Juan, PR 00936-8574
Email: quality@apspuertorico.com

K. Ancillary Services

1. Laboratory Services

APS maintains contracts with laboratory providers. All lab work must be done through these contracted providers. The provider ordering the lab test will not be billed when using the participating laboratory. APS providers must use the APS Plan's contracted laboratory provider for all outpatient lab tests.

2. Pharmacy Services

Members with a prescription rider to their policy, can fill prescriptions at any participating pharmacy. A complete listing of participating pharmacies can be found in the member's Provider Directory.

L. MIXED PSYCHIATRIC/MEDICAL PROTOCOL

In order to promote the access and the delivery of quality care for members with both medical-surgical and behavioral health conditions, APS and the plan work together to successfully coordinate members' care. Medical necessity, level of care criteria and

administrative procedures are determined by the payer responsible for claims adjudication.

M.GRIEVANCE SYSTEM

All contracted providers should provide services of optimal quality at all times. APS Healthcare registers and responds to verbal and written complaints and grievances received from beneficiaries or its authorized representative. All comments are important and are viewed as a potential opportunity for improvement in the care provided by contracted providers.

APS has a grievance system in place to address enrollees concerns and appeals of service decisions for all Lines of business.

Appeal process for members with Puerto Rico Government Health Insurance

The Grievance System includes Complaints, Grievances, Appeals and in some circumstances the Administrative Law Hearing.

I. Definitions:

a. **Complaint-** as expressions of dissatisfaction about any matter other than an Action that are resolved at the point of contact rather than through filing a formal Grievance;
b. **Grievance-** is the procedure for filing an expression of dissatisfaction about any matter other than an Action
c. **Action-** The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by this Contract; The failure of the Contractor to act within the timeframes provided in 42 CFR 438.408(b)
d. **Appeal-** is the request for review of an Action.

e. **Administrative law Hearing-** The appeal process administered by the Government of Puerto Rico and as required by federal law, available to Enrollees after they exhaust the Contractor's Grievance System and Complaint Process.

II. Complaints process (APS) has established a process for receiving and handling complaints which a complainant may have about an aspect of the APS's operation, such as dissatisfaction with plan administration; appeal of an Adverse Determination; the denial, reduction or termination of a service; the way a service is provided; or disenrollment decisions. APS follows a consistent procedure in responding to complaints including the following:

a. A beneficiary or its authorized representative shall file a complaint within 15 calendar after the date of occurrence;

b. Filing of a compliant may be orally or in written;

c. APS will resolved the compliant in 72 hours or less;

d. The resolution notice shall include the right to file a grievance or appeal and information on how the member can request for an administrative law hearing.

III. Grievances- a beneficiary or its authorized representative may file a grievance through APS or the Health Advocate Office of Puerto Rico, either orally or in written. A provider may file a grievance on behalf of a beneficiary only when the enrollee has granted written consent to do so. APS follows a consistent procedure in responding to grievances including the following:

a. The grievance has to be filed within 60 calendar days after the event. APS may extend this timeframe by up to 14 calendar days;

b. The grievance will be responded no later than 30 calendar days from the date it was received. If the grievance involves a minor, the timeframe is 20 days.

c. After the investigation is performed, a notice of resolution is issued containing the basis for the resolution.

IV. Appeals process- It involves a formal petition by an Enrollee, an Enrollee's Authorized Representative, or the Enrollee's Provider, acting on behalf of the Enrollee with the Enrollee's written consent, to reconsider a decision (an action). There are two kinds of appeal that can be requested: expedited appeals or standard appeals:

a. Expedited appeals- shall be resolved in 72 hours since it was requested. The expedited appeal resolution timeframe can be granted to the enrollee based on the information provided or when the provider indicates (when filing the appeal on behalf of the enrollee) that taking the time for standard resolution could seriously jeopardize the enrollee's health or ability to attain, maintain, or regain maximum function. An expedited appeal may be filed orally and verbally. The 72 hours resolution timeframe may be extended for up to 14 calendar days;

b. Standard Appeals- shall be resolved no later than 45 calendar days since it was requested The 45 calendar days resolution timeframe may be extended for up to 14 calendar days.

APS follows a consistent procedure in responding to appeals including the following:

c. The Enrollee, the Enrollee's Authorized Representative, or the Provider acting on behalf of the Enrollee with the Enrollee's written consent, may file an Appeal to the Contractor during a period no less than twenty (20) Calendar Days and not to exceed ninety (90) Calendar Days from the date on the APS Notice of Action or Notice of Adverse determination;

d. The provider acting on behalf of the Enrollee with the Enrollee's written consent will be given an opportunity to present evidence and allegations in writing. In those cases in which the appeal is requested by the Provider acting on behalf of the enrollee, the APS Appeals Coordinator shall ensure the provider submits a form of consent completed an sign by the enrollee before proceeding with the appeal. This is regardless it is an expedited or a standard appeal.

e. APS shall provide written notice of all appeals resolution. Such notice shall include the following information:

   i. The right to request an Administrative La Hearing;
   ii. How to request and Administrative Law Hearing;
   iii. The right to continue to receive benefits pending the Administrative Law Hearing;
   iv. How to request the continuation of benefits; and
   v. Notification that if the APS's-PR action is upheld in a hearing, the enrollee may be liable for the costs of any continued benefits.

V. Administrative Law Hearing- the ASES may grant an Administrative Law Hearing if the enrollee or the providers acting on behalf the enrollee requests it regardless the APS appeal process has been used. The process applicable to the Administrative law Hearing are govern by the following steps:

a. If the enrollee (or the provider acting on behalf of the enrollee with its written consent) file an appeal of an action with APS first, ASES will allow an Administrative Law Hearing not less than 20 calendar days and no later than 90 days from receipt of the APS appeal resolution notice;

b. If the enrollee seeks for an Administrative Law Hearing without recourse to the APS appeal process, the ASS will allow it as expeditiously as the enrollee's health requires it, but no later than 3 calendar days after the ASES receives directly from the enrollee a hearing request on a decision to deny a service, when it is determined by the ASES that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or its ability to attain, maintain, or regain maximum function;

c. The decision issued by the ASES as a result of the Administrative Law Hearing is subject to appeal before the Court of Appeals of the Commonwealth of Puerto Rico.

Appeal process for Medicare Advantage and Commercial Behavioral Health Insurance Plan Appeals

In the case of Medicare Advantage and Commercial BH Health Plans, APS will adhere to the standards established by the Centers for Medicaid and Medicare Services (CMS) for handling appeals. This means that APS will make timely handle and process appeals based on the standard and expedited timeframes established by CMS.

An Appeal is the request for review of an APS adverse determination. It is a formal petition by an Enrollee, an Enrollee's Authorized Representative. If a provider wishes to appeal a standard pre-service determination, he/she may do so if such appeal is based on a difference of a clinical nature and not for refusing to follow APS processes. Appeals made by the provider on behalf of a beneficiary must be made in writing and must be made after acquiring the beneficiary's written consent. Additionally, beneficiaries who submit expedited requests or facilities that submit expedited requests on behalf of the beneficiary must send APS a written signed request for appeal. A party may request a standard reconsideration by filing a signed, written request with the APS.

A member or the provider acting as the members appointed representative will have a period of sixty (60) days from the date of the notice of the organization determination sent by APS to submit the corresponding appeal.

The provider acting on behalf of the Enrollee with the Enrollee's written consent will be given an opportunity to present evidence and allegations in writing.

Upon reconsideration of an adverse organization determination, APS will make its determination as expeditiously as the enrollee's health condition requires. This must be no later than thirty (30) calendar days from the date APS receives the request for standard reconsiderations (appeals). The time frame will be extended by up to 14 calendar days by APS if the enrollee requests the extension or if APS requires additional information and documents how such delay is in the interest of the enrollee. Hospitals are required to provide APS access to obtain all necessary medical records and other pertinent information within the required time limits to resolve the appeal.

APS will mail an acknowledgement letter to the enrollee to confirm the facts and basis of the appeal, and request that the enrollee sign and return the acknowledgement letter. The letter must explain that until the acknowledgement letter is returned, no final decision can be issued;

APS will not issue a final decision on the appeal until it receives the signed acknowledgement letter, or other signed document relevant to the appeal request; and If APS does not receive a returned, signed acknowledgement by the conclusion of the appeal timeframe, plus extension, it will forward the case to the independent review entity with a request for dismissal (if applicable).

An enrollee or any physician may request that APS expedite a reconsideration (appeal) of a determination, in situations where applying the standard procedure could seriously

jeopardize the enrollees life, health, or ability to regain maximum function. In light of the short time frame for deciding expedited reconsiderations, a physician does not need to be an authorized representative to request an expedited reconsideration on behalf of the enrollee. A request for payment of a service already provided to an enrollee is not eligible to be reviewed as an expedited reconsideration.

If APS denies a request for an expedited reconsideration, it must automatically transfer the request to the standard reconsideration process and then make its determination as expeditiously as the enrollee's health condition requires, but no later than within 30 calendar days from the date the appeal was received. APS shall provide the enrollee with prompt oral notice of the denial of the request for reconsideration and the enrollee's rights, and subsequently mail to the enrollee within 3 calendar days of the oral notification, a written letter.

If the Medicare health plan approves a request for an expedited reconsideration, then it must complete the expedited reconsideration and give the enrollee (and the physician involved, as appropriate) notice of its reconsideration as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receiving the request.

To properly submit an appeal on behalf of a beneficiary the hospital or facility will be required to contact one of our Grievance & Appeals Coordinators at (787) 522-5727 or (787) 641-0774 Extension 252740. Also, providers can send an email to grievances_appeals@apspuertorico.com or send a fax to: (787) 641-2752

VI. CLAIMS DEPARTMENT

Provider agrees to safeguard beneficiary privacy and confidentiality and assure accuracy of beneficiary health records and encounter data. Those Providers that submit paper claims must use the standard format CMS-1500 for professional services and UB-04 for Institutional claims. The Provider must comply with prompt payment law requirements for timely claims submissions. All required supporting documentation must also be submitted with a claim. Claims returned to providers as non-processable must be re-submitted with all corrections and/or required supporting documentation. Any request of an adjustment to a claim previously paid and/or denied must comply with submission timeframe of twenty days (30) from the EOP (Explanation of Payment). Each form type has its own required fields, depending on provider type. The required fields must be completed on all form types in order for APS to evaluate and process your claim.

In order to process a claim adequately and promptly the Provider must submit a clean claim to APS Healthcare. Our contract requires that APS comply with all, Medicaid laws, regulations and CMS instructions applicable to the Medicaid Program. Therefore, our Claim Adjudication System applies all regulatory payment rules, according to the provider type, and corresponding contract.

Regulators, such as CMS, implemented several initiatives to prevent improper payment before a claim is processed, and to identify and recoup improper payments after the claim has been processed. These initiatives have been in place for many years and commonly used and reported to Providers by the Medicare and Medicaid contractors, such as APS. These initiatives have the purpose of reducing payment error by identifying and addressing billing errors related to coverage and coding made by providers.

Providers are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination. Should Providers determine that claims have been coded incorrectly, they are responsible to contact APS Healthcare to submit a correct bill for the corresponding adjustment. There are other payment rules which may be applicable to the different methodologies according to the provider type and contract that the Provider might have with APS.

Submit all claims to the appropriate address within ninety (90) days of the date of service or date of discharge. Submit claims to the following address:

APS Healthcare Puerto Rico, Inc.
Claims Department
P.O. Box 71474
San Juan, PR 00936-8574

When submitting claims to APS, it is requested that regular charges are billed. APS will pay for authorized covered services, less the co-payment or coinsurance amount, at the rate listed on the provider's agreement or billed charges, whichever is lower.

All HCFA 1500s and UB04s should contain standard required information. To speed the processing of claims, please follow the guidelines listed below:
All Claims

- Member name and ID Number as they appear on the member's ID card.
- CPTIV Code or Revenue Code that corresponds to the services included in your provider contract.
- The APS authorization number should be listed in each form
- Complete information concerning other insurance
- The Tax Identification Number of the group, facility, or individual that holds the contact with APS and has been authorized to render the services being billed. Providers contracted with APS as a member of a group practice must bill with the Tax Identification Number of the group practice and not their individual social security number.

A. Coordination of Benefits

Coordination of benefits (COB) guidelines are used by APS to arrange for claims payment when an individual is covered under more than one group health insurance policy. The

first determination of the primary insurer is based on the employer-employee relationship. The policy held by a person through their employer is primary for that person.

When dependent children of married parents are covered under more than one policy, APS follows the guidelines of the National Association of Insurance Carriers (NAIC), which recommend using the "birthday rule" to determine primary coverage. This rule states that the policy of the parent whose birthday falls first in the calendar year, using month and day only, is primary for the children. When both parents have the same birthday, the primary insurance carrier is determined by the policy effective date.

When dependent children of divorced or separated parents are covered under more than one group health policy, the following order is used to determine the sequence in which benefits are paid:

1) the policy of the parent with custody of the children;
2) the policy of the spouse of the parent with custody of the children;
3) the policy of the non-custodial parent;
4) the policy of the spouse of the non-custodial parent.

If it is determined that APS is the responsible party as a secondary payor, an authorization for services is still required in order for APS to reimburse the provider for services rendered.

Medicare covers medical expenses as the primary carrier for retired persons over age sixty-five (65), disabled individuals and persons with End-State Renal Disease (ESRD). Medicare is typically the primary carrier for Medicare beneficiaries over age 65. However, there are situations, working aged beneficiaries and certain ESRD patients, when the typical rules do not apply. Please contact APS customer service if you need assistance in determining if Medicare is the primary or secondary carrier.

When Medicare is the primary carrier, APS will reimburse providers for any applicable deductible and coinsurance. Once the deductible is met, Medicare Part A covers inpatient hospital services, home health services and institutional services. Medicare Part B covers eighty percent (80%) of the allowed amount for physicians services and other outpatient services. All other State and Federal laws governing COB are followed even if not explicitly stated here.

B. Claims Payment Appeals

Should a provider disagree with the manner in which a claim was paid or the reason for a denial of payment, the provider may appeal to APS. When submitting an appeal, all pertinent information and a written request is to be sent to APS at the following address:

APS Healthcare Puerto Rico, Inc.
P.O. Box 71474
San Juan, PR 00936-8574

Phone: (800) 503-7929 ext. 3015

Appeals are to be filed within ninety (90) days of the date the claim was originally processed. A response will be sent to the provider within thirty (30) days of receipt of all information necessary to review the appeal.

C. Member Hold Harmless Provision

1. Charges to APS Members

Providers and Physicians agree to collect applicable co-payments, if any, from Members at the time services are provided by the Provider or Physician. The Provider and Physician shall look only to APS for compensation for Necessary Covered Services. In addition, Provider and Physician shall under no circumstances, including the termination of the existing Agreement or the insolvency of APS or breech of the existing Agreement, assert any claim for compensation against Members or persons acting on their behalf for Covered Services in excess of applicable co-payments.

Providers and Physicians agree to provide continuation of services until discharge of any Members confined in an inpatient facility on the date of insolvency or other cessation of operations or through the premium-paid period for which member has made prepayment, or on whose behalf prepayment has been made. Provider and Physician further agree that this provision shall survive the termination of the existing Provider Agreement regardless of the cause giving rise for termination and shall be construed to be for the benefit of the APS Member/enrollee, and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and/or Physician and Member, enrollee, or persons acting on their behalf.

VII. TERMINATED MEMBERS

Authorizations from APS are not a guarantee of payment. APS authorizes services based on benefit eligibility information available at the time the authorization decision is granted. If the member's benefits are terminated between the time an authorization is granted and the date of service, APS will not reimburse the provider for services provided (Unless specifically prohibited by law). In this situation, a provider may bill the member directly for the services delivered at their usual and customary fee.

If APS determines that a provider has been paid for services delivered to an ineligible member, APS reserves the right to collect the amount of the overpayment from the provider or to withhold the overpaid amount from future payments.

In instances when a members benefits are terminated or benefits end for any reason, providers are expected to work with APS and the member to transition the member to other care that is appropriate.

1. APS is prohibited from retaliating against a Group or any Member, including refusing to renew or canceling coverage under the existing agreement, because Group or Member, or a person acting on behalf of Group or Member, reasonably filed a complaint against APS or appealed a decision of APS relating to the Member, including, but not limited to, a medical necessity determination. APS also is prohibited from retaliating against a Participating Provider for reasonably filing a complaint against APS or appealing a decision of APS for issues pertaining to themselves or on behalf of a Group or Member.

VIII. Quality Improvement Activities

1. Availability and Accessibility

a. **Monitoring the Availability of Behavioral Health Practitioners and Providers**
Description: Completion of the following activities:

- Measurement of performance against cultural availability needs of the membership.
- Annual measurement of performance against numeric and geographic standards for the availability of practitioners and providers.

b. **Providing Enrollees with Appropriate Access to Care**
Description: Annual assessment of member access to non-life threatening emergency care, urgent care and routine care.

2. Satisfaction Surveys

a. **Practitioner Satisfaction Survey (Medicaid, Commercial and Medicare)**
Description: APS conducts an annual practitioner satisfaction survey measuring overall satisfaction with APS and satisfaction with:

- Utilization Management Processes
- Customer Services
- Network
- Provider Relations Services
- PCP communication

Objective: To improve performance of the following satisfaction measurements:

- Improve to 85% satisfaction with the ease of referring to a psychiatrist for an evaluation.
- Improve to 85% satisfaction with the timeliness and accuracy of claims payment.
- Improve to 85% satisfaction with the number of sessions authorized.
- Improve to 85% satisfaction with the time it takes APS to notify practitioners of their network status.

3. **Routine Monitors**

On at least a quarterly basis data are compiled and reviewed by the APS PR Quality Improvement Committee for the following routine monitors:

- Utilization management statistics
- Credentialing performance indicators
- Member and practitioner complaints processing
- Appeals processing
- Care management quality assurance audits
- Customer service representative quality assurance audits
- Telephone performance for member services and practitioner/provider services
- Claims processing
- Treatment Record Review

IX. Confidentiality

APS Healthcare and its subsidiaries and affiliates are committed to ensuring that privacy practices regarding individually identifiable health information comply with industry best practices, covenants given to its clients (" Covered Entities and Business Associates") and, as applicable, all federal and state laws and regulations including but not limited to the Standards for Privacy of Individually Identifiable Health Information promulgated pursuant to the Health Insurance Portability and Accountability Act ("HIPAA") ("the HIPAA Privacy Rule" or "the Privacy Rule"). Consequently, APS is committed to maintaining an administrative structure, reporting procedures, due diligence procedures, training programs and other methodologies of an effective compliance program relative to the use and disclosure of its customers' protected health information ("PHI"). The APS Chief Privacy Officer is responsible for development and implementation of APS's confidentiality policies and procedures.

X. PROGRAM INTEGRITY, SPECIAL INVESTIGATIONS UNIT AND AUDITS

As part of our legal and contractual obligations contained in the applicable state and federal statutes[1], APS has developed an Integrity Program to enforce the policies and procedures applicable to the activities performed to prevent, detect and correct different forms or instances of fraud, waste and abuse (FWA). These activities are carried out by the Special Investigations Unit (SIU) that is part of the organization's Compliance Department. Among the tools used to achieve the objectives of the Program Integrity are:

[1] See 42 CFR Chapter V, Subchapter A & B. See also the Attachment 14 of the Puerto Rico Health Insurance Administration Contracts with the MCOP for the Government Health Plan..

- Claims data analysis. This process is performed quarterly, and it involves the analysis of the claims data paid to our network providers during each quarter of the year. The result of the analysis is used to open investigations, detect payment errors, and amend payment policies.

- Members interviews. This process is performed monthly, and its purpose is to confirm with the members if they acknowledge receipt of the services billed by providers.

- Paid claims audits. This process involves the evaluation of a sample of medical records to determine if the service billed by providers meets the established criteria for payment.

Any participating provider may be selected for an audit, and it may be based on the claims data analysis mentioned above or even on a referral. The audit will be scheduled as described below:

- The SIU staff should notify in advance the audit, but in some instances the audit may not be notified in advance.

- The date and schedule selected for the audit must be prompt and reasonable for both parts.

- Although the audit sampling method may vary depending on the case, in most cases it will be at least 25% of all claims processed during the period evaluated.

- The result of an audit shall be delivered in written to the provider no later than 30 days.

- Depending of the results of the audit, APS may take any of the following administrative or legal actions:

    - Require the implementation of a corrective action plan that will be monitored through a later audit process.
    - Recoupment of the amount paid for those services or claims that were found not compliant with the indicators evaluated[2].
    - Referral to a law enforcement agency (Office of the Inspector General).
    - Termination of provider's participation in the APS network.

- Upon receipt of the audit report, the network provider shall have the opportunity to submit his/her comments or grounded objections. This process may include meetings with the SIU staff.

For more information, please contact the SIU staff at (787) 641-9136.

[2] See the applicable guidelines at fcso.com, cms.gov, and the Current Procedural Terminology Mnual (CPT).

XI. Monitoring of Behavioral Health Facilities (BHF) and the Reverse Collocation Model:

APS established a mechanism to monitor and maintain a proper level of compliance for Behavioral Health Facilities in accordance with the contract requirements and guidelines mandated by ASES. This mechanism seeks to provide reasonable assurance of the availability of services within the hours, days, staffing and the adequacy of the staff required for Behavioral Health Facilities (BHF). In addition this process measures the compliance with the Reverse Collocation Guidelines established by ASES, to ensure among others matters, that physical and Behavioral Health Services are fully integrated.

An APS Compliance Auditor specifically assigned to perform the Behavioral Health Facility Monitoring, designs a rotation plan on a quarterly basis, in order to perform at least one (1) intervention (one visit and /or telephonic intervention) to the corresponding BHF. In these assessments, APS will confirm and measure the compliance with the following requirements:

A. Behavioral Health Facilities (BHF) Availability and Staffing Assessment:

- APS shall monitor Behavioral Health Facilities to confirm if such facilities meet the number of hours of availability and minimum staff guidelines required by ASES. The following is a list of the time requirements for Behavioral Health Facilities by type:

  a. Psychiatric Hospitals, Emergency or Stabilization Unit have open services hours covering twenty 24 hours a day seven (7) days a week.
  b. Partial Hospitalization Facilities to have open services hours covering ten (10) hours per day at least five (5) days per week and shall have available one (1) nurse, one (1) social worker and one (1) psychologist / psychiatrist.
  c. All other Behavioral health Facilities (Intensive ambulatory services units, Ambulatory services units, Residential units and Addiction service units) have open service hours covering twelve (12) hours per day, at least (5) days per week and shall have available one (1) nurse, one (1) social worker and one (1) psychologist / psychiatrist.

- The results of such interventions are presented to the BHF and discussed within the Compliance Department so that appropriate follow up may take place.

- Based on the results of these monitoring, interventions and validation the APS Compliance Department establishes a compliance level by BHF in its report. In cases of non-compliance the APS Compliance Department requires that the BHF submit a corrective action plan within 7 days of APS's report and correct the issue within 30 calendar days.

- APS Staff will perform a follow-up audit review to confirm that corrective actions performed in accordance actions taken.

B. **Behavioral Health Facilities Reverse Colocation Assessment:**

- APS shall monitor Behavioral Health Facilities (BHF) to confirm compliance with the minimum staff requirements and the minimum hours of availability of the reverse collocation model. The following is a list of the minimum PCP staff required that should be available within the Reverse Collocation Model per Behavioral Health Facilities:

a. Psychiatric Hospitals (or a unit within a general hospital):
    i. Psychiatric Hospitals are required to have at least a PCP on call on a daily basis.
b. Emergency or Stabilization Units:
    i. Stabilization units must have one PCP for consultation (on call) on a daily basis.
c. Partial Hospitalization Units:
    i. Partial Hospitalization Units must have at least one collocated PCP 1 day per week for 3 hours.
d. Intensive Ambulatory Services Units:
    i. Ambulatory Services Units must have at least one collocated PCP 4 day per week for 4 hours.
e. Ambulatory Services Units:
    i. Ambulatory Services Units must have at least one collocated PCP 4 days per week for 4 hours.
f. Addiction Services Unit (detoxification, ambulatory, inpatient):
    i. Addiction Services Units must have at least one collocated PCP 3 days per week for 4 hours.

- The results of such interventions are presented to the BHF and discussed within the Compliance Department so that appropriate follow up may take place.

- Based on the results of these monitoring, interventions and validation the APS Compliance Department establishes a compliance level by BHF in its report. In cases of non-compliance the APS Compliance Department requires that the BHF submit a corrective action plan should be submit to APS's and correction shall be no later than 60 calendar days form that day of the finding identified.

- APS Staff will perform a follow-up audit review to confirm that corrective actions performed in accordance actions taken.