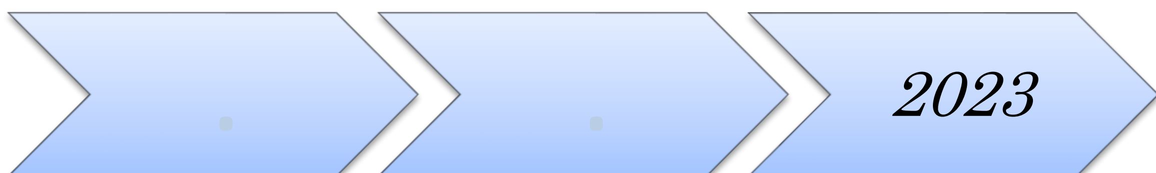
APS HealthCare

APS Healthcare Puerto Rico

Participating Provider’s Manual
A Guide for Contracted Providers and Facilities



INDEX

I. **Introduction**.. 5

II. **APS Healthcare Puerto Rico, Inc**... 6

III. **Member Rights and Responsibilities**.. 6

IV. **Provider Operations**.. 9

A. Provider Service Line.. 9

B. Changes in Provider Information...9

C. Provider Access...9

D. Facility Standards... 12

E. Service Standards.. 12

F. On-call Coverage... 15

G. Credentialing/Recredentialing... 15

H. Provider Appeal Rights 19

I. Provider Orientation Program 21

J. Onsite Review Process 21

V. **Quality Improvement Programs and Activities**.....................................22

A. Treatment Record Review 22

B. Complaints and Quality of Care Issue 25

C. Adverse Incidents 26

D. Availability and Accessibility..26

E. Satisfaction Surveys 26

VI. **Providers Education** 27

VII. **Utilization Management**…………………………………………………………… 27

A. Access to Behavioral Health Services …………………………………..… 28

B. Call Center……………………………………………………………………..29

C. Case Management Program…………………………………………………29

D. Retrospective Review……………………………………………………..…..29

E. Prospective Review……………………………………………………………29

F. Concurrent Review……………………………………………………………30

G. Emergency Services…………………………………………………………..31

H. Discharge Planning……………………………………………………………32

I. Electroconvulsive Therapy (ECT)……………………………………………32

J. Neuropsychological Testing…………………………………………………..32

K. Potential Administrative Non-certifications………………………………….32

L. Initial Clinical Adverse Determination………………………………………..33

M. Peer to Peer Clinical Case Discussion………………………………………33

N. Clinical Adverse Determinations.……………………………………….…33

O. Facility Appeals………………………………………………………………...34

P. Ancillary Services………………………………………………………………34

Q. Mixed Psychiatric/Medical Protocol…………………………………………..34

VIII. **Grievances and Appeals**…….…………………………………………………...35

IX. **Claims**……………………………..……………………………………...… 37

A. Coordination of Benefits…………………………………………..……......41

B. Claims Payment Appeals……......……………………………………………42

C. Member Hold Harmless Provision……………………………………………42

X. **Terminated Members**…………………….…………………………………... 42

XI. **Confidentiality**…………………..…………………………………………………43

XII. **Program Integrity, Special Investigations Unit and Audits**…………………...43

XIII. **Behavioral Health Facilities and Reverse Collocation……**……………………44

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 excellence while properly managing costs.

This Provider's Manual was developed to answer your questions, provide 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. 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) 641-0781

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 degree 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 established 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
* Addressing provider's situations
* 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 line is available from 7:00 a.m. - 5:00 p.m. Monday - Friday. The phone number is (787) 641-0781. Also, providers can receive an in-person orientation 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, email, 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 a life-threatening emergency, they should be seen immediately. Members who present 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 case of an emergency.** 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 patients from APS on the same basis as you are accepting non-APS patient; 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 notice in writing 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, 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, must 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 for 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 person 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;
    - Patients admitted are seen at least once within any 24 hour period;
    - The Initial Assessment to be completed within twenty-four (24) hours of admission, as instructed by Puerto Rico Law 408;
    - Individualized Treatment Plan must be completed and discussed with the patient and/or authorized representative within 72 hours of admission;
    - 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;
- Scheduling a post-discharge outpatient appointment at least 2 business days before discharge;
- Ensure post discharge appointment is scheduled within the next fifteen (15) days;
- A Discharge Summary is necessary in all discharged patients for all high levels of care. Therefore, it must be sent electronically to APS.
- 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:

- 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 contracted 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 includes network providers to obtain peer review.

2. Primary Source Verification

Choosing the practitioners who will work nicely in the provisioning of services 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. All applications and supporting documents must be reviewed and completed within a 180 days period (160 days for URAC Accredited lines of business).

(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) Criminal background check will be performed to all providers.

(l) For Optimind Employee Assistance Program providers, Law 300 certification.

(m) 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.

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

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

(p) 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) Quality of Care Issues
(d) Complaints and Grievances History
(e) Adverse Incidents Record
(f) Patient Satisfaction
(g) Medical Records (meeting objective criteria for completeness and legibility)
(h) Results of Office Site Visits

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 submit an application 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 (Chairman)
- 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
- Provider Network Director or 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. 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 Provider 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 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 access, billing practices, utilization management, provision of services, cost effective use of inpatient services, unless adequately justified.

(d) Failure to meet timeline requirements of the credentialing program.

(e) 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.

(f) 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.

(g) 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.

(h) Provider being part of a litigation or arbitration that has resulted in material judgments, settlements, or warnings against its practice.

(i) Provider knowingly or directly advising an APS beneficiary to become enrolled with any other Health Maintenance Organization, Provider Organization, or any other similar hospitalization or medical payment plan or insurance program.

(j) 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, a process 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 process 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
Membership:

- VP Medical Affairs, (Chairman, 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.
- Provider Director (non-voting staff)
- Credentialing Supervisor (non-voting staff)
- APS Legal Counsel (non-voting staff)
- Quality Improvement Manager (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 (NPDB) 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 Orientation Program

The purpose of this program is to familiarize new providers into 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.

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 will 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 (15) fifteen days of the site visit.

V. Quality Improvement Programs and Activities

APS established a Quality Improvement Program that promotes objective and systematic measurement, monitoring and evaluation of services and implements quality improvement activities based upon the findings. All measures are quantifiable to establish acceptable levels of performance and defined in the Quality Management Work Plan. Measurements are established with a comparing baseline and will be remeasured at a minimum annually. Objectives and approaches utilized in the quality management activities will be monitored monthly and quarterly with a final annual report. Implementation of action plans to improve or correct identified problems to meet acceptable levels of performance are monitored daily, monthly, and quarterly.

APS quality improvement methods include:

- Monitor important aspects of care and service
- Identification of opportunities for improvement because of monitoring clinical care and service
- Implementation of interventions addressing the identified opportunities for improvement, and
- Re-measurement to determine if the interventions were effective in improving clinical cares and service.

A. Treatment Record Review

Providers may be reviewed between the re credentialing cycles to monitor the quality of the performance and services.

APS conduct reviews of the Provider’s treatment record in accordance with Law 408, HIPAA, and national standards such as NCQA, URAC and AMA. Reviewers are licensed healthcare professionals with a contractual and professional obligation to maintain confidentiality. The providers included in the annual treatment record review sample are select randomly.

Records are selected from APS enrollees that have started treatment with the practitioner during the prior year. Treatment records may be reviewed on site in the providers office or APS may request that the records be copied and forwarded by fax, mail, or secure email to APS for review. In any case, the records should be labeled using methods that does not disclose the patient’s name.

Providers shall receive written notification of their results within 30 days of the review and the compliance with the standards requires an overall score of 80%. Providers who fall below the acceptable threshold (above), a Corrective Action Plan will be required, and APS will complete a follow up audit visit review to confirm corrective actions were

performed. Also, the results of the Treatment Record Review are submitted to the Quality Committee and the Credentialing 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.

Please see below for the Treatment Record documentation standards:

1. **Treatment Documentation Guidelines**
    a. Initial Session/Admission date noted.
    b. Each page in the record contains the patient's name or identification number.
    c. Each record includes patient's address, employer or school, home and work telephone numbers including emergency contacts, marital or legal status, appropriate consent forms (including consent for treatment) and guardianship information if relevant.
    d. All clinical notes in the treatment record include the responsible clinician's name, professional degree and relevant identification number.
    e. All clinical notes are dated.
    f. Treatment records are in a safe, private and lock area.
    g. The record is legible to someone other than the writer and ink.
    h. Informed consent for medication is documented and the patient understanding of the treatment plan is documented.
    i. Complete developmental history is documented (physical, psychological, social, academic and work related).
    j. Relevant Medical conditions are listed, prominently identified and revised, if applicable.
    k. Presenting problems, along with relevant psychological and social conditions affecting the patient's medical and psychiatric status are documented.
    l. Assessment of severity and imminence of potential harm to self or others is completed and documented.
    m. Patients who become homicidal, suicidal or unable to conduct activities of daily living are promptly referred to the appropriate level of care, if applicable.
    n. Each record indicates what medications have prescribed, the dosages of each and the dates of initial prescription or refills.
    o. 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.
    p. Initial Psychiatric Evaluation is documented
    q. 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.

r. Treatment record documents screenings tools such as PHQ-9, MCHAT, among others.
s. Substance abuse evaluation is documented in members with primary mental health diagnosis, if applicable.
t. Mental health evaluation is documented in members with primary substance abuse diagnosis, if applicable.
u. 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.
v. DSM-V diagnosis is documented, consistent with the presenting problems, history, mental status exam and /or other assessment data.
w. Treatment plan is consistent with diagnosis and has objective, measurable goals.
x. Treatment plan has estimated time frames for goal attainment or resolution and/or discharge plan.
y. Focus of treatment interventions are consistent with treatment plan goals and objectives.
z. Treatment record documents that STAT psychiatric consults were facilitated by appointment, if applicable.
aa. The treatment record documents preventive services, as appropriate (e.g., relapse prevention, stress management, wellness programs, lifestyle changes and referrals to community resources).
bb. Treatment records provides evidence of disclosure notice to communicate with other behavioral health care providers or practitioners when appropriate.
cc. Treatment record provides evidence of communication and coordination of care with other behavioral healthcare providers or practitioners if they exist.
dd. Evidence of discharge plan
ee. The treatment record documents date of follow-up appointments or, as appropriate.
ff. 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.
gg. Major Depressive Disorders

- Completed risk assessment for every visit.
- Patient has 3 follow up visits in a period of 84 days
- Patient was treated with antidepressant 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.

hh. ADHD

- Family or caretaker's 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.

ii. Bipolar Disorder

- 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.

B. Complaints and Quality of Care Issues

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 allegations, by the number of less serious complaints received or a quality-of-care issue identified. In all cases, a Quality Coordinator or a Grievances and Appeals Coordinator will contact provider to gain additional information about the content of the complaint and start an investigation before a scale level is assigned. In some instances, as a part of the investigation, APS performs a site visit to the practitioner, a treatment record review of APS members in treatment with practitioner and/or contact by the APS VP Medical Affairs, Quality Improvement Manager, or his/her delegate to further discuss the issues.

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 that will make recommendations regarding the network status of the provider as well as the actions to be taken by APS. A provider may be suspended or terminated from the network because of the review of the Credentialing Committee.

C. Adverse Incidents:

Adverse occurrences are defined as suicides, attempted suicides, homicides, attempted homicides, physical or sexual abuse. If an APS patient experiences such an occurrence, the provider must report the incident to APS immediately. APS will offer the provider with a risk management protocol to assist them with an intervention. Notification to APS does not substitute the state or federally mandated reporting requirements for abuse, neglect or danger to self or others.

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Quality Department
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San Juan, PR 00936-8574

If APS identifies an adverse incident involving a patient, the event will be notified to the most recent rendering providers and may request a copy of the clinical records for evaluation and discussion by the Adverse Incident Panel.

D. Availability and Accessibility

APS measures provider performance against cultural availability needs, plus numeric and geographic standards for the availability of practitioners and providers.

APS completes assessment of provider availability to ensure timely access to life-threatening and non-life threatening emergency care, urgent care services and routine care.

E. Satisfaction Surveys

- **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. Initiatives might be taken by APS to address survey outcomes and to improve the relationship between providers and APS.

- **Members Satisfaction Survey**

APS conducts the ECHO Behavioral Health Survey (ECHO) to ask health plan enrollees about their experiences with behavioral health care and services. The ECHO Survey is used for multiple purposes:

- To improve the quality of mental health and substance abuse services.
- To evaluate and monitor the quality of behavioral health care organizations.

VI. Provider Education

APS distributes a Provider Network Newsletter to all network providers. The newsletter update providers on APS's operational procedures and educational material.

APS collaborates with MCO's in Providers Educational Activities and shares the information about providers participation in such activities.

VII. 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. APS holds URAC HUM accreditation and is subject to re-accreditation every 3 years.

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 Team provides active, next day follow-up for all members who have been identified through triage as *"Urgent"* or *"Emergent"*. Using our *Utilization Management Guidelines and Review Criteria including CMS Guidelines for Medicare patients*, 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 UM Clinical Reviewers monitors 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 those instances where UM Clinical Reviewers and providers have difficulty determining the proper diagnosis, course of treatment or proper level of care, our physician advisors are available to help.

The APS clinical staff uses a proprietary electronic platform to document all managed care transactions.

A. Access to Behavioral Health Services

1. 24/7 Availability

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

2. Information Service Line

An Information Service Line to respond to questions, concerns, inquiries, and complaints regarding insurance services from the enrollee, enrollee's family, or enrollee's authorized representative; and to advise enrollees about how to resolve non-emergency medical or behavioral health concerns.

An APS coordinator processes patient requests for routine referrals during business hours. The coordinator verifies eligibility, updates demographic information, and educates enrollees regarding their benefits. In most instances, calls are received directly from the member seeking treatment. However, APS will work with a PCP or family member with the permission of the beneficiary seeking treatment.

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

Information Service Line is available Monday through Friday from 7:00 a.m. to 7:00 p.m. A.S.T. The primary function of the line is assisting enrollees with requests to APS and participating physicians and providers. The Service Line can be reached by calling the number listed at the back of each enrollee's card.

2. **Clinical Call Center**

- Provides telephonic interventions including counseling, service coordination for all mental health services, including all levels of care, hospitalizations, partial hospitalization, intensive outpatient, and outpatient services.
- Crisis intervention and emergency management.
- Coordination with hospitals and ambulance services.
- Specific information for a service or provider, including but not limited to availability, location, name and address of the provider and any service limitations.
- For individuals who are hearing impaired, the Service Center is also equipped with a TTY line.
- These care managers are licensed clinicians which enables us to conduct emergency evaluations and facilitate appropriate responses.

3. Case Management Program

APS Clinical Case Managers closely monitor all members identified as high utilizers or complex case due to the extraordinary health conditions. 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, further post stabilization transitions and post-discharge following an inpatient stay. The model includes important interventions of psychosocial determinants pertinent to member care.

4. 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 contracted by APS (this happens mostly when the services are furnished out of the services area). To appropriately evaluate the patient's medical necessity, the provider should send complete record copies to **APS UM Department** at hospitales@apspuertorico.com or APS Healthcare Puerto Rico Att. Utilization Management Department, PO Box 71474 San Juan, PR 00936-8574.

5. 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. APS requires the initial referral documents to the

requesting provider and the pre-certification form as applicable for discharge coordination purposes. All prospective reviews will have an organization determination issued in the following timeframe:

- 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 and 24 hours for Government Health Plan determinations.
- Non-urgent care requests shall be processed within 14 calendar days for Medicare Advantage/Medicaid and 72 hours for Government Health Plan determinations.

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

If a decision to provide the treatment or stay is granted, it is expected that the rendering facility notifies the patient of such authorization.

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

6. Concurrent Review

1. The Utilization Clinical Reviewer is responsible for the concurrent review of all the following services to determine appropriateness, intensity, severity, expected length of stay, and the adequacy of the discharge plan.
   - Inpatient
   - Partial hospitalization
   - IOP admissions
   - Residential Programs
2. All Concurrent Reviews are based on medical 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 following established organizational policies.

When conducting routine concurrent reviews, APS accepts information from any reasonably reliable source such as the member, member authorized representative, provider facility or attending physician. Collects only the information necessary to certify the admission, procedure or treatment, length of stay, or frequency or duration of services. APS 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. It is expected that during concurrent review, all clinical notes submitted by the facility/provider must be readable, signed and dated at the time of the review, or it will result in an administrative non certification.

If a decision to extend the treatment or stay is granted, it is expected that the rendering facility notifies the patient of such authorization.

7. 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 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 they believe 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.

Emergency services are delivered by a provider in cases where the practitioner 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 promote 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 Clinical Care Managers are available through our 800 number twenty-four (24) hours a day to assist providers with emergency situations.

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

8. Discharge Planning

Hospitals are responsible of completing discharge planning and coordinating post discharge appointments. Discharge planning includes preparing the patient and the family for the next level of care and arranging for placement or provision of additional services. This process begins at the patient's hospital admission and the UM Clinical Reviewer will ensure provider compliance with Discharge Planning process.

The APS Transition of Care team works with hospitals and programs to assure a smooth transition and the use of participating providers for follow-up care within 15 days of discharge.

9. Electroconvulsive Therapy (ECT)

APS follows guidelines consistent with national standards on electroconvulsive therapy (ECT) as endorsed by the American Psychiatric Association's task force on electroconvulsive therapy. Also available upon medical recommendation for certain psychiatric diagnosis and always under member consent. All Outpatient and inpatient electroconvulsive therapy will be reviewed by an APS Physician Advisor. Inpatient and outpatient ECT must be conducted at a network facility by a network psychiatrist who is trained and has experience in the administration of this therapy. ECT must be conducted with the specific instruments and environment to ensure patient safety required for this procedure. An APS Physician Advisor will authorize a specific number of inpatient or outpatient ECT sessions based on medical necessity.

10. Neuropsychological Testing

Neuropsychological testing is frequently utilized to further differentiate diagnostic etiologies to propose treatment accordingly. This may include differentiation of organic signs and symptoms versus psychiatric that may coexist and require treatment optimization. APS uses national and local guidelines to evaluate medical necessity for this type of testing.

11. Potential Administrative Non-Certifications

The following instances during UM prospective, concurrent or retrospective review, may result in Administrative Non-Certifications, including all the service standards listed on page 13:

a. Non registering an inpatient admission within the first 24 hours.

b. UM team requests a case for concurrent review and not provided to the clinical reviewer.
c. For partial and IOP case closures, a daily census and attendance list at case closure must be submitted.
d. For Medicare patients, the Detail Notice of Discharge document must be completed and signed.

12. Initial Clinical Adverse Determination

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. All adverse determinations are issued by a Physician Advisor **only.** UM Clinical Reviewers will present all potential cases lacking medical necessity criteria for Physician Advisor determination. All adverse determinations are subject for peer-to-peer discussion.

13. Peer to Peer Clinical Case Discussion

All initial determinations that lack medical necessity subject to a potential denial can be discussed between requesting physicians and an APS Physician Advisor. During this discussion physicians will consider information that may change the initial determination outcome. All cases that result in an overturned decision will require the documentation that support such outcome. All cases that result in a sustain decision are subject for a clinical appeal. Peer to peer clinical discussion requests is to be completed in one business day. Requests not completed by this timeframe will have the right to file an appeal.

14. Clinical Adverse Determination

Clinical adverse determinations will be performed by a physician advisor. 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 verbally or in writing to the provider or facility, and the member. The adverse determination notifications include the principal reason(s) for the determination, instructions on how to request an appeal of the determination and the alternative treatment option recommended.

Providers may want to discuss the guidelines used in the evaluation of the service request, please call APS at 787-641-0774 ext. 253016 within five (5) calendar days after receiving the denial notice. When the attending physicians, ordering providers, or facilities 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 within one business day from the call or request.

15. Facility Appeals

It is the policy of APS Healthcare that participating facilities 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 has not complied with an administrative process requirement (Example; getting a pre-authorization of partial hospitalization 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.

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

In Clinical Appeals all cases will be reviewed a physician advisor not involved in the initial determination. Attending physicians/providers requesting the services may be contacted by the physician advisor for additional information.

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.

16. 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.

17. Mixed Psychiatric/Medical protocol

To promote the access and the delivery of quality care for members with both medical-surgical and behavioral health conditions, APS and the MCO 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.

18. Grievances and Appeals

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 process in place to address enrollees concerns and appeals of service decisions for all lines of business. A member or the provider acting as the members (with the corresponding written consent) may request an appeal for the review of an APS adverse determination.

<u>Grievances and Appeals with Puerto Rico Government Health Insurance (ASES)</u>

I. **Complaints:** An expression of dissatisfaction regarding any matter other than an Action that is resolved at the point of contact rather than through filing a formal Grievance. APS shall resolve each Complaint within seventy-two (72) hours from the time the initial Complaint was received, whether orally, in writing or in person. If the Complaint is not resolved within this timeframe, the Complaint shall be classified and treated as a Grievance.

II. **Grievances:** An expression of dissatisfaction about any matter other than an Action. 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. In the case of Grievances, APS shall resolve and send out a written notice of disposition as expeditiously as the Beneficiaries health requires, but in any event, no later than ninety (90) Calendar Days from the day APS receives the Grievance. This timeframe may be extended for up to 14 calendar days.

III. **Appeals:** The request for review of an Action. It is a formal petition by an Enrollee, a Beneficiaries Authorized Representative, or the Beneficiary's Provider acting on his/her behalf with the corresponding written consent, to reconsider a decision where the Enrollee or provider does not agree with the action taken. **All appeals requests by the provider must be filed in written.**

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 for beneficiaries. The

72 hours resolution timeframe may be extended for up to 14 calendar days;

b. Standard Appeals- shall be resolved no later than 30 calendar days since it was requested. This timeframe may be extended for up to 14 calendar days.

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

i. The right to request an Administrative Law 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 action is upheld in a hearing, the enrollee may be liable for the costs of any continued benefits.

Grievances and 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 grievances and appeals. This means that APS will make timely handle and process of grievances and appeals based on the standard and expedited timeframes established by CMS.

I. **Grievances:** An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination.

II. **Appeal:** Any of the procedures that deal with the review of adverse initial determinations made by the plan on the health care services or benefits the enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service as defined in 42 CFR 422.566(b) and 423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review.

a. 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 for Medicare. For commercial lines will have a period of one hundred eighty (180) days.
b. 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.
c. 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), and sixty (60 days) for payments 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.
d. APS will mail an acknowledgement letter to confirm the receive of the appeal.
e. 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 enrollee's 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.
f. 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 a grievance or an appeal the hospital or facility will be required to send an email to grievances_appeals@apspuertorico.com or send a fax to: (787) 641-2752.

19. Claims

Provider agrees to safeguard beneficiary privacy and confidentiality and assure accuracy of beneficiary health records and encounter data. 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 for APS to evaluate and process your claim.

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.

An adequate and complete paper claim is one that has all the require information for proper processing. If a paper claim is missing one of the following items, the claim can not be processed.

Required Information and Fields for Form: 1500 Paper Claim

1. Insurance Type (Not Required by APS)	21. Diagnosis
1a. Insured's ID Number (Contract)	24. Date of Service
2. Patient's Name	24.b Place of service
3. Patient's Date of Birth and Sex	24.d CPT Code
5. Patient's Address	24.f Charges
10. Patient's condition related to:	24.g Days or units
10.a Employment	27. Accept Assignment
10.b Auto Accident	28. Total Charge
10.c Other Accident	31. Signature of Physician or supplier and Date
11. Insured's Pol. Group-Feca Number (Not Required by APS)	32. Service Facility Location
12. Patient's signature and date	33. Billing Provider Info & PH #
17. Referring Provider NPI (when applicable)	

Conditional Information and Fields for Form: 1500 Paper Claim

4. Insured's Name	11b. Other Claim ID
6. Patient Relationship to Insured	13. Insured's/Authorized Person Signature
7. Insured's Address	24j. Rendering Provider ID
9. Other Insured's Name	25. Federal Tax ID Number
9a. Other Insured's Policy	26. Patient's Account Number
9d. Insurance Plan or Program	29. Amount Paid
11a. Insured's Date of Birth	

Required Information and Fields for Form: UB 04

1. Billing Provider Name, Address and Phone	45. Serv. Date
3a. PT CNTL #	46. Serv. Unit (s)
4. Type of Bill	47. Total Charges
5. Fed Tax No.	Page _of_/Creation Date
6. Statement Covers Period	50. Payer
8. Patient's Name	51. Health Plan ID
9. Patient's Address	52. Rel. Info.
10. Birthdate	56. NPI
11. Sex	58. Insured's Name
12. Admission Date	59. P. Rel.
17. STAT	60. Insured Unique ID
42. Rev CD.	66. Dx
44. HCPCS/Rate/HIPPS Code	69. Admit Dx
76. Attending, NPI, QUAL, Last, First	

Situational Information and Fields for Form: UB 04

3b. Med. Rec #	63. Treatment Authorization Codes
Condition Codes (18 through 28)	64. Document Control Number
Occurrence Code/Date (31 through 34)	65. Employer Name
54. Prior Payments	66. Dx (from A to Q, all that apply)

61. Group Name	70. Patient Reason Dx (a, b, c)
62. Insurance Group No.	

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

Or submit by email to grievances_appeals@apspuertorico.com or send a fax to: (787) 641-2752.

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 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 way 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

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 more than 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.

20. 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 member's 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.

21. 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.

22. 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:

- 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

[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..

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 Manual (CPT).

23. 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.