FACILITIES HANDBOOK

Procedural Guide
for Participating Facilities

MEDICARE ADVANTAGE

2025

TABLE OF CONTENTS

SECTION 1: INTRODUCTION **5**

A. Welcome to FHC of Puerto Rico, Inc. 5
B. About FHC of Puerto Rico, Inc. 6
C. Overview 6
D. Non-disclosure notice 6

SECTION 2: NETWORK PARTICIPATION **7**

A. Providers Department 7
B. Communications 7

SECTION 3: STANDARDS AND RESPONSIBILITIES **8**

A. Provider responsibilities 8
B. Provider/patient relationship 8
C. Facility/Professional Responsibility 9
D. Professional standards 9
E. Confidentiality, privacy, and security of identifiable health information 9
F. Cooperation with Quality Improvement (QI) Programs 9
G. Adverse Incident reporting 10
H. Integration of physical and mental health 10
I. Compliance with educational activities 10

SECTION 4: ACCESS AND ACCESSIBILITY **12**

A. Emergencies 12
B. Coordination of Care 12

SECTION 5: NETWORK CREDENTIALING REQUIREMENTS **13**

A. Provider rights as part of the credentialing and recredentialing process 13
B. Confidentiality 14
C. Credentialing 14
D. Recredentialing 14
E. Primary and secondary source verification 15
F. Verification of exclusion lists 15
G. Ownership and controlling interest disclosure 15
H. Reporting material changes relating to credentialing or recredentialing process 16
I. Provider updates 17
J. Site visits 17
K. Review process regarding credentialing decisions 18

SECTION 6: FACILITY AGREEMENT **19**

A. Term and Termination 19
B. Disciplinary actions and Providers termination 19
C. Member complaints and grievances 20
D. Provider complaints and grievances 20
E. Provider satisfaction surveys 21

SECTION 7: COMPLIANCE PROGRAM ... 22
A. Overview ... 22
B. Special Investigations Unit record requests ... 22
C. Fraud, waste, and abuse ... 23
D. Reporting fraud, waste, and abuse ... 24
E. Confidentiality ... 24

SECTION 8: QUALITY IMPROVEMENT (QI) PROGRAM ... 26
A. Overview ... 26
B. General Guidelines ... 26
C. Requirement to respond to FHC inquiries ... 26
D. Scope of Providers participation on the Quality Improvement Program ... 26
E. Clinical Practice Guidelines ... 27
F. Healthcare Effectiveness Data and Information Set (HEDIS®) ... 27
G. Behavioral Health Screening Programs descriptions ... 28
H. Identification of Social Determinants of Health ... 32
I. Member rights and responsibilities ... 32
J. Obligation to report/duty to warn ... 33
K. Affirmative statement regarding incentives ... 33
L. Information on Advance Directives ... 34

SECTION 9: REQUIREMENTS DURING A PSYCHIATRIC ADMISSION ... 35
A. General expectations ... 35
B. Other interventions required during hospitalization: ... 35
C. Treatment Plan ... 36
D. Expectations under specific conditions ... 36
E. Compliance with the discharge planning and transition of care ... 37
F. Discharge summary ... 37
G. Early readmissions ... 38
H. Therapeutic restrictions ... 38
I. Documentation and readability ... 38

SECTION 10: UTILIZATION MANAGEMENT PROGRAM ... 40
A. Utilization Management ... 40
B. Purpose of the Utilization Management Program (UMP) ... 40
C. Objectives and functions of the UMP ... 40
D. Scope of the Utilization Management Program ... 41
E. Cultural Competency ... 41
F. Referral process ... 42
G. Medical Necessity ... 42
H. Clinical criteria for UM decisions ... 43
I. Clinical information for conducting UM activities ... 44
J. Clinical review process ... 44
K. Timeliness of UM determinations ... 45
L. Clinical appeals ... 46
M. Case Management Program ... 46
N. Identification of complex cases and members at risk ... 47
O. Transitions of Care (ToC) Program ... 48
P. Pharmacy Management Program ... 49
Q. State and federal reporting requirements ... 49
R. Mechanisms to monitor the effectiveness of the UM Program ... 49
S. Continuity of care ... 50

T. CONFLICT OF INTEREST 50

SECTION 11: PROVIDER REIMBURSEMENT 51

A. CLAIMS AND PAYMENT 51
B. COMPENSATION AMOUNTS AND RESPONSIBILITY 51
C. CLAIMS SUBMISSION 51
D. TIMELY BILLING FOR MEDICARE ADVANTAGE 51
E. CODING SOCIAL DETERMINANTS OF HEALTH 52
F. COORDINATION OF BENEFITS 53
G. NO BALANCE BILLING 54
I. NO SURPRISE BILLING 54
J. NON-CERTIFIED SERVICES 54

SECTION 1: INTRODUCTION

A. Welcome to FHC of Puerto Rico, Inc.

FHC of Puerto Rico, Inc. (FHC) is a Managed Behavioral Healthcare Organization (MBHO) that administers mental health and substance abuse services provided by health insurance companies to their beneficiaries.

In FHC, we are committed to providing services guided by the highest standards in the healthcare industry, promoting a timely, professional service for all our customers. We continuously strive to improve and identify the needs of the people we serve following the principle of service excellence.

Our Mission

To offer alternatives to alleviate the emotional challenges of individuals, their families, workplaces, and communities, promoting prevention and recovery.

Our Vision

To be recognized as the leader in the management and delivery of mental health services in Puerto Rico and the Caribbean.

Our Principles

- Create programs and interdependencies within the mental health system to provide the highest possible degree of recovery to participants.
- We are responsible for the lives of participants, to help reduce the mental health stigma and increase access to quality mental health services to support their needs.
- We recognize that all participants are able to achieve a healthy lifestyle to improve their wellbeing and contribute to the lives of others.
- We contribute to our communities by the continuous quality improvement of our programs and by establishing healthy relationships with participants.
- Our products evolve to offer participants options for personal and professional progress.

FHC services

- Service, credentialing and contracting of the Providers' network.
- Management and coordination of mental health benefits
- Utilization Review
- Access Center 24/7
- Case Management
- Transition of Care
- Pharmacy Management

B. About FHC of Puerto Rico, Inc.

FHC is oriented in prevention and recovery models, focused on enhancing people's opportunities to recover from mental health disorders. Founded in 1996, FHC has experience working with Medicare Advantage Organizations, Puerto Rico Government Health Plan, Municipalities, Health Insurance Companies and Employers.

FHC is a subsidiary of Universal Health Services, Inc. (UHS). Founded in 1978, UHS is one of the most prominent and respected mental health companies in the United States that manages hospitals, mental health centers and outpatient clinics.

FHC is accredited by URAC in Utilization Management and Case Management and in 2019 became the first Managed Behavioral Health Organization of Puerto Rico to obtain the full accreditation status from the National Committee for Quality Assurance (NCQA).

C. Overview

To provide quality services to patients with mental, behavioral health and/or substance abuse problems, it is necessary that FHC and the Providers maintain a relationship of cooperation and communication through the term of the contractual agreement. FHC has the responsibility to ensure that our Providers are aware of their rights and responsibilities, contractual agreements, and professional standards. The Facility Agreement, addendums, and this Handbook outline the requirements, quality measures and procedures applicable to participating Providers in the FHC network and shall be delivered within fifteen (15) calendar days of award of the Facility Agreement.

The Facilities Handbook outlines FHC's standards, policies and procedures for individual Providers, affiliates, group practices and Facilities. It is an extension of the Facility Agreement, and it offers our participating Providers all the necessary guidelines, quality measures and information about policies and procedures to assure professional best practices for members and office management.

The Provider has the responsibility to cooperate with all terms and conditions as established in the Facilities Handbook, which may be amended or supplemented from time to time. FHC will notify Providers in writing of additions, deletions and modifications to the Facility Agreement and Facilities Handbook.

FHC policies and procedures comply with local and federal laws and regulations and with the Centers for Medicare and Medicaid Services (CMS), NCQA, URAC, Puerto Rico Health Insurance Administration (ASES) and the Patient Protection and Affordable Care Act (PPACA) requirements.

We strongly recommend our Providers to review this manual and to periodically visit the FHC Website www.fhcsaludmental.com to verify the applicable changes in the procedures. Please note that this Handbook may use the terms Facility, Provider or Organizational Provider to refer to the contracted Facility.

This Handbook replaces in its entirety all previous versions.

D. Non-disclosure notice

This document and all its components contain proprietary information of FHC and may not be reproduced, distributed in any format, or otherwise used for any other purpose than the described in this document.

SECTION 2: NETWORK PARTICIPATION

A. Providers Department

The Providers Department of FHC is responsible for credentialing and recredentialing of psychiatrists, psychologists, social workers, and Organizational Providers (hospitals, partial hospitals, and residential treatment facilities), in compliance with local and federal laws. FHC shall also be responsible to maintain an adequate and accessible network that complies with local and federal guidelines.

Our main goal in the Providers Department is to improve relationships with Providers, and to maximize Provider experiences while participating in our network.

FHC's Providers Department has a team willing and available to help our network by providing guidance through our Provider Call Center for Medicare Advantage, and other service matters, as well as through visits to the Providers' office when necessary.

To maintain open communication, we encourage you to direct questions and concerns to the Providers Department. Provider Call Center has a bilingual menu for your convenience and our service representatives are available to answer calls related to credentialing and recredentialing status, contracting information, complaint, and grievance process, among others.

The beneficiaries must be excluded from any dispute between the participating Provider and FHC.

B. Communications

FHC regularly communicates with participating Providers via email. Providers shall maintain accurate contact information on file with FHC, especially valid email addresses, to receive communications in the most efficient manner. Communications include regulatory requirements, information on quality improvement activities and measures, protocol changes, helpful reminders regarding claim submission and other topics. FHC uses email encryption when communicating protected health information (PHI) and personally identifiable information (PII).

FHC First Healthcare PROVIDERS

SECTION 3: STANDARDS AND RESPONSIBILITIES

A. Provider responsibilities

It is the Provider's responsibility to provide to members those covered services that are within their specialty and that are determined to be medically necessary under FHC quality assurance and utilization management procedures.

Provider's responsibilities include, but are not limited to the following:

- Verify member eligibility and benefits before rendering services.
- Preauthorize, when required, before rendering services.
- Collect members' copayment/deductible at the time of service according to the benefit coverage of the member.
- Advise members of financial responsibility regarding services that are not covered, before rendering such service.
- Adhere to the accessibility and availability standards established by FHC.
- Refer members to participating Providers and or facilities when alternative or different mental health or substance abuse services are necessary in accordance with member's condition.
- Submit claims on behalf of members.

The Provider shall ensure that a copy of each member's medical record is made available, without charge, upon the written request of the member or authorized representative within fourteen (14) calendar days of the receipt of the written request.

B. Provider/patient relationship

Nothing in the Facility Agreement or in this Handbook shall change or alter any clinical relationship that exists or may come to exist between a Provider and any member. The Provider has the same duties, liabilities, and responsibilities to members as those that exist between the Provider and any patient. The Provider shall always exercise his/hers/theirs best clinical judgment in the treatment of members. The benefit coverage and payment determinations by FHC or payers shall not be construed as a directive from FHC or payers that medically necessary treatment be withheld. The Provider will not be prohibited from or penalized for a communication between Provider and members regarding available treatment options, including appropriate or medically necessary care for the member.

FHC will not prohibit or otherwise restrict a health care professional, acting within the lawful scope of practice, from advising or advocating on behalf of a member about:

1. The member's health status, appropriate or medically necessary care, or available treatment options (including any alternative treatments that may be self-administered), as well as providing sufficient information to give an opportunity for the member to decide among all relevant treatment or nontreatment options.
2. The risks, benefits, and consequences of treatment or nontreatment.
3. The opportunity for the member to refuse treatment and to express preferences about future treatment decisions.
4. Any grievance and appeal process, Case Management activities, Utilization Management process or individual authorization to obtain necessary health care services.

C. Facility/Professional Responsibility

The Provider has an independent responsibility to provide mental health and/or substance abuse services to members who are their patients and shall ensure that members are treated in a manner that respects their rights and responsibilities.

The Provider must ensure that all employees, medical staff, contractors, vendors, and others with whom the Provider does business with are properly screened for exclusions and are authorized to participate in federal and state healthcare programs.

D. Professional standards

Providers must render covered services in a quality and cost-effective manner in recognition of FHC standards and procedures (as described in this Handbook); in accordance with accepted medical standards and all applicable laws and regulations; and pursuant to the same standards as services rendered to other patients of the Provider. Provider must not discriminate against any member based on race, color, gender, gender identity, sex, sexual orientation, age, religion, national origin, ancestry, ethnicity, disability, marital status, health status, or source of payment in providing services.

Providers must not discriminate against members that may be considered "high-risk" that may need special treatment or that may require costly treatment.

E. Confidentiality, privacy, and security of identifiable health information

Providers are: (a) expected to comply with applicable federal and state privacy, confidentiality and security laws, rules and/or regulations, including without limitation the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules and regulations promulgated thereunder, and 42 C.F.R. Part 2; and (b) are responsible for meeting their obligations under these laws, rules and regulations, by implementing such activities as monitoring changes in the laws, implementing appropriate mitigation and corrective actions, and timely distribution of notices to patients(members), government agencies and the media when applicable.

If FHC receives a complaint or becomes aware of a potential violation or breach of an obligation to secure or protect member information, FHC will notify the Provider, including non-participating Providers, utilizing the general complaint process; and request the Provider, including non-participating Providers, respond to the allegation and implement corrective action when appropriate. The participating Providers must respond to such requests and implement corrective action within the timeframes as required by FHC. All Providers and their business associates interacting with FHC staff should make every effort to keep protected health information secure.

F. Cooperation with Quality Improvement (QI) Programs

The Provider is responsible for participating and cooperating with FHC in peer review processes to ensure quality of service, including providing access to the facility where services are offered or copies of patient records and other pertinent data, subject to applicable confidentiality laws.

The Provider will cooperate with FHC's QI program initiatives, including the collection of performance measurements, clinical and service measures. When required by FHC, the facility shall participate in the organization's clinical and service quality improvement programs. The QI initiatives are provided upon contracting of Provider and anytime during the contract when adoption or modification of the initiative is required.

G. Adverse Incident reporting

Providers are required to report to FHC adverse incidents involving members within twenty-four (24) hours from the event. Adverse incidents are defined as "occurrences that represent actual or potential serious harm to the well-being of a FHC member or to others by a FHC member who is in active behavioral health treatment services or has been recently discharged (i.e., within the past 6 months) from behavioral health treatment services".

Providers are expected to report any such occurrence, especially those that require medical or behavioral health treatment to address actual or potential harm resulting from the incident, or that result from identified deficiencies from a reasonable standard of care (i.e., major staff misconduct). Examples of adverse incidents include, but are not limited to:

- Unanticipated deaths or complications
- Self-inflicted harm
- Violent/assaultive behavior by or toward a FHC member
- Adverse treatment or medication reactions
- Sexual assault by or toward a member
- Elopements with a perceived danger to self or others
- Injuries due to accident
- Major property damage resulting from alleged intentional acts by a FHC member.
- Medication/treatment errors
- Human rights violations of any kind
- Any incident involving a threat of litigation involving a member.

Provider reports of adverse incidents are treated confidentially and are processed in accordance with "peer protection" statutes. Based on the circumstances of each incident, or any identified trend of incidents, FHC may undertake an investigation designed to ensure patient safety. As a result, Providers may be asked to engage in corrective action to address any identified or suspected deviations from a reasonable standard of care. The Credentialing Committee may also require such other actions as it deems necessary based on the results of an investigation, or from any failure to cooperate with a request for information pursuant to an adverse incident investigation.

Providers can contact FHC by telephone to report adverse events, through the toll-free line for Medicare Advantage **1-800-760-5691**.

H. Integration of physical and mental health

FHC has implemented a mental health model integrated with physical health. The integrated model focuses on early detection and treatment of any mental condition at the primary Provider level, resulting in less utilization of higher restriction levels of care or treatment, such as hospitalizations.

Providers must cooperate in the implementation and operations of the integrated model to achieve the desired results.

I. Compliance with educational activities

FHC offers Providers a complete and accessible educational program to ensure that FHC members receive services from a network that meets quality requirements. FHC shall ensure that all contracted Providers receive information or training about current and available clinical guidelines, clinical organizational policies, medical management

procedures, quality assurance, among others. The attendance of Providers to these educational activities is required to comply with the QI initiatives.

FHC may grant continued education credits/hours to Providers who attend the seminars.

SECTION 4: ACCESS AND ACCESSIBILITY

FHC, our clients and national accrediting bodies place a high value on the ability of members to access care in a timely manner, consistent with the severity and intensity of their treatment needs. Members and Providers can access the FHC Medicare Advantage Call Center toll-free number **1-800-760-5691** for information and coordination of services.

Hours of operation may be no less than those offered to privately insured or other members.

A. Emergencies

- Providers shall provide emergency services to any member at the time that a need for emergency services arises.
- Emergency services shall be provided at clinically appropriate locations. In an emergency, the Provider shall contact FHC within twenty-four (24) hours after a member presents for treatment.
- Pre-certification for psychiatric hospitalization is not required for members experiencing a medical emergency. The member's condition must meet medical necessity criteria for acute inpatient care.

B. Coordination of Care

FHC recognizes the importance of integrating the delivery of behavioral and physical health services to a given member. FHC also encouraged the Provider is to identify all Providers involved in the health care of a member and to inform and coordinate the delivery of care which includes medication reconciliation with these Providers if the member consents in writing to the release of such specific information.

SECTION 5: NETWORK CREDENTIALING REQUIREMENTS

FHC credentialing and recredentialing program for participating Providers is designed to comply with national accrediting organization standards as well as local and federal laws. FHC will not discriminate in terms of participation, reimbursement or indemnification, against any health care professional who, acting in the scope of his/hers/theirs license, advocates in benefit of members. Participating status shall not be denied based on sex, race, creed, color, national origin, age, disability, sexual orientation or the types of procedures or patients in which the Provider specializes.

A. **Provider rights as part of the credentialing and recredentialing process- Providers have the right to be informed through oral or written communication about the following:**

1. **Review the information** obtained by FHC from external sources as part of the evaluation of the application and credentials submitted for credentialing or recredentialing purpose.
    - Providers have the right to review information that has been obtained from outside sources to support their credentialing application, upon request.
    - The Providers Department notifies Providers that the review of the credentialing information should be requested in writing.
    - The review does not include references or recommendations or any other information that is produced through the peer review process in the Credentialing Committee when discussing and reviewing Provider application.

2. **Correct discrepancies** when the information obtained by FHC through other sources varies substantially from the information provided by the Provider.
    - Any necessary clarification will be notified to the Provider verbally or in writing.
    - Corrections must be submitted verbally or in writing to the credentialing staff identified in the credentialing letter within ten (10) business days of receipt of the letter.
    - A clarification form will be sent to the Provider, if applicable.

3. **Status of the application** of credentialing or recredentialing process through the following sources:
    - Email Providers Department: **providerspr@uhsinc.com**
    - Provider Call Center for Medicare Advantage: **1-855-622-9804**

    The following information about the status of the credentialing or recredentialing process may be shared with the Provider, verbally or in writing, within the next five (5) business days from the date of the Provider's request:
    - The application has not been received.
    - Application returned to the Provider due to incomplete information.
    - Documents pending receipt from the Provider.
    - Application in process
    - Pending for evaluation of the Credentialing Committee
    - Additional information requested by the Credentialing Committee
    - Credentialing or recredentialing decision.

B. Confidentiality

Provider information obtained in the credentialing process will remain confidential, except as otherwise provided by law. Applications, credentials received from Provider, validations of information, performance reports and contract agreements, among other information, are maintained in hard copy in a file folder identified with the name, specialty and NPI of the Provider. The access of information into the FHC data system is restricted by departments to prevent unauthorized staff from accessing screens containing confidential information.

Credentialing information could be shared with other departments or external clients only with a written consent from the Compliance Department.

The Provider Department staff, Credentialing Committee members and Appeals Committee members must sign a confidentially agreement annually.

C. Credentialing

All Providers who participate in FHC network must be credentialed according to regulations and FHC requirements on policies and procedures. Initial credentialing processes begin with submission of a completed and signed application, along with all required supporting documentation.

The Provider must attest to the following:

- Suspension, revocation, voluntary relinquishment, or any other action against the Facility's license and/or the license of the owners/officers to operate in the Commonwealth of Puerto Rico.
- Any malpractice and/or public liability action brought against the Facility and/or its owners/officers or been settled in the past five (5) years.

Before contracting with a Provider, FHC will confirm or obtain information relating to the Provider applicant with various sources. The following is not intended to be an exhaustive list. FHC reserves the right to amend this list of standards.

- Confirms the Facility maintains a current liability insurance, as evidenced by copy of Malpractice insurance certificate, for no less than $1,000,000/$3,000,000.
- Pharmacy license
- Biomedical Waste
- Sanitary License
- DEA or CDS Certificate
- ASSMCA Certificate
- Medicaid enrollment
- Fire Department of Puerto Rico certificate
- Ownership and control disclosure of business transactions, and criminal conviction information
- Accreditation of an approved body

D. Recredentialing

FHC recredentials its Providers according to the processes that fully comply with federal and Commonwealth of Puerto Rico mandates. This process aims to update credentials and must be completed for continuing participation in the network. FHC will assure that all contracted Providers will complete the recredentialing at least every three (3) years.

In the recredentialing process performance indicators, such as those collected through the QI programs, the utilization management system, the grievance system, member satisfaction surveys and other activities of FHC are considered.

The recredentialing will begin approximately six (6) months before the expiration of the credentialing cycle. The Enrollment Application must be filled, signed, dated, and returned to FHC with all requested documentation attached. Required supporting documentation cannot be more than one hundred eighty (180) calendar days from the date of receipt to the date of the credentialing decision. Credentialing information that is subject to change must be reverified from primary sources during the recredentialing process.

Providers that have added a new practice location or changed group affiliations since the previous credentialing decision must undergo a structured site visit review to ensure conformity with FHC standards.

E. Primary and secondary source verification

During credentialing and recredentialing processes, FHC verifies the following credentialing information.

- Confirms that the entity is in good standing with the Puerto Rico regulatory bodies, as evidenced by a copy of the License to Operate issued by the Department of Health of Puerto Rico in accordance with the provisions of Act 101 of June 26, 1965, the Law of Facilities of Puerto Rico, as amended.
- Confirms that the Organizational Provider is approved by the Joint Commission or any other acceptable accrediting body, when applicable, and evidenced by an accreditation report or letter. An attestation from the provider is not accepted.
- Confirms the Organizational Provider maintain a current liability insurance, as evidenced by copy of Malpractice insurance certificate for not less than $1,000,000/$3,000,000 for inpatient and residential services.
- Medicaid enrollment
- Medicare/Medicaid sanction activity
- National Practitioners Data Bank (NPDB)
- Accreditation status

F. Verification of exclusion lists

FHC performs a verification with the List of Excluded Individuals and Entities (LEIE) and with the System for Award Management (SAM) for information on sanctions, exclusions, and limitations to ensure that all Organizational Providers are not excluded or will be excluded from participation in federal health care programs, or any other information that may affect Provider’s participation in the FHC network.

The Provider is responsible for screening any employee, temporary employee, volunteer, consultant, governing body member, and vendor before hiring or contracting, and monthly thereafter against the LEIE, SAM and excluded individuals posted by the Office of the Inspector General (OIG) on its website; and disclose to FHC all exclusions and events that would make them ineligible to perform work related, directly or indirectly, to federal health care programs.

G. Ownership and controlling interest disclosure

It is required by regulation that the Provider discloses the following information to FHC:

- Any person who has ownership or control interest in your practice who is an agent or managing employee that has been convicted of a criminal offense related to the involvement of your practice in any program under Medicare, Medicaid or the Title XX services since the inception of those programs (42 CFR §455.106).

- Managing employee(s) as general manager, business manager, administrator, director, officer, governing board member or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization, or agency (42 CFR §455.101).
- Name and address of each person or organization with a direct or indirect ownership or control interest of five percent or more (5%+) of your practice. (42CFR §455.104).
- Ownership name and address of any subcontractor with whom you have had business transaction totaling more than twenty-five thousand dollars ($25,000) during the most recent twelve (12) month period.
- Any significant business transactions between the Provider and any wholly owned supplier, or between the Provider and any subcontractor, during the five (5) year period ending on the date of the request.
- Current or previous affiliations with a Provider or supplier that has uncollected debt or has been subject to a payment suspension.
- Current or previous affiliations with a Provider or supplier that has been excluded from Federal health care programs.
- Name and address of the billing agency, company or individual, that you contract with to prepare and submit your claims.
- Current or previous affiliations with a Provider or supplier that has had its billing privileges denied or revoked.

Disclosure must be provided before FHC enters or renews a Facility Agreement, within thirty-five (35) days after any change in ownership of the disclosing entity, or at any time upon written request by FHC. FHC may refuse to enter or may terminate a Facility Agreement if it determines that the Provider did not fully and accurately make any disclosure required as specified above.

H. Reporting material changes relating to credentialing or recredentialing process

Providers are required to report to the Provider Department any material changes to the information that was submitted to FHC as part of the credentialing or recredentialing process.

Except as noted below, all information must be reported in writing within five (5) business days after the Provider becomes aware of the information. These changes include, but are not limited to:

- Any action against any of its licenses or accreditations by the Joint Commission (JCAHO), the Commission on Accreditation of rehabilitation Facilities (CARF), American Osteopathic Association (AOA), The American Psychological Association Commission on Accreditation (COA) or any successor thereof.
- Any changes in ownership or business address.
- Any legal or government action initiated that could materially affect the rendering of services in connection with this agreement.
- Any legal action commenced by or on behalf of an FHC member against the Provider.
- Any initiation of bankruptcy or insolvency proceedings regarding the Provider, whether voluntary or involuntary.
- Any other occurrence known to the Provider that could materially affect the rendering of services in connection with the Facility Agreement.
- Discovery that a claim, suit, criminal or administrative proceeding is being brought against the Provider relating to the Provider's malpractice, compliance with community standards and applicable laws, including any action by licensing or accreditation authorities and exclusions from government programs (i.e., Medicare/Medicaid).

- Termination or lapse of the insurance requirements (must be notified at least thirty (30) calendar days before the expiration, termination, or material change to such coverage).
- Suspension or revocation of Facility's license or credentials to provide any covered services it was previously licensed to provide.

A Provider who has not renewed his/hers/theirs license or any certification for which the Provider was previously entitled, will be immediately terminated from the Provider network. Providers have ten (10) calendar days after each annual renewal to demonstrate the compliance by sending a copy of the current credential(s). Failure to comply with the above may result in immediate disenrollment from the network.

I. Provider updates

FHC requires immediate notification of any changes in the demographic information or changes in practice patterns since the last credentialing or recredentialing process, using ***Hoja de Actualización Información Demográfica***. This information includes but is not limited to changes, terminations, or additions of:

- Postal and physical address
- Phone/fax number
- Practice name
- Provider status (private practice/group/facility)
- Hours of operation
- Email address

Any changes to the Provider profile must be submitted in writing using ***Hoja de Cambios en el Perfil del Proveedor***. Both forms can be sent by any of the following means:

Email: providerspr@uhsinc.com
Fax: 1-866-912-2312
Mail: FHC of Puerto Rico, Inc.
Departamento de Proveedores
17 Calle 2 Suite 520
Guaynabo, PR 00968-1750

Updating this information promptly will help FHC communicate information to the Provider, including claims payments, correspondence, directory listings and coordination of services.

J. Site visits

When the Facility is not accredited or certified, a site visit is required, and the facility must pass with at least 85% of the possible score. If the Facility does not meet the threshold score, the facility must develop an action plan of improvement that must follow the evaluation criteria. Accreditation will not be guaranteed until deficiencies are met.

FHC will reevaluate the facility site at least every three (3) years during each recredentialing process and when any of the following occurs:

- The Facility opens a new site.
- The Facility moves from one location to another and there has been no previous site visit at the new location.
- As part of monitoring due to an investigation stemming from a member complaint or other quality issue.

- As part of audits and investigations stemming from proactive data analysis performed by the Special Investigations Unit (SIU), internal referrals from the different FHC departments, or external referrals which may include, but are not limited to complaints from the health plan, the members, other Providers, reports from regulatory or law enforcement agencies, fraud alerts, media reports and other public sources.
- Federal and local governmental agencies could conduct site visits.

1. Site visit evaluation criteria:

  - Exterior and interior access
  - Accessibility for disabled patients or can demonstrate alternative arrangements to serve members with special needs.
  - Physical appearance
  - Safety
  - Infection control
  - Paper or electronic records
  - Patient rights, privacy, and confidentiality
  - Staff
  - Credential verification
  - State or federal review - Certification from CMS or state quality review may by accepted in lieu of the site visit if the review is less than 3 years old, and it states that the review was performed and passed inspection.

The Provider will be contacted by FHC to arrange a mutually convenient time for the site visit. It is important to note that the site visit process is intended as a consultative and educational process. It allows us the opportunity to acknowledge areas of strength and identify opportunities for improvement in our Provider network.

Following the site visit, the Provider will receive a written report that details any finding. Included in the report will be an action plan that will provide guidance in areas that the Provider needs to strengthen to comply with FHC standards. The instrument currently applied during the site visit is continuously under study and FHC reserves the right to modify it as needed.

K. Review process regarding credentialing decisions

FHC has designated the Credentialing Committee to make recommendations regarding credentialing decisions. The Credentialing Committee has the responsibility of reviewing and approving credentialing and recredentialing standards by clinical peers and shall examine the evidence regarding character, professional competence, qualifications, prior behavior, and ethical standing of the Provider, among others. The Credentialing Committee shall also determine, through information contained in the file or given by the applicant or any other source available, whether the applicant meets all the necessary credentialing criteria and qualifications before directing its members to receive health care services.

The Credential Committee conducts peer review of all Providers that are subject to Credentialing Committee oversight and makes recommendations such as:

  - Credentialing or recredentialing approval or denial
  - Termination of participation in FHC Provider network
  - Monitoring process

SECTION 6: FACILITY AGREEMENT

A. Term and Termination

1. **General Term –** The Facility Agreement are effective from the date specified on the execution page of the FHC agreement and can be terminated within sixty (60) calendar days before the renewal date of the agreement. Either party must provide written notice of their intent to terminate the agreement(s).
2. **Termination Without Cause** – The Facility Agreement may be terminated by either party hereto for any reason upon sixty (60) calendar days, written notice to the other party. FHC and the Facility agree that there will be no requirement or obligation to provide a reason for exercising its right to terminate the agreement pursuant to this provision.
3. **Continuation of Service** – Unless FHC advises to the contrary, Provider shall continue to provide Covered Services, at the rates and pursuant to the requirements specified in this Agreement, to Members receiving active treatment at the time of termination until the course of treatment is completed, until FHC makes reasonable and medically appropriate arrangements to have another Provider render such services.

B. Disciplinary actions and Providers termination

Though FHC can resolve most Provider credentialing and quality issues through consultation and education, occasionally further action is necessary to ensure quality service delivery and protection of members. The Credentialing Committee may impose disciplinary actions and termination procedures for Providers for reasons related to an action or inaction that in FHC's sole discretion, results in a threat to the health or well-being of a member or for regulatory compliance.

1. **Monitoring of performance** – Could be carried out for any of the following reasons, among others:
    - Complaints regarding ethics, access of care and breach of contract.
    - Any issue of quality of care.
    - Member satisfaction survey results.
    - Investigation of possible fraud, waste, and abuse.
    - Quality improvement.
    - Noncompliance with utilization management standards and procedures.
    - Site visit or medical record review results.

2. **Contract Termination** – FHC may suspend or terminate a Provider including, but not limited to, the following reasons:
    - Failure to comply with the code of professional ethics.
    - Breach of contract
    - The Facility has made a misrepresentation or a false, misleading inaccurate or incomplete statement in his/hers/theirs application.
    - Unsatisfactory performance, including:
        - Quality of care issues
        - Results of quality audits
        - Member complaints (the assessment of complaints will be qualitative and not quantitative)
        - Results of SIU audits
        - Noncompliance with the site visit criteria

- Fraud, waste, and abuse issues
- The Provider fails to comply with the recredentialing process.
- Nonrenewal of the Facility Agreement
- The Provider is excluded or suspended from participation in Medicare or Medicaid programs.

3. **Immediate Termination** - FHC shall retain the right to exercise immediate termination because of an administrative decision for any, but not limited, to the following reasons:
    - When there is reason to suspect that a Provider continued participation in FHC's network could pose imminent danger to members or for reasons related to regulatory compliance with Medicare.
    - When complaints of possible fraud and abuse have been presented against a Provider and according to the investigation outcome it is determined that there is base for referral to law enforcement or regulatory agency
    - Providers that fail to participate in and cooperate with the investigation of a complaint related to possible fraud, waste and abuse, quality assurance, quality improvement; utilization management standards and procedures, Providers that do not meet the provision of services in a quality and cost-effective way, in compliance with FHC standards and all applicable laws and regulations.
    - Suspension or revocation of license or credentials to provide any covered services the Facility was previously licensed.
    - Termination or lapse of the insurance requirements as specified in this Handbook.
    - The Provider has been expelled or suspended from the Medicare or Medicaid programs.

C. Member complaints and grievances

A grievance is any 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. Grievances made by a member can include concerns about the operations of Providers or health plans such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, the respect paid to members, the claims regarding the right of the member to receive services or receive payment for services previously rendered.

FHC processes grievances received by members, according to the applicable regulations and contract requirements. FHC will accept and process information or evidence concerning the grievance orally or in writing. FHC will conduct a full investigation of the grievance as expeditiously as the member's case requires, based on the member's health status, but no later than thirty (30) calendar days from the date the oral or written request is received.

If a member files a grievance against a Provider related to quality of care or service received, FHC will notify the Provider and request medical records for review. The Provider has five (5) calendar days to respond and submit the medical record for review.

D. Provider complaints and grievances

FHC offers an effective method and a reliable procedure for the informal resolution of complaints, issues, concerns, or disputes from participating Providers that may arise related to the credentialing/recredentialing process, service-related complaints, FHC policies and procedures, among others.

Provider grievances and complaints can be submitted to the Providers Department Monday through Friday, between 8:00 a.m. and 5:00 p.m. by calling **1-855-622-9804**, by e-mail **providerspr@uhsinc.com**, or by writing to:

FHC of Puerto Rico, Inc.
Departamento de Proveedores
17 Calle 2 Suite 520
Guaynabo, PR 00968-1750

Providers are expected to report any occurrences that represent actual or potential serious harm to the well-being of a FHC member or to others, by a FHC member, as outlined in the Section 3 of the Facilities Handbook, and in the Facility Agreement.

FHC shall issue a written decision on the Provider's complaint within fifteen (15) calendar Days of receipt of the Provider's written complaint.

E. Provider satisfaction surveys

Annual satisfaction surveys are conducted by FHC. These surveys measure Providers' opinions regarding FHC administrative services, and their experience with the utilization management and care coordination, among others.

Data is aggregated, trended, and used to identify improvement opportunities. The information obtained is an essential component of our quality program. Results are shared through the Quality Committee and corrective action plans, where appropriate, are managed through the Quality Department.

SECTION 7: COMPLIANCE PROGRAM

A. Overview

Compliance is the act of abiding by the guidelines, laws and requirements established by federal and local laws, regulatory agencies, and industry standards. FHC has a Compliance Program tailored to our operations and based on the following:

- Compliance Program Guidelines, Chapter 9 of Prescription Drug Benefit Manual & Chapter 21 of Medicare Managed Care Manual
- Federal Sentencing Guidelines, Chapter 8, Sentencing of Organization
- United States Department of Health and Human Services Office of Inspector General (HHS-OIG) -Compliance Program Guidelines
- URAC -Core Standards-Core 4, Regulatory Compliance

Compliance Program has measures to prevent, detect and correct actual or potential situations of non-compliance, as well as fraud, waste, or abuse.

B. Special Investigations Unit record requests

FHC Special Investigations Unit (SIU) reviews and monitors claims and billing practices of Providers/Facilities in response to referrals. Referrals may be received from a variety of sources, including without limitation from: (a) members; (b) external referrals, federal and other regulatory agencies; (c) internal staff; (d) data analysis; and (e) whistleblowers. FHC also conducts random audits.

SIU may request a sample of medical records from the Facility to compare against claims submissions. Following the review of the sample, SIU may request additional records or pursue a more comprehensive audit that may include interviewing the Provider's patients or employees.

Providers/Facilities can submit the documentation in person at FHC offices, by mail or electronically. SIU will manage medical records in accordance with FHC's privacy policies and in compliance with HIPAA Privacy rules. SIU medical record reviews are an auditing function for fraud and abuse detection which is considered a health care operation permitted by the HIPAA Privacy Rule (see 45 CFR 164.501 and 506)

Records reviewed may include, but are not limited to, medical, administrative and financial records, as well as current and past employee rosters, the signed Facility Enrollment Application, the Facility Agreement, and any communications between the Provider/Facility and FHC, including informative letters, Compliance Bulletins and any other information published for Providers/Facilities on FHC's website www.fhcsaludmental.com.

Providers/Facilities must supply the requested documents to FHC within the required timeframe. The required time will be specified in the record request letter.

During an SIU Record Review, documents and records provided are compared against the claims submitted. Claims must be supported by adequate documentation of the treatment and services rendered according to applicable regulations, including state and federal regulatory criteria found in CMS National Coverage Determination (NCD) and Local Coverage Determination (LCD) as well as the nationally recognized criteria found in the HCPCS or CPT Manuals

published by the American Medical Association (AMA). Providers'/Facilities' strict adherence to these guidelines is required.

Following completion of review of the documents and medical records received, SIU will provide a written report of the findings to the Provider/Facility. In some instances, such report of the findings may include a request for additional records. SIU's report of findings may include specific requirements for corrective action to be implemented by the Provider/Facility if the review identifies improper documentation of the medical record or unsubstantiated billings of services. Requirements may include, but are not limited to:

- Education/corrective actions
- Recovery of paid claims

The report will specify any overpayments to be refunded. The overpayment amount will be based on the actual deficiency determined in the audit process or the value of the claims identified as billed without accurate or supportive documentation. FHC does not use extrapolation to determine overpayment amounts identified for financial recovery. The Provider/Facility will be responsible for paying the actual amount owed, based on FHC's findings within sixty (60) calendar days of receiving the Recovery letter from FHC Finance Department, unless the Provider/Facility has an approved extended repayment schedule (ERS) or installment payment plan.

If the Provider/Facility disagrees with aa report's findings, the Provider/Facility may request an appeal of the report. All appeals must be submitted in writing and received by FHC on or before thirty (30) calendar days from the receipt of the results letter. Appeals must include: the Provider's/Facility's name and identification number; contact information; identification of the claims at issue, including the name or names of the members, dates of service, and an explanation of the reason/basis for the dispute. FHC may consider additional or missing documentation and/or records associated with billing errors for payment adjustment, within the parameters established in Puerto Rico's Prompt Payment Law.

The appeal will be reviewed within thirty (30) days of receiving the Provider's/Facility's request for appeal. FHC may uphold, overturn, or uphold in-part the findings after completing the appeal review. FHC may also pend the appeal and request more information from the Provider/Facility or other sources. The appeal results will be documented and communicated to the Provider/Facility within ten (10) business days of the appeal decision. If additional time is needed to complete the appeal, SIU will submit a letter of extension to the Provider/Facility requesting any additional Information required of the Provider/Facility and estimating a time of completion. If repayments are required after the appeal review, the Provider/Facility must submit the required repayments within sixty (60) calendar days of receiving the Recovery letter from FHC's Finance Department, unless an installment payment plan is approved.

FHC will take appropriate legal and administrative action in the event a Provider/Facility fails to supply requested documentation, and member records or fails to cooperate with a FHC investigation or corrective action plan. FHC may also seek termination of the Facility Agreement and actions to recover amounts previously paid on claims involved in the investigation. FHC will report any suspicion of fraud, waste or abuse to the appropriate regulatory agencies or law enforcement as required or when appropriate.

C. Fraud, waste, and abuse

It is the responsibility of Providers and Facilities to understand and comply with the professional and legal requirements within the state(s) in which they practice and render services. FHC's compliance and anti-fraud programs were

established to prevent and detect fraud, waste, or abuse of the behavioral health services through effective communication, training, review, and investigation.

- **Fraud**
  - Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain, by means of false or fraudulent pretenses, representations or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.
  - Solicit, receive, offer, and/or pay a remuneration or kickback to induce or compensate referrals for healthcare services paid for by a federal program.
  - Make prohibited referrals for certain healthcare services.

- **Waste**
  - Includes practices that, directly or indirectly, result in unnecessary costs to the Medicare and Medicaid Programs, such as overusing services.
  - Is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.

- **Abuse**
  - Includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare or Medicaid Programs.
  - Involves paying for items or services when there is no legal entitlement to that payment and the Provider/Facility has not knowingly or intentionally misrepresented facts to obtain payment.

If FHC identifies that fraud, waste or abuse has occurred based on information, data, or facts, FHC must immediately notify relevant state and federal program integrity agencies following the completion of ordinary due diligence regarding a suspected fraud, waste, or abuse case.

D. Reporting fraud, waste, and abuse

Providers and Facilities should report fraud, waste and abuse, or suspicious activity thereof, such as inappropriate billing practices (e.g., billing for services not rendered, upcoding, among others). Reports and questions may be made in writing to FHC at the address below or by calling UHS Compliance Hotline at **1-800-852-3449**.

FHC Special Investigations Unit
17 Calle 2 Suite 520
Guaynabo, PR 00968-1750

E. Confidentiality

Participating Providers and Facilities shall maintain the medical and claims-related data concerning services provided to members that they would maintain in the normal course of business. Upon reasonable notice and during facility's regular business hours, FHC, its authorized representatives and duly authorized third parties (such as governments and payers) have the right to inspect and be given copies of medical records related to services rendered to members.

Providers and Facilities must ensure that each member's medical record is treated as confidential to comply with all state and federal laws and regulations regarding the confidentiality of patient records. They must cooperate with FHC and payer to ensure that all consents or authorizations to release member records comply with applicable state and federal laws and regulations governing the release of records maintained in connection with mental health and/or substance abuse treatment. Providers and Facilities must also ensure that all records meet applicable federal and state laws and regulations related to the storage, transmission, and maintenance of said records, including without limitation the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Public Law 104-191) and the rules and regulations promulgated thereunder, as well as guidance issued by the United States Department of Health and Human Services (DHHS).

FHC provides training to employees on their responsibilities regarding HIPAA Privacy Rule. All employees sign a confidentiality agreement upon employment and annually thereafter, attesting that they have read, understand, and abide by confidentiality policies.

FHC recognizes that members have the right to privacy of their personal information and records. Access to member information lies solely with the member except in the case of a parent or guardian with legal custody of a minor child; or a person with legal authority to act on behalf of an adult or emancipated minor in making decisions related to health care.

All requests for release of information are reviewed by the Privacy Officer and responded in accordance with FHC policy.

FHC First Healthcare PROVIDERS

SECTION 8: QUALITY IMPROVEMENT (QI) PROGRAM

A. Overview

FHC has an ongoing QI Program that promotes objective and systematic measurements of services rendered to guarantee the delivery of services of the highest quality. The QI Program includes, but is not limited to, the oversight of clinical and non-clinical quality measures, controlled studies, surveys, evaluations, and audits. Through the QI Program, FHC ensures that behavioral health services are:

- Clinically-driven and outcome oriented
- Cost-effective
- Delivered in accordance with guidelines and criteria based on scientific evidence, best practices, and professional standards.
- Culturally sensitive, accessible, and safe to all members

Through the QI Department, FHC accomplishes this by integrating, analyzing, and reporting from the overall operation and other sources. The QI Department has the responsibility of developing, implementing, and overseeing all the quality-driven strategies to improve the delivery of care. Providers who have questions about FHC's QI Program or have questions related to the quality activities can contact FHC's QI Department at:

Phone: 787-622-9797 ext. 2010, 2096
Address: FHC of Puerto Rico, Inc.
Quality Improvement Department
17 Calle 2 Suite 520
Guaynabo PR 00968-1750
Email: fhc-prquality@uhsinc.com

B. General Guidelines

Contracted Providers agree to allow oversight, including providing access to the facility where services are provided, and are subject to applicable state and federal confidentiality laws. Provider participation is an integral part of the QI Program and is a condition of network participation. As part of the Organizational Quality Structure, Providers may participate in several forums to offer ideas and recommendations to improve services. Additionally, participating Providers must cooperate with quality activities applicable to accrediting bodies such as URAC and NCQA. Cooperation includes collection and evaluation of data and participation in FHC's Quality Improvement Programs.

Refusal to cooperate with quality improvement activities may adversely affect continued network participation or result in sanctions up to and including disenrollment.

C. Requirement to respond to FHC inquiries

FHC may contact Providers with questions, concerns, or feedback. It is crucial to respond to such contacts. Repeated failure to respond can result in sanctions up to disenrollment.

D. Scope of Providers participation on the Quality Improvement Program

Providers are expected to cooperate with Quality Improvement activities such as, but not limited to:

- Treatment record reviews conducted as part of health plan operations. These reviews may occur:

  - In response to a specific quality issue or concern that arises, and/or
  - As part of the yearly audit schedule (which is randomly selected)
- Medicare Advantage Programs (i.e., 5 Stars Programs)
- Healthcare Effectiveness Data and Information Set (HEDIS®) Measures
- Adherence to Clinical Practice Guidelines
- Satisfaction or other subject surveys
- Case Management Program
  - Providers are responsible for referring eligible members to FHC's Case Management Programs. Please refer to referral options in Section 10.M.
  - Respond to outreach performed by FHC's Case Managers for discussing and coordinating the transition of care and discharge planning of members admitted in acute facilities. Care Coordinators may contact Providers to discuss other matters related to members' health and Providers must be available to carry out such discussion.

E. Clinical Practice Guidelines

Clinical Practice Guidelines are known to be effective in improving health outcomes. Guidelines assist Providers in making decisions regarding health care in specific clinical circumstances. FHC's Clinical Advisory Committee (CAC) selects the evidence based clinical practice guidelines, which are grounded on health needs and opportunities identified. FHC adopts evidence based clinical practice guidelines from recognized sources for at least three behavioral conditions, with at least one guideline addressing children and adolescents. Adopted guidelines are promoted to Providers to improve health care quality and reduce unnecessary variation in care.

Clinical practice guidelines are reviewed against clinical evidence at least every two (2) years or when the national guidelines change. The revision of the adopted guidelines is carried out by the CAC. Guidelines are available on FHC's website www.fhcsaludmental.com.

Clinical Practice Guideline	Link
Practice Guidelines for the Treatment of Patients with Major Depression Disorder	Click here for guideline
Practice Guidelines for the Treatment of Patients with Bipolar Disorders	Click here for guideline
Practice Guidelines for the Treatment of Patients with Schizophrenia	Click here for guideline
Clinical Practice Guideline for the Management of Substance Use Disorders	Click here for guideline
Treatment of Children and Adolescents with Attention Deficit/Hyperactivity Disorder	Click here for guideline

Participating Providers may be selected randomly for an audit to monitor adherence to selected guidelines.

F. Healthcare Effectiveness Data and Information Set (HEDIS®)

The Healthcare Effectiveness Data and Information Set (HEDIS®) is one of health care's most widely used performance improvement tools. The HEDIS® measurements enable comparison of performance among managed care plans. The sources of HEDIS® data include administrative data (claims/encounters) and medical record review data. Participating

Providers are required to be well-informed about the following HEDIS® measures and cooperate in activities to improve their results:

- Follow-up after hospitalization for mental illness (FUH)
- Transition of care (TRC)
- Initiation and engagement of alcohol and other drugs abuse or dependence (IET)
- Antidepressant medication management (AMM)
- Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD)
- Adherence to antipsychotic medication for individuals with schizophrenia (SAA)
- Plan All-Cause Readmissions (PCR)

FHC will keep participating Providers updated on HEDIS® measures specification, changes adopted for measures or other relevant information. HEDIS® is a registered trademark of NCQA.

G. Behavioral Health Screening Programs descriptions

FHC has been involved in the provision of behavioral and mental health services since 1996. We are committed to a system that promotes access to the highest standards of care. Our quality improvement philosophy encompasses prevention and early detection of health issues that could affect life functionalities and the progression of conditions of the populations we serve.

In order to implement this quality improvement philosophy, FHC has chosen two (2) screening programs. These programs will advance the wellness of patients and aid in the reduction of negative effects of mental illness and substance use disorders, through the promotion of early screening and assessment. The first screening program addresses coexisting mental health and substance use disorder in patients diagnosed with bipolar disorder; the second addresses the screening for metabolic syndrome in patients on second generation antipsychotics (SGAs).

These two screening measures are based on scientific evidence, best practices, and industry standards. FHC will review available scientific evidence and update these programs every two years or more often when applicable. FHC obtained appropriate Providers input on the program design and implementation through the creation of the Behavioral Health Screening Task-Force. This Task-Force is composed of Psychiatrists, Psychologists, Social Workers and facilities who are part of our Providers Network. The overall program design, established by them, included: a) the selection of the screening measures; b) conditions where screening is indicated or required; c) identification of population screened; and d) recommended frequency of the screenings. Prior to its implementation, the Task-Force approved the final programs designs. These programs were initially implemented in 2016 and have been revised and updated ever since. Among the major changes implemented are the adoption of the AUDIT-C and DAST-10 for alcohol and substance use screening, respectively, and the addition of depression screening for patients with substance use disorder.

Both programs are publicized through FHC's website. The information is mailed to Providers who do not have fax, e-mail, or Internet access. The screening programs are distributed to appropriate existing Providers at least every two (2) years and when revised or new programs are added. Screening programs are also distributed to new Providers as part of their credentialing process when they receive the Facility Handbook.

A. Screening Programs to Address Coexisting Mental Health and Substance Use Disorders

According to SAMHSA, the coexistence of both a mental health and a substance use disorder is referred to as co-occurring disorders. SAMHSA reports that for 2019 in the United States (US), approximately 9.5 million adults have co-occurring disorders, and only 7.8% of these individuals receive treatment for both conditions. These percentages in 2019 were similar to the percentages in 2015 to 2018. For Hispanics, similar needs were identified, for which approximately 1.4 million adults have co-occurring disorders and only 6% of these individuals receive treatment for both conditions.

The screening of coexisting mental health and substance use disorders is a fundamental performance within the quality-of-care spectrum and sound clinical practices. As explained, individuals with an alcohol misuse and alcohol use disorder (AUD) are more likely than the general population to have coexisting psychiatric disorders. According to Petrakis (2014), there are high rates of comorbid AUDs among psychiatric patients: highest prevalence is among those with bipolar disorder.

Co-occurring psychiatric and substance use disorders (SUD) are common in all treatment settings (i.e.., centers for the treatment of substance use disorders, mental health clinics, primary care settings, emergency departments) and in the general community, according to the American Psychiatric Association. In community population samples studied in the National Comorbidity Survey, individuals with alcohol dependence had high rates of clinically significant depression during their lifetime (men: 24% depression and 11% dysthymia; women: 49% depression and 21% dysthymia) and individuals with bipolar disorder had high rates of alcohol (61%) and other substance (41%) dependence [VIII].

Therefore, FHC recommends screening for substance use disorders in members with existing or newly diagnosed bipolar disorders and assess all patients with a substance use disorder for the presence of co-occurring depressive disorder.

For this initiative, our systematic approach is based on requiring our entire Network to perform screenings to patients they identify with the diagnosis or newly diagnosed of bipolar disorder or SUD. Patients are eligible for screening if they present an already existing bipolar disorder or SUD diagnosis, during treatment or when they are first diagnosed. Follow up screens must not span longer than a year after last screening.

1. Screening for SUD in patients with bipolar disorder

FHC has chosen the utilization of the Alcohol Screening Questionnaire C (AUDIT-C) and the Drug Screening Questionnaire (DAST-10), which allow us to determine, in a fast and sensitive manner, if a patient diagnosed with bipolar disorder could have a problem with the use of alcohol or substances.

For alcohol use disorder screening, the Provider must administer the Audit-C. The minimum score (for nondrinkers) is cero (0), and the maximum possible score is twelve (12). Consider a screen positive for unhealthy alcohol use if AUDIT-C score is ≥4 points for men or ≥3 points for women. For substance use disorder screening, ask for lifetime use of cannabis, solvents, tranquilizers, barbiturates, cocaine, stimulants, or narcotics, but do not include alcohol or tobacco. If patient has used any of the drugs mentioned in the established frequency, clinician must administer the DAST-10.

Affirmative responses count as one point. No responses represent zero points. Clinician must add all responses to obtain a total. The total score correlates with a zone of use. The clinician must determine the risk zone depending on the total score.

2. Screening for a Depressive Disorder in patients with SUD

FHC requires Providers to screen for Major Depressive Disorder using the 9-question Patient Health Questionnaire (PHQ-9) since it is the most prevalent diagnosis seen in the population served by FHC. Major depression is diagnosed if five (5) or more of the nine (9) depressive symptom criteria have been present at least "more than half the days" in the past two (2) weeks, and one (1) of the symptoms is depressed mood or anhedonia. Other depression is diagnosed if 2, 3 or 4 depressive symptoms have been present at least "more than half the days" in the past two (2) weeks, and one (1) of the symptoms is depressed mood or anhedonia. One of the nine (9) symptom criteria ("thoughts that you would be better off dead or of hurting yourself in some way") counts if present at all, regardless of duration. The Provider is expected to rule out physical causes of depression, normal bereavement, and history of a manic episode. As a severity measure, the PHQ-9 score can range from cero (0) to twenty-seven (27), since each of the nine (9) items can be scored from cero (0) (not at all) to three (3) (nearly every day) [IX].

B. Screening for Metabolic Syndrome in patients who are on Second Generation Antipsychotic

SGAs have been a key component for the pharmacological treatment of multiple psychiatric symptoms. Due to their minimal risk of extrapyramidal symptoms, they have become the first line of treatment for schizophrenia, other psychotic disorders, and bipolar disorder. According to the American Diabetes Association, one of the downsides to the treatment with SGAs is the high risk of developing Metabolic Syndrome. Metabolic Syndrome, as defined by the National Institute of Health (NIH), is the name for a group of factors that raises the risk of heart disease and other health problems, such as diabetes and stroke. These factors include: a large waistline, high triglyceride levels, a low HDL cholesterol level, high blood pressure, and high fasting blood sugar. These adverse effects along with lifestyle and genetic components, contribute to the decreased lifespan of patients, including those with schizophrenia. As stated, the Centers for Disease Control and Prevention (CDC), heart disease is the leading cause of mortality and morbidity in the general population.

Considering the possible health risks for members treated with SGA's and the impact to their wellbeing; FHC has chosen the screening for Metabolic Syndrome as our second program. This program focuses on the detection of the Metabolic Syndrome identified by three (3) or more of the following: increased waist circumference, high blood pressure, elevated triglycerides levels, low HDL cholesterol levels or high fasting plasma glucose (see Table #1). Psychiatrists should screen patients for whom they are prescribing SGA's by ordering laboratory tests, at least. Psychiatrists may perform the complete syndrome assessment, including physical examination, may refer the patient to their PCP to assess all the factors for the diagnosis of the syndrome, or may confirm assessments performed by PCPs by requesting evidence of recent tests performed. The non-physician Providers will comply with our program by referring members to their primary care physicians or psychiatrists for the detection of the condition. FHC recommends for patients to be screened as soon as SGA treatment is identified or prescribed. For screening frequency, refer to Table #2.

Large waistline	• Women ≥ 35 inches • Men ≥ 40 inches

High triglyceride level	≥ 150 mg/dL
Low HDL cholesterol level	• Women ≤ 50 mg/dL • Men ≤ 40 mg/dL
High blood pressure	≥ 130/85 mmHg
High fasting blood sugar	≥ 100 mg/dL

Table 1. Factors for the diagnosis of Metabolic Syndrome on patients who are on SGAs[V, VII].

Criteria	Baseline	4wk	8 wk	12 wk	Quarterly	Annually	Every 5 yr
Personal / Family history	X					X	
Weight (BMI)	X	X	X	X	X		
Waist circumference	X			X			
Blood pressure	X			X		X	
Fasting plasma glucose	X			X		X	
Fasting lipid profile	X			X		X	X

Table 2. Monitoring recommendations for patients receiving antipsychotic treatment [IV].

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III. VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders (2015).

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H. Identification of Social Determinants of Health

According to Healthy People 2030 social determinants of health (SDOH) are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. DOH can be grouped into five (5) domains: economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, social and community context. Growing evidence indicates that disparities and inequities in these domains can lead to poorer health outcomes for people and higher health care costs. Therefore, FHC is committed to address member needs, including SDOH, to ensure better health outcomes.

In its effort to improve the health of members, FHC requests participating Providers to identify psychosocial factors that may influence adversely the health or functioning of members during any treatment or counseling session. FHC selected the following SDOH that Providers must identify in their intervention with members:

- Problems related to education and literacy.
- Unemployment
- Low income
- Lack of adequate food and safe drinking water
- Homelessness
- Limited transportation: Specific economic problem
- Problems related to housing circumstances.
- Social and community issues
- Inadequate family support: Other specified problems related to primary support group.
- Other problems related to primary support group, including family circumstances.
- Unavailability of health services, including where services are needed.
- Limitation of activities due to disability
- Problems related to feeling unsafe in neighborhood.
- Inadequate housing

Network participants must document identified SDOH in the treatment record and use the group of codes provided in the current ICD for reporting/billing factors influencing health status and contact with health services, commonly known as Z Codes. Section Named "Coding Social Determinants of Health" (Go to Section) will provide the necessary information to use the Z Codes (current ICD) to identify SDOH.

I. Member rights and responsibilities

FHC ensures that members receive services that are under their coverage in a cost-efficient manner and that they meet quality standards in recognition with the applicable rules and procedures. It is also responsible for ensuring that members are treated in a manner that respects their rights and dignity.

The Provider must not discriminate in the provision of services to any patient because of race, color, gender, sexual orientation, age, religion, national origin, disability, health status or source of payment. He/She/They is also forbidden to discriminate against patients who may be considered "high risk", who may need special treatment or who may require expensive treatment.

The following is a summary of member rights and responsibilities:

- Right to receive information about the organization, its services, its Providers and member rights and responsibilities.
- Right to be treated with respect and recognition of their dignity and right to privacy.
- Right to participate with Providers in making decisions about their health care.
- Right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Right to voice complaints or appeals about the or the care it provides.
- Right to make recommendations regarding the organization's member rights and responsibilities policy.
- Responsibility to supply information (to the extent possible) that the organization and its Providers need in order to provide care.
- Responsibility to follow plans and instructions for care that they have agreed to with their Providers.
- Responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

Providers are required to inform FHC members under their care of these rights and responsibilities. The FHC Member Rights and Responsibilities Statement can be copied and posted or distributed to members at their initial visit.

J. Obligation to report/duty to warn

Participating Providers must comply with all applicable state and federal child/elder abuse and other reporting laws. It is the Provider responsibility to understand and comply with the professional and legal requirements in the commonwealth of Puerto Rico and Federal guidelines.

The duty to warn a potential victim of possible harm from a patient may override the usual right to confidentiality of which an individual is assured when speaking to a clinician. This applies to any participating Provider who receives information during assessment or treatment. In any threatening situation, relevant clinical data or history may be released to authorities. If the Provider believe that a patient represents a threat to self or others, the Provider may be required to attempt to protect the patient and to warn the potential victim(s) in a timely manner. It is preferable to contact the police, but the Provider should warn the intended victim by telephone if that is the best way to assure the potential victim's safety. It is the Provider's responsibility to be thoroughly familiar with the duty-to-warn rules of the state(s) in which it practices. FHC should also be made aware of any such situation as detailed in this Handbook on Section 3.G Adverse Incident Reporting. FHC may contact the Provider when we are notified first of a potential situation. In such a situation, the Provider will be called upon to exercise his/hers/theirs duty-to-warn obligations.

K. Affirmative statement regarding incentives

FHC Utilization Management (UM) and other care management staff base their utilization related decisions on the clinical needs of the members, benefits eligibility, and appropriateness of care. FHC in no way rewards or incentivizes, either financially or otherwise, Providers, Utilization Review Coordinators (URC), Physician Advisers (PA) or other

individuals involved in conducting utilization review for issuing denials of coverage or services, or inappropriately restricting care. FHC does not incentivize Providers to encourage barriers to care and services that result in underutilization.

Objective scientifically based clinical criteria and treatment guidelines serve as a foundation to the decision-making process in the context of the Provider or the member supplied clinical information.

L. Information on Advance Directives

Advance directives are written instructions, such as living wills or durable powers of attorney for health care, recognized under state law, and signed by a patient, which explain the patient's wishes concerning the provision of health care if the patient becomes incapacitated and is unable to make those wishes known.

FHC and the Provider must comply with State Law 160 of 2001 that requires any Provider of health services to inform patients of their right to make decisions concerning their medical care, including the right to accept or refuse medical treatment, and the right to formulate advance directives.

FHC maintains written policies and procedures that meet the requirements for advance directives, specifically for Mental Health and Psychiatric incapacitating events. FHC cannot refuse care or otherwise discriminate against a member based on whether the person has executed an advance directive or not.

Providers must document in a prominent part of the member's clinical record whether the individual has executed an advance directive or not. The Provider and the member have the right to file a complaint about FHC noncompliance with advance directive requirements which will activate the procedure described in this Handbook in Section 6.C Member Complaints Grievances. In this case the complaint can be filed with:

- FHC
- The Health Plan
- The Office of Patient Advocacy
- Center for Medicaid and Medicare Services

If FHC or the Provider cannot implement an advance directive as a matter of conscience, he/she/they must issue a clear and precise written statement of this limitation. The statement must include information that:

- Explains the objections based on conscience;
- Identifies the legal authority permitting such objection; and
- Describes the range of medical conditions or procedures affected by the conscience objection.

If a member is incapacitated at the time of initial enrollment and is unable to receive information due to an incapacitating condition, the Provider may give advance directive information to the member's family or surrogate. The Provider must follow-up the individual progress to assure that the information is given to the individual directly at the proper time.

SECTION 9: REQUIREMENTS DURING A PSYCHIATRIC ADMISSION

A. General expectations

It will be the responsibility of the hospital to know the details about the processes established by the plan for the management of its members. It will also be the facility's responsibility to know the member's eligibility and coverage before admission.

Within the first twenty-four (24) hours after the member is admitted to an acute psychiatric treatment facility, the hospital will perform the following:

- A medical history and physical examination.
- A nursing evaluation/assessment.
- Laboratory tests according to the member's clinical picture and medical conditions.
- A complete present and past psychiatric history, including relevant data from previous hospitalizations within the institution.
- Psychiatric evaluation - will establish a diagnosis according to specific criteria of the current DSM and ICD. Non-specific diagnoses and diagnoses to be ruled out must include a narrative justifying the diagnosis and the plan to follow to rule out and/or confirm specific diagnoses in the treatment plan.
- Medication reconciliation.
- Beginning of discharge plan and transition of care.
- A screening for alcohol and other drug use, including toxicology screening if clinically indicated.
- Medical and/or pharmacological interventions supervised by a psychiatrist which, if not provided immediately, may delay the patient's recovery.
- Informed consent for treatment that complies with the requirements of Act 408.
- Monitoring by nursing or other mental health personnel twenty-four (24) hours a day.
- Electronic registration of admission through https://hospital.fhcsaludmental.com

B. Other interventions required during hospitalization:

- A psychosocial evaluation within forty-eight (48) hours, or sooner if clinically indicated.
- Establish communication with outside Providers and family members within seventy-two (72) hours to obtain history information and other relevant clinical information.
- Individual, group, or family therapies at least once a day.
- At least one face-to-face family intervention unless clinically contraindicated, where effective discharge planning and transition of care is concretized. It should include education about the disease process, medications, needs and barriers to recovery according to the member's preferences.
- Daily clinical assessments of the patient's mental status, therapeutic interventions, and progress of the patient's condition by psychiatrists and clinical therapists.
- Daily documentation evidencing medical necessity and active treatment.
- Psychiatric medical evaluations must be performed at least every forty-eight (48) hours and must be performed daily for members requiring treatment for more than six (6) days.
- Facilities will have a policy and/or procedure detailing their transition of care process and reduction of readmissions.

- Facilities will comply with inpatient peer discussions between the FHC psychiatrist and the patient's attending psychiatrist when requested by FHC.

C. Treatment Plan

The treatment plan formulated according to the timelines and stipulations of Act 408. That is interdisciplinary, individualized, safe and humane that corresponds to the findings of clinical assessments and expectation of improvement and provides direction toward recovery by specific and measurable methods:

- This is required to include the prognosis and estimated date of discharge, the specific treatments that will be ordered, including the type, amount, frequency, and duration of treatments.
- Expected outcomes should be measurable, functional, and with specific timelines.
- The focus of treatment should be directed at the factors that brought the person to this level of severity.
- Updates to the treatment plan should reflect active treatment, indicating in the documentation the changes, frequency and duration of services that address progress toward the expected outcomes.
- Plan updates are required to be made weekly or more frequently, if necessary.
- For Medicare Advantage beneficiaries, the treatment plan will be in accordance with Local Coverage Determination L33975.
- For patients who, for justifiable reasons, are unable to continue under the care of the admitting psychiatrist, the new psychiatrist in charge must implement his or her recommendations within the framework established in the initial treatment plan. If the psychiatry determines, based on his/hers/theirs clinical judgment, that the treatment should be modified to deviate from the initial treatment plan, the psychiatry should produce an update to the plan on the same day of the determination, discussed with the other professionals on the team and the patient, containing all required parts of a treatment plan. This also applies to patients under the care of a group of psychiatrists.
- FHC's medical division does not consider psychiatric groups that do not guarantee a single physician in charge of the patient during treatment to be a high standard of care. Understanding that because of changes in who leads the treatment plan, variations in clinical judgment predispose to fragmentation of the continuum of care, which may affect the course of the patient's recovery.

D. Expectations under specific conditions

- For suicidal patients, an analysis is expected that identifies the causes, risk/danger factors and thoughts that have led to these ideas; daily interventions are expected that are aimed at discovering, preventing, correcting, curing and/or alleviating the behavior, causes and modifiable risks that lead the patient to present this thought and/or behavior.
- Assessment and management by a mental health professional with addiction counseling training is required for patients presenting with alcohol or other substance use problems.
- For a patient requiring electroconvulsive therapy treatment during hospitalization, the patient's screening and consent requirements under Act 408 must be complied with.
- The hospital will have to facilitate and cooperate with involuntary placement and treatment processes to members who require it.
- Children from 0 to 12 years of age must be provided services in accordance with their age and gender, with individualized therapies separate from the treatment of adolescents and adults. Hospital services may be shared between the child and adolescent population, with strict supervision. Child and adolescent treatment services will never be mixed with adult services.

E. Compliance with the discharge planning and transition of care

- Begins at the time of admission and must include discharge projection.
- Includes a specific final diagnosis, or if not clarified during hospitalization, must include a suggested plan to the next level of care for clarification of temporary diagnosis(es).
- Identification of all available support resources.
- Conduct an analysis of potential physical, cognitive, psychological, family, social, transportation and economic barriers and factors that may limit the continuity of treatment and transition of effective care, and as a result, promote relapses and readmissions. They will make recommendations and referrals based on the findings of that analysis, including to the FHC Case Management program.
- Direct coordination with caregivers, family members, outpatient Providers, self-help groups and other community resources to achieve effective transition to various levels of less restrictive care and community reintegration.
- Direct coordination for continuity of mental health treatment within seven (7) days or less of discharge date. The Provider must coordinate treatment with a psychiatrist on or before thirty (30) days directly with the primary psychiatrist, or in the absence of availability or new admission, with a Provider within the geographical limitations of the member. It is not considered satisfactory coordination to give an appointment date without having established communication and validated availability with the follow up Provider.
- When the post-discharge coordination is with multidisciplinary clinics, it must consider that these appointments are not always with a psychiatrist. The hospital, confirming the date on which a physician from the clinic will provide follow-up, must provide a post-discharge prescription with enough medication until the date of the medical evaluation.
- Include referrals and coordination with other professionals and levels of care based on clinical diagnoses and findings, such as to primary care physician, continuity electroconvulsive therapy, addiction specialists, outpatient intensivists, FHC Case Management, etc.
- Refer to FHC Case Management any member with potential for readmission as soon as risk is identified, and to high utilizers to assist in the transition of care prior to discharge.
- Prescription medication with enough to cover days until post-discharge appointment with psychiatrist. The medication formulary must have been considered according to the member's coverage, and the pre-authorization process for medications that require it must have been completed.
- A comprehensive discharge summary that will be transmitted to the patient, caregiver, outpatient psychiatrist and any other relevant physical or mental health Provider. The instructions and recommendations therein must be explained and validated to be understood by the member and/or caregiver.
- Notification of discharge to FHC through census document within 24 hours of discharge via fax 1-866-464-0928 or email FHC-PRUtilizationreview@uhsinc.com.

F. Discharge summary

- The summary will address an individualized, ongoing plan of care directed to outpatient Providers that includes final diagnosis, reason and precipitants for hospitalization, course of hospitalization, medication reconciliation, level of care recommendations, specific treatment recommendations, appointments, and referrals.
- Shall have a medication reconciliation containing all prescribed physical and mental health medications indicated and in use by the patient. It shall also include long-acting injectable medications. All medications should be documented with name, dosage, frequency, date administered and next dose (for long acting injectables) and indication.

- It will also include instructions to the patient and/or caregiver on the use of medications, potential side effects, management of their condition, warning signs, community resources and contacts for clarification and any need for guidance.

G. Early readmissions

An early readmission is an event where a beneficiary is admitted to an acute psychiatric hospital on or before thirty (30) days after discharge from any psychiatric hospital. This event is attributed to the discharging psychiatric hospital prior to readmission.

Readmitting beneficiaries have or are having needs that have prevented them from achieving stability. For this reason, these individuals require greater attention to reduce the risk of further deterioration and relapse.

For beneficiaries whose ongoing admission is a readmission event, the hospital must:

- Evidence in the record an analysis of the prior hospitalization, assessment of the reasons, factors and barriers that enhanced the readmission, and clear interventions directed at the factors that have led the member to relapse.
- Mediate a physician-to-physician discussion within forty-eight (48) hours to report progress, continued medical necessity, additional management alternatives, and discharge projections.
- Consider prior admission and readmission factors into the treatment plan.
- The facility shall have a policy and/or procedure detailing its transition of care process for patients who have been, or are at risk of being, readmitted.
- Early readmissions where it is identified that the early readmission could have been prevented by a failure in discharge planning or transition of care may result in partial or total denials of the prior admission.

H. Therapeutic restrictions

- Both medications intended to manage acute agitation/aggressivity and intramuscular medication used for treatment when oral alternatives are available are considered chemical restraints. Intramuscular medication that is for depot/long term treatment is not considered restraint.
- Therapeutic restraints must comply with the requirements as stipulated by Act 408 and the Joint Commission.

I. Documentation and readability

Each individual clinical record is required to contain the documentation necessary to meet the medical necessity criteria for the level of service being provided. The professionals providing the service must document in a clear and legible manner. The record is required to contain the following:

- Documentation of each assessment provided by each of the Providers, as well as for each intervention, procedure, and prescribed order.
- Daily individual progress notes.
- Documentation requires a detailed description of the behavior presented and the intervention offered. It is not sufficient to simply state the required criteria. For example, structured plan is not considered a clinical description but details the structure, methodology and feasibility of the plan. Also, for example, command hallucinations, is not considered a clinical description but details the content, intensity, frequency, and effect on the patient. Documentation with checklists checked off, without a description of the behavior, will not necessarily be sufficient for medical necessity criteria to be met.

- Interventions and therapies are required to include:
    - Description of the nature of the service,
    - the patient's status, changes, and detailed progress (signs, symptoms, behavior, verbalizations, mental status) during the service,
    - the patient's response to each therapeutic intervention,
    - the relationship to the goals set forth in the treatment plan (deviations from the plan, achievements, etc.), and
    - the immediate plan for continued treatment or discharge.
- Individual and Group Psychotherapy Progress notes must also specifically present the type of psychotherapy provided in accordance with the goals established in the treatment plan. The note is required to detail the service provided: a brief description of the content of the session, what the patient communicates, and the patient's response to the session.
- Each note must be legible, dated, signed, and bear the name and title of the professional who provided the intervention.
- The treatment plan shall be updated at least every seven (7) days according to the progress, evaluations, current clinical status and with the necessary changes. If there is a lack of progress, its relationship to active treatment and expectation of improvement should also be evidenced.
- The narrative, clinical analysis, treatment plan and progress of each member is expected to be individualized. Similarities in documentation that suggest a non-individualized process could be considered for denial. Evidence of plagiarism of notes from other patients, or from the same patient with different dates will be referred to the FHC fraud and abuse department.
- If there is a difference in clinical findings between the evaluating professionals, the reason for the discrepancy and the next step based on that finding must be documented.

If any relevant content in any of the documents is not legible or is incomplete, this could affect the medical necessity analysis. Failure to provide legible, complete documentation with the necessary criteria to support the treatment provided may result in denial of services or claims.

SECTION 10: UTILIZATION MANAGEMENT PROGRAM

A. Utilization Management

The FHC Utilization Review Program offers easy and immediate access to the most appropriate, high quality mental health and substance abuse services for members. The main purpose is to encourage members to achieve their recovery goals by provoking continuity of services and management of available resources.

FHC has designed a system of care, based on principles of recovery and quality, which is flexible in meeting the needs of diverse populations, communities, and members to:

- Provide easy and timely access to appropriate treatment on the least restrictive level of care.
- Collaborate with Providers in delivering quality care according to accepted best-practice standards.
- Address the needs of special populations, such as children, the elderly, and complex populations.
- Identify common illnesses or trends of illnesses.

B. Purpose of the Utilization Management Program (UMP)

This program promotes the provision of quality, cost-effective and medically appropriate services that are offered across a continuum of care, integrating a range of services appropriate to meet individual needs. It maintains flexibility to adapt to changes, as necessary, and is designed to influence member care by:

- Managing available benefits effectively and efficiently while ensuring quality care is provided.
- Evaluating the necessity and efficiency of services across the continuum of care.
- Coordinating, directing, and monitoring the quality and cost-effectiveness of health care resource utilization.
- Implementing comprehensive processes to monitor and control the utilization of health care resources.
- Ensuring that services are available promptly, in appropriate settings, and are planned, individualized, and measured for effectiveness.
- Reviewing processes to ensure care is safe and accessible.
- Ensuring that qualified health care professionals perform all components of the process.
- Ensuring that utilization management decision tools are appropriately applied in determining medical necessity decisions.
- Providing mental and behavioral health care which includes inpatient services, outpatient services, and other clinical procedures.

C. Objectives and functions of the UMP

- Review and evaluate healthcare services for:
  - Quality
  - Medical necessity and appropriateness
  - Appropriate benefit application
  - Appropriate level of care
  - Planning needs
- Ensure confidentiality of member and Provider information.
- Support communication between the Primary Care Provider (PCP), the health plan, and other Providers involved in the care of the member.
- Review utilization data, identifying over- and underutilization practices, and to identify and implement improvements that enhance appropriate utilization.

- Ensure application of timeliness requirements established by local and federal regulations and contractual requirements.
- Support HEDIS® initiatives.
- Ensure adherence to the guidelines in Utilization Management as set forth by the NCQA and URAC, federal and local regulations and evidence based clinical guidelines.
- Educate Providers regarding medical necessity criteria and accessing services and requirements.
- Identify opportunities for improvement in all programs; implementing interventions when indicated, to maintain the goals and objectives.
- Inform Providers about Grievance and Appeal System for dual eligible Medicare and Medicaid members (commonly known as Platino members in Puerto Rico), together with information about applicable procedures, timeframes, and the member's right to file Grievances and Appeals, including the availability of assistance in filing Grievances and Appeals and the right to request continuation of benefits during a pending proceeding.

D. Scope of the Utilization Management Program

FHC provides members and Providers multiple venues of access to care through the following:

- Call Center for emergency care/clinical referral line available toll-free 24/7
- Case Managers
- Behavioral and Substance Use health services referrals and coordination at different levels of care, outpatient evaluations with contracted psychiatrists, psychologists, and clinical social workers.
- Psychiatric Hospitals
- Partial Hospitalization facilities
- Home Health Services
- Behavioral Health Procedures
- Intensive Outpatient Programs

Members have access to services that address:

- Mental Health
- Substance Abuse
- Pharmacy Management (when applicable)
- Case Management

E. Cultural Competency

FHC will ensure that all services are provided in a culturally and linguistically competent manner and are accessible to all members, including those with limited Spanish or English proficiency, limited reading skills, hearing incapacity or those with diverse cultural and ethnic backgrounds as well as complex needs.

FHC assures that the staff receives training regarding the linguistic and disability related needs and cultural differences of its members. All individuals providing linguistic services to FHC members shall be adequately proficient in the required language to both accurately convey and understand the information being communicated. FHC's objectives for culturally competent care include that Providers support and implement a culturally sensitive care model for members.

FHC approaches the cultural and linguistic needs of its membership by determining, on an annual basis, the need for the service materials to be available in different languages, if it is the first language of more than five percent (5%) of the geographical population within the service area. FHC also provides service for the hearing impaired through a Teletypewriter (TTY) Service Line. We also provide interpreting services for those members who require it.

F. Referral process

When a service request is made by a Provider for a determined level of care, clinical information is obtained from the Provider or designee. Once it is established that the member is eligible for benefits under the identified plan, the Utilization Review Coordinator (URC) reviews the clinical information submitted by the treating physician and applies it to the clinical criteria as well as the clinical practice guidelines to determine if it meets the conditions for the requested level of care.

As a part of the assessment of service request, the URC evaluates the following:

- If the service is appropriate to the member's needs
- Member's condition and symptoms meet medical necessity criteria for the requested level of care.
- If the service site is a contracted Provider. For services requested by a nonparticipant Provider or facility, the URC refers to the member's health plan benefit coverage.

If the service request is received from a member or member representative requesting outpatient care, the URC conducts a brief assessment to ensure that the member does not meet the criteria for urgent or emergent care. Referrals to outpatient Providers are made taking into consideration the member's preferences such as, geographic location, hours of service, cultural or language requirements, Provider specialty and gender.

G. Medical Necessity

FHC coordinates services that are medically necessary, clinically relevant, and provide for the identification and treatment of members' presenting symptoms.

Medical necessity means everything that a licensed, prudent, and reasonable physician understands that is medically necessary on any health service or procedure that is provided to a patient for diagnosing or treating a disease, injury, illness, ailment, or symptoms or to improve the functioning of a member in a way that is consistent with:

- Generally accepted standards of medical practice, considering modern means of communication and teaching.
- Clinically appropriate in terms of type, frequency, grade, location and duration of health services or procedures.
- That is not made merely for the convenience of the patient or the physician or for the economic benefit of the member, health service organization or other health plan Provider, of the treatment physician by himself/herself/themselves or from another health care Provider.
- It is within the scope of the practice and medical specialty of the licensed medical professional that determined the medical necessity. Expected to improve an individual's condition or level of functioning and increase chances for recovery.
- Individualized, specific and in accordance with the member's needs, as per their symptoms and diagnosis.
- Essential and consistent with nationally accepted standards based on clinical evidence recognized by mental

health or substance abuse care professionals or publications.

- Reflective of a level of service that is safe, where no other equally effective, more conservative, and less costly treatment is available.
- No more intensive or restrictive than necessary to balance safety, effectiveness, and efficiency.
- Not a substitute for non-treatment services addressing environmental factors.

Medical necessity determinations include:

- Decisions about covered behavioral healthcare benefits defined by the organization's Certificate of Coverage of benefits.
- Decisions about care or services that could be considered either covered or not covered, depending on the circumstances.

The Health Plan does not consider preexisting conditions as a single criterion to deny services.

H. Clinical criteria for UM decisions

Clinical criteria are medical protocols or clinical guidelines used by FHC in the evaluation of medical necessity and appropriateness of requested admissions, procedures, and services under the auspices of the applicable health benefit plan.

The main sources of clinical criteria are based on nationally recognized clinical guidelines, including, but not limited to:

- InterQual®
- CMS National Coverage Determination (NCD)
- CMS Local Coverage Determination (LCD)
- American Society of Addiction Medicine
- American Academy of Child and Adolescent Psychiatry
- American Psychiatric Association
- American Medical Association Journals Current publications in professional journals and books
- Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA)

These clinical guidelines provide:

- National consistency
- Unsurpassed quality of clinical content
- Inter-rater reliability tools
- Objective evidence-based recommendations.
- Support to make appropriate care decisions.
- Provide for appropriate services reducing under and over utilization.
- Alternatives to maximize treatment.
- Support on quality monitoring

The following factors that relate to the individual must be considered when applying clinical UM criteria:

- Age

- Comorbidities
- Complications
- Progress of treatment
- Psychosocial situation
- Home environment, when applicable

FHC shall utilize written UM decision making criteria that are objective and based on sound medical evidence. When a service requested does not have clear medical necessity criteria in any of the sources mentioned above UM staff will refer to guidelines from national professional organizations. InterQual® Level of Care Criteria are updated annually.

Clinical guidelines are available to FHC Providers upon request and free of charge. These criteria sources are also discussed on Provider forums, through the Provider's newsletters, and during individual meetings.

I. Clinical information for conducting UM activities

URCs are only able to certify care that is medically necessary based on adequate information in the facility medical record concerning the member's clinical condition. Examples:

- Significant changes in health status
- Current medical treatment
- Current medications
- Behavioral health problems/concerns

FHC engages Psychiatric Consultants as secondary reviewers for any potential adverse certification. Their review includes information from reliable sources that will assist in the certification process. Clinical information can be provided by the physician or Providers with responsibility for treating the member.

The URC's collect the clinical information necessary to certify the medical necessity of the admission, procedure, or treatment under consideration.

Clinical information used to guide the decision-making process is collected from patient records, conversations with appropriate Providers and service request forms submitted by members, Providers, and facilities. When medical or treatment records are necessary to make medical necessity determinations, the URC will request the specific information to make the medical necessity determination.

J. Clinical review process

1. Types of reviews

- Prospective Review (Preservice or Pre-certification) - A process in which clinical information and requests are reviewed to determine medical necessity before rendering services. Review determinations are based on the medical information obtained at the time of the review.
- Concurrent Review (Continued Stay Review) - NCQA defines concurrent review as a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the Organization did not previously approve the earlier care.
- Utilization management conducted during a patient's hospital stay or course of treatment (including outpatient procedures and services). Sometimes called "continued stay review" (URAC).

- Retrospective Review (Post-service) - A process to obtain medical information and to determine medical necessity as it relates to services that have been given when there has been no notification or request for review during the preservice or concurrent process. Medical records are required for the post-service review process. Review determinations are based solely on the medical information available.

2. Discharge Planning - The process that assesses a patient's needs to help arrange for the necessary services and resources to affect an appropriate and timely discharge or transfer from current services or level of care. Discharge planning supports continuity of care and efficient use of resources and incorporates the involvement of the member and their significant other(s) in the decision-making process. The process begins at the time of admission and is coordinated by the facility's discharge planner.

3. Peer-to-peer Review - A Psychiatric Consultant reviews the available information to conduct a peer-to-peer discussion, which involves a direct telephone conversation with the attending or primary Provider to discuss the case. Through this communication, the Consultant may obtain clinical data that was not available to the URC at the time of the review. The peer-to-peer discussion allows the Psychiatric Consultant the opportunity to explore alternative treatment plans with the Provider and to gain insight into the attending Provider's anticipated treatment goals, interventions, and time frames. The Psychiatric Consultant may request more information from the Provider to support specific treatment protocols and ask about treatment alternatives. Also, the Psychiatric Consultant can clarify why a case does not meet medical necessity criteria. Peer to peer discussions is available to the Providers during preservice, concurrent, retrospective and appeal process.

K. Timeliness of UM determinations

FHC follows the subsequent decision and notification time frames for all utilization review determinations:

Category	Medicare Decision Time Frame
Expedite/Urgent determination	Within 72 hours of receipt of the request
Standard/Routine determination	Within 14 days of receipt of the request
Concurrent review	If a Provider requests to extend the current course of treatment previously approved, FHC will issue the determination within: • 24 hours of the request for a determination, if it is a case involving urgent care and the request for extension was received at least 24 hours before the expiration of the currently certified period or treatment; or • 72 hours of the request for a determination, if it is a case involving urgent care and the request for extension was received less than 24 hours before the expiration of the currently certified period or treatment.
Retrospective review	Within 30 calendars days from receipt of request

Category	Medicare Decision Time Frame
Standard Appeals	Must be received 60 calendar days from receipt of adverse determination. Decision time frame within 30 calendar days from receipt of request.
Expedite Appeals	Within 72 hours of receipt of the request

The URC notifies the requesting Provider of any decision to deny or approve a service request. Approvals may be communicated orally, but denial decisions are always conveyed in writing, via letter. If the denial involves a preservice request, the member will also be notified in writing, via letter.

L. Clinical appeals

A clinical appeal is the process that deals with the review of adverse determinations (service denials) that a member believes he or she is entitled to receive.

If the FHC Psychiatric Consultant determines that there is no medical necessity for a requested service, the member, the member's representative or treating Provider may initiate the appeal request reconsideration. Clinical appeals will be managed by a Psychiatric Consultant that was not involved in the original adverse determination.

The member, member's representative or Provider may submit any information they feel is pertinent to the appeal request, and all such information is considered in the appeal review, whether it was available to FHC reviewers during the initial consideration. FHC has procedures in place to provide a prompt response to preservice, concurrent reviews, post-service, and expedited and standards appeals.

M. Case Management Program

1. FHC's Case Management program (CMP) consists of a specific approach to managing the care of members who have not been able to stabilize with standard case management strategies. FHC also has a Complex CMP for members who have experienced a critical event or diagnosis that requires extensive use of resources. Our approach corresponds to the definitions of "Case Management" as described by URAC and NCQA. URAC defines "Case Management" as, a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes. NCQA quality standards emphasize in a precise, member centered and high-quality care coordination, ensuring that members with complex conditions receive effective, coordinated member -centered services that lead to good outcomes. FHC CMP's have the framework of an integrated delivery system oriented on the recovery model.

2. Principles that regulate Case Management Services:
    - Offers access to integrated services to the member.
    - Offers continuity of care to the member.
    - Interacts with multiple systems.

- Mobilizes resources, negotiates with formal systems, serves as an advocate in representation of the member and follows up with informal networks.
- Based on the members strengths, promotes individualism, self-direction and collaborates with a multidisciplinary team and health care Providers.
- Focuses on the use of community resources and community services.
- Member centered: strongly believes in the member's right of self-determination while giving him/her/them options and alternatives for the appropriate level of care.
- Serves as an advocate for the member at government agencies, family support departments and legal systems.

3. Referral Process

The referral process begins with the completion of the referral form, as well as, with any other type of verbal or written communication to request an evaluation for admission to the CMP. It is the responsibility of the Case Manager (CM) or Supervisor to evaluate the referral and determine if the individual meets the admission criteria. Referrals are accepted from the following sources:

a. Discharge planners: Can refer members to the CMP using the **Referral Form** available on the FHC website or through the consultation process during their contacts with FHC's clinical staff.
b. Mental health Providers: Are informed about their ability to refer members using the **Referral Form** available on the FHC website. Providers are also informed through educational workshops offered by FHC. Mental health Providers can also contact FHC by telephone to complete the referral process, through the toll-free line for Medicare Advantage: **1- 800-760-5691**.

The CM offers the member:

- A professional service that guarantees confidentiality, in accordance with Puerto Rico Law 408 and HIPAA.
- Collaborative work between the member and the CM to achieve an optimal level of functioning in the least restrictive treatment.
- The opportunity to contact public agencies that help the member work with their social determinants of health.
- An individual and personalized management.
- Link between the member and their mental and physical health Providers to guarantee integrated quality services.

The Member and his/hers/theirs family are expected to make a commitment, not only to the program, but also to their recovery and treatment process, complying with the recommendations offered by their health Providers and case manager.

Information about the Case Management Program, including additional referral sources is available in our website: www.fhcsaludmental.com. Please visit the following link: Case Management Program.

N. Identification of complex cases and members at risk

Referrals of at-risk members may come from members, parents/guardians, Providers, external sources, and internal sources such as FHC Call Center for emergency care. Members identified through these channels as potentially requiring case management services are contacted by a Case Manager to further assess their unique needs and verify

if enrollment in Case Management is appropriate. This process also includes assigning the level of care for the member by applying clinical protocols and conducting assessments.

- Level IV: Intensive Need/Special Interventions - Complex member with intensive needs, immediate intervention required, a need to assess alternate care options.
- Level III: High Risk - High Risk member with multiple chronic conditions. Member is not medically stable, not engaged with Mental Health Providers, and not taking preventive steps.
- Level II: Moderate Risk - Complex member with multiple chronic conditions. Member is medically stable, engaged with Mental Health Providers, and taking preventive steps.
- Level I: Low Risk - Member with newly diagnosed chronic conditions who needs help getting more education via Provider or Community Resource.

O. Transitions of Care (ToC) Program

FHC's Transitions of Care (ToC) is define as the coordination and continuity of care from one care setting to another as the member's health status changes. This is accomplished by providing members with the tools and support that promote knowledge and self-management of their condition, and by facilitating the member and the Provider improvement of their understanding of their roles, expectations, schedules, and goals. Such transitions occur, for example, when a member moves from a home to a hospital as the result of an exacerbation of a chronic condition or is discharged from a hospital to a Partial Hospitalization program. The goal is to offer proactive coordination and continuity of care if needed before and after discharge from the hospital.

FHC uses two methods for outreach in the ToC Program:

1. ToC with psychiatric hospitals clinical staff - The facility Primary Therapists or Care Manager, in coordination with FHC's CM, identify those individuals with criteria for CMP or are considered high risk. If needed, the CM can assist the facility's staff in identifying resources for referrals and community services.

2. ToC interventions to identified members - Designed once the member identified as high risk is discharge from a psychiatric hospitalization. The CM contacts the member to ensure that he/she/they was oriented about the date and importance of the outpatient appointment and his/hers/theirs commitment to attend it. During this intervention, the CM explores any issues that may interfere with the member showing up to the outpatient appointment and assists in eliminating such barriers.

Both methods are employed to facilitate the transition of care and to coordinate services needed with appropriate Providers. FHC will work with hospitals to demonstrate the increased value of the ToC interventions in preventing hospital readmissions.

The aim of the ToC includes the prevention of hospital readmissions, optimal transitioning from one care setting to another and the identification of unexpected changes in conditions requiring further assessment and interventions. Continuity of care post discharge communications may include, but not be limited to, phone calls and follow up letters to members, specialty Providers, other treating Providers and agencies offering community resources.

The FHC ToC re-establishes the member's connection to their medical services by ensuring that an appointment has been scheduled with the member's mental health Provider prior to discharge from a hospital or appointment with their

behavioral health specialist as applicable. The goal is to arrange an appointment to occur within seven days of hospital discharge. Follow-up phone calls will also be made to support the member.

P. Pharmacy Management Program

The aim of the Pharmacy Management Program is to ensure that drugs are used appropriately, safely, and effectively to improve patient health status. This program features a comprehensive and integrated approach to treatment. A Clinical Pharmacist conducts a drug utilization analysis to help identify therapeutic appropriateness and under- or overutilization of medications to protect members from adverse drug events, duplicate therapy, low or high doses, drug-drug interactions, duration of treatment, drug gender precautions, polypharmacy, inappropriate diagnosis based on treatment, and uses of potentially inappropriate medications as high-risk medications (HRM) to the elderly population. In addition, this review detects members with poor adherence to the drug regimen.

The program seeks to provide valuable feedback for the prescriber and to contribute to rational medication use among members under the care of a physician, and includes activities that improve the quality of services, patient safety and cost-effectiveness. Some of the activities performed include: medication reconciliation post discharge (MRP), medication quality assurance measures (antidepressant medication management, antipsychotic use in persons with dementia, adherence to antipsychotic medications for individuals with schizophrenia, diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications, people with cardiovascular disease and schizophrenia, polypharmacy in drugs that affect the central nervous system and combination of opioid and benzodiazepines) and physician interventions.

These activities promote a more rational prescribing approach and provide an opportunity to share information with the Providers about their prescription patterns and opportunities to prevent and avoid adverse events.

Q. State and federal reporting requirements

All states require licensed clinicians to report abuse of children and dependent adults to the designated state department. In accordance with these laws, any clinical staff that suspects or becomes aware of potential or alleged abuse that falls within reporting statutes must make a report to the appropriate agency. Often, the Provider or facility providing clinical data has already complied with any such statutory requirements. However, when they have not, or if compliance is unclear, the clinical staff must do so following FHC policy.

R. Mechanisms to monitor the effectiveness of the UM Program

- Indicators to Monitor Efficiency in Utilization - Utilization data is reviewed for detecting and correcting potential under- and overutilization of services. This data includes admissions per thousand, average length of stay (ALOS), diagnoses, readmissions rates, number of units of service per level of care, appeal rates, and percentage of overturned appeals, for determinate levels of care and at specific sites. and complaints and satisfaction survey data.
- Provider specific patterns of under and overutilization - Are evaluated during the practitioner recredentialing process. These profiles report both quality and utilization data for each practitioner. The utilization data are diagnosis specific and report the number of mental health services delivered by the Provider for each member served. If there is significant variation from what is expected, the practitioner's profile is sent to the SIU for further evaluation.
- Inter-rater Reliability (IRR) - It is the policy of FHC to review peer activities of clinical services. This activity represents a continuous evaluation of the appropriateness of clinical decision making and treatment planning.

FHC has implemented the IRR tests to monitor the consistency with which medical necessity criteria is applied among clinical and medical staff. Tests are conducted in multiple areas such as, child/adolescents, adults and geriatrics, psychiatric services, and substance use disorder. The test sets are updated annually.

- Satisfaction Standards - Member and Provider satisfaction surveys are performed at least on an annual basis. Results are summarized and reported in the QI and UM committees for analysis and follow-up.
- An annual facility satisfaction surveys is also performed. This survey measures provide opinions regarding FHC's clinical and administrative services and practices. Data is analyzed and used to identify improvement opportunities.

S. Continuity of care

FHC ensures continuity of care for new members per regulatory requirements and for existing members in situations where there is a discontinuation of services by the Provider, or if the treating Provider is not a participating Provider of FHC's network.

Unless FHC advises to the contrary, Provider shall continue to provide Covered Services to Members receiving active treatment at the time of termination of their Facility Agreement until the course of treatment is completed, until FHC makes reasonable and medically appropriate arrangements to have another Provider render such services or for ninety (90) calendar days, whichever is less.

Additionally, the Call Center staff facilitates the transition of care for members whose benefits have come to an end. Alternatives to coverage are explored with the member, the PCP, community resources and any new plan coverage to ensure continuity of care and that healthcare needs are addressed.

T. Conflict of interest

No person may participate in the review and evaluation of any case or clinical activities in which he or she has been professionally involved or where judgment may be compromised. UM decision making is based solely on the clinical appropriateness of the care and services needed. FHC does not provide incentives to individuals engaged in utilization review for issuing denials of coverage or service, or for rendering decisions that result in underutilization. Psychiatrists, psychologists, nurses, social workers, and other mental health professionals who conduct care management or peer review activities must be free from conflict of interest when reviewing the work of Providers. Among other things, this means that clinical staff, including peer reviewers, must not review the work of any health care facility or entity where they have active staff privileges, treat members or from which they derive any income.

SECTION 11: PROVIDER REIMBURSEMENT

A. Claims and payment

FHC maintains claims processing procedures designed to comply with clients' requirements and applicable federal and local laws, rules, and regulations.

B. Compensation amounts and responsibility

FHC shall be financially responsible for compensation to the Provider at the rates specified in the Fee/Reimbursement Schedule within thirty (30) days of the filing of a clean claim. FHC delivers to Providers the Fee/Reimbursement Schedule within fifteen (15) Calendar Days of award of the Facility Agreement (along with this Facility Handbook and other addendums).

The compensation paid to the Provider shall be the lesser of the rates contained in the Fee/Reimbursement Schedule or Provider's billed charges for covered services.

FHC reserves the right to clarify, supplement or amend the rates specified in the Fee/Reimbursement Schedule.

C. Claims Submission

- Electronic Claims submission - Providers in the FHC network are encouraged to submit all claims electronically. To start the electronic claims submissions, the Provider must contact a clearing house or use a computer with software that meets electronic filing requirements.

- Paper Claims submission - Submit claims using UB-04 or CMS-1500 forms printed with all applicable fields completed and all elements/information required by FHC. Paper claims may be delivered to Payor's facilities or sent by mail to the following address:

MCS Advantage, Inc.
Departamento de Reclamaciones
PO BOX 191720
San Juan, PR 00917-1720

D. Timely billing for Medicare Advantage

Paper and electronic claims must be filed within ninety (90) days of the covered serviced being rendered. If FHC is the secondary payer, the ninety (90) days period defined above, shall begin to count on the date the participating Provider receives the determination from the primary payer.

FHC shall not establish any administrative procedures, such as administrative audits, authorization number or other formalities under the control of FHC, which could prevent the practitioner from submitting a claim. FHC will pay in full any clean claim for payment within thirty (30) calendar days of receiving the clean claim.

FHC will suspend an unclean claim and notify to the Provider any objection within thirty (30) calendar days of receiving the claim, clearly specifying the reasons for which the claim is not actionable for payment and indicating the documents or additional information that must be submitted. The claim or part of a claim not objected by FHC within the term, shall be deemed a clean claim and must be processed for payment.

Within the following twenty (20) calendar days of having received the notice objecting the claim, the Provider must answer the objection. The failure to do so shall be deemed to be an admission of the deficiencies notified.

Once the Provider submits the required information or documents perfecting the claim, FHC shall proceed to pay the claim within thirty (30) calendar days following the receipt of the information or documents. The wrongful notification of not-processable claims shall not interrupt the thirty (30) calendar days for payment term. Any clean claim not paid within thirty (30) calendar days shall bear interest in favor of the Provider on the total unpaid amount of such claim, according to the prevailing highest legal interest rate fixed by the Puerto Rico Commissioner of Financial Institutions. Such interest shall be paid together with the claim.

The Provider is required to cooperate with FHC in providing any information requested in connection with claims and in obtaining necessary information relating to coordination of benefits, subrogation, verification of coverage, and health status.

Claim payments are regulated by Prompt Payment Act No. 150 of July 27, 2011, Amendment to Rule 73, Regulation No. 6559 of May 11, 2012, its regulations, and Facility Agreement.

Claims submitted for services rendered to members of Medicare Advantage are subject to the following billing and payment terms:

Person/Entity Responsible	Process	Timeframe
Provider	File a claim	90 calendar days from the date the service was rendered
FHC	Pay a clean claim	30 calendar days of receiving the clean claim
FHC	Suspend an unclean claim	30 calendar days of receiving the unclean claim
Provider	Answer an objection	45 calendar days from receiving the Explanation of Payment (EOP)
FHC	Pay an objected claim	30 calendar days of receiving the objected claim

E. Coding Social Determinants of Health

Providers must collect SDOH data through health risk assessments, screening tools, member-Provider interaction, or member self-reported data. The information collected shall be documented in the member's record and included in the claim by assigning a Z Code (current ICD).

FHC requests participating Providers to assess for the presence of the following SDOH and use the assigned Z Code when filing the claim. Assessment must occur in every encounter with the member and shall be listed in the diagnosis field on the initial evaluation or progress note along with other diagnoses.

The use of Z Codes will not affect the reimbursement of claims submitted if the claim is filed appropriately.

Social Determinants of Health (Identified Problem)	Z Code (ICD-10)
Problems related to education and literacy	Z55.9
Unemployment	Z56.0
Low income	Z59.6
Lack of adequate food and safe drinking water	Z59.4
Homelessness	Z59.0
Limited transportation: Specific Economic problem	Z59.8
Problem related to housing circumstances	Z59.9
Social and community issues	Z60.9
Inadequate Family Support: Other specified problems related to primary support group	Z63.8
Other problems related to primary support group, including family circumstances	Z63.9
Health Service Unavailable, or Not Available at the Time Needed	Z75.9
Limitation of activities due to disability	Z73.6
Feeling unsafe in neighborhood	Z60.8
Inadequate housing	Z59.1

Providers may identify and include other SDOH as appropriate.

F. Coordination of Benefits

The Provider shall cooperate with FHC in providing any information requested in connection with claims and in obtaining necessary information relating to coordination of benefits, subrogation, verification of coverage, and health status. Provider shall make reasonable efforts to determine if members have insurance or other health care coverage other than through Payor and will promptly report any duplicate coverage to FHC. Provider also shall notify FHC promptly in the event he/she/they provide services in connection with work related injuries, motor vehicle accidents or other occurrences that may involve third party liability.

Provider further understands and agrees that the coordination of benefit rules of the applicable Payor's Plan will determine payment to the Provider and that, in no event, shall a Payor be obligated to pay Provider any portion of a secondary payment whereby the sum of the primary payment, plus the secondary payment, exceeds the compensation specified in the Reimbursement Schedule. Nothing contained herein, however, shall restrict or otherwise affect the Provider's rights or obligations with respect to third party payors other than Payor.

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G. No Balance Billing

The Provider will hold harmless and will not seek reimbursement from the members for covered services, other than the applicable copayments, coinsurance, or deductibles. The Provider may not balance bill members when any of the following occurs:

- Claims are denied for administrative reasons, such as pre-certification when it is required.
- There is a dispute or payment delay involving a Payer.

This provision supersedes any oral or written contrary agreement previously entered between the Provider and the member or anyone acting on their behalf. Provider shall abide by the terms of this provision in case of non-payment by FHC or Payor for any reason, including, but not limited to voluntary or involuntary bankruptcy proceedings involving FHC or Payor.

I. No Surprise Billing

The No Surprises Act contains key protections to hold consumers harmless from the cost of unanticipated out-of-network medical bills.

Health plans must cover surprise bills at in-network rates. The law requires private health plans to cover surprise medical bills for emergency services, as well as out of network Provider bills for services rendered at in-network hospitals and facilities.

The law requires surprise bills must be covered without prior authorization and in-network cost sharing must apply. In-network cost sharing for surprise bills will be based on a "recognized amount," which in most cases will be the median in-network payment amount under the plan for the same or similar services.

The law also requires that federal external appeal rights apply if consumers feel their health plan has not correctly identified and covered a surprise medical bill.

Reference: Ending Surprise Medical Bills | CMS

J. Non-certified services

If the Provider does not secure pre-certification from FHC for services, when applicable, that are included in the member's plan, the member shall not be held liable for the cost of such services. The Provider may bill members for services that are included in the member's plan but that are not certified as medically necessary only if FHC notifies the Provider that: (i) proposed treatment or services for a member will not be authorized; or (ii) treatment or services for a member which had previously been authorized will no longer be authorized. The Provider may initiate an appeal of the service denial by following FHC Clinical Appeals procedure as specified Section9: Utilization Management Program in this Handbook.

If a member wishes to continue to receive such non-authorized treatment from the Provider after the appeals process is completed and the denial determination was upheld, the Provider must obtain the member's written consent to be financially responsible for any such non-certified treatment or services received from the Provider thereafter. The member's consent must be in writing, signed and dated, and may not be obtained until after the date on which the

appeals process is completed. Any prior agreement by a member to be financially responsible for non-certified treatment or services shall be invalid and the Provider agrees that he/she/they will not attempt to enforce any such agreement.

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Fax: 1-866-912-2206
Hearing Impaired: 1-866-912-2788
www.fhcsaludmental.com

Call Center: Available 24 hours a day, 7 days a week
Department of Utilization Review:
Monday to Friday: 8:00 am – 6:00 pm and Saturday: 7:00 am – 4:00 pm

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