FHC First Healthcare

PROVIDER HANDBOOK

FOR MEDICARE ADVANTAGE

2025

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SECTION 1: INTRODUCTION

A. Welcome to 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.

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

Our Vision is 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.

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 2023 became the first Managed Behavioral Health Organization of Puerto Rico and United States to obtain the Transition of Care designation. In 2019, we became the first managed behavioral health organization in Puerto Rico to receive full accreditation status from the National Committee for Quality Assurance (NCQA).

D. FHC services

- Customer 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

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 Provider 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 Provider Agreement.

The Provider Handbook outlines FHC's standards, policies and procedures for individual Providers, affiliates, group practices and facilities. It is an extension of the Provider 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 Provider Handbook, which may be amended or supplemented from time to time. The policies and information stated in this manual should align with the terms of your agreement with FHC. If they don't, the terms of your agreement override this manual.

The Provider is also responsible for complying with all applicable laws and regulations. FHC may issue notifications regarding legal requirements as laws or regulations change. However, the Provider is responsible for compliance regardless of whether FHC issued a notification.

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 Practitioner or Provider to refer to the contracted Provider.

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, licensed counselors, 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 assist our network by providing guidance and assistance through Provider office visits when necessary, and our Provider Call Center for Medicare Advantage.

To maintain open and effective communication, we encourage you to direct questions and concerns to the Providers Department by e-mail at **providerspr@uhsinc.com** and or the Provider Call Center. Our 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.

B. Communications

FHC typically communicates with participating Providers via e-mail, therefore Providers must maintain accurate contact information on file, especially valid e-mail 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).

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.
- Collaborate with FHC Case Management staff on identification and discussion of member's care needs.

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 Provider 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. 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

A. Access standards

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.

Providers are expected to maintain established office/service hours that are convenient and do not discriminate against members. Hours of operation may be no less than those offered to privately insured or other members.

It will be expected from all Providers to make appointments according to standards for appointment availability and in office waiting times as specified below.

Type of Service	Standard
Emergency and urgently needed services	Immediately
Services that are not emergency or urgently needed, but the enrollee requires medical attention	Within seven (7) business days
Routine and preventive care	Within thirty (30) business days

Emergency service means covered inpatient and outpatient services that are rendered by a provider qualified to furnish emergency services, and are necessary to evaluate or stabilize an emergency medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, having knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

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.

Contracted Providers who do not maintain coverage twenty-four (24) hours per day, seven (7) days per week are required to maintain a system for referring members to a source of emergency assistance during nonbusiness hours. The preferred methods are through a live answering service or an on-call pager system. However, Providers may maintain a reliable recorded answering machine system. Members experiencing an emergency must be given clear instructions about accessing immediate help after hours.

Urgently needed services means covered services, which are not emergency services as defined in this section, but the services are medically necessary and are required immediately as a result of an unforeseen illness, injury or condition; and it was not reasonable under the circumstances to obtain the services through the organization (provider network).

Regular and Routine Care - Behavioral health services shall be provided within seven (7) business days following the request unless the member requests a later date. Routine follow-up visits must be provided within thirty (30) business days of the request made by the member.

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, upon request, by oral or written communication of 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 practitioner 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 practitioner must attest to the following:

- Limits on his/hers/theirs ability to perform essential functions of the position.
- Absence of current illegal drug use.
- History of loss of license and felony conviction.
- History of loss, limitations of privileges or disciplinary actions.

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.

- Current, valid license to practice as an independent practitioner at the highest level certified or approved by the state for the Provider's specialty or facility/program status, not affected by restrictions, including, but not limited to probation, suspension and/or supervision or monitoring requirements.
- Clinical privileges in good standing at the institution designated as the primary admitting facility, with no limitations placed on the practitioner's ability to independently practice in his/hers/theirs specialty.
- Graduation from an accredited professional school and/or highest training program applicable to the academic degree, discipline, or licensure.
- Board certification, if applicable
- Malpractice certificate endorsed to FHC for no less than $100,000/$300,000 for practitioners.
- Drug Enforcement Administration (DEA) and Controlled Dangerous Substance (CDS) Certificate, if applicable.
- Puerto Rico Administration of Mental Health and Anti-Addiction Services (ASSMCA) Certificate, if applicable
- Substance Abuse and Mental Health Services Administration (SAMHSA) certificate, if applicable
- Professional affiliation (*Colegiación*), if applicable
- Work History/Curriculum Vitae
- Medicaid enrollment
- Certificate of Penal Record
- Malpractice history
- Medicare Opt-Out
- Office of Foreign Assets Control (OFAC) Sanction List
- Sanctions and exclusions from government programs
- Current specialized training as required for practitioners
- Medicare and/or Medicaid sanctions
- Ownership and control disclosure of business transactions, and criminal conviction information
- Site visit results

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.

- A valid license to practice.
- Highest level of education from an accredited institution
- Board certification, if applicable
- Medicaid enrollment
- Medicare/Medicaid sanction activity
- National Practitioners Data Bank (NPDB)
- Accreditation status, applicable to facilities

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 practitioners and 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 Provider 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 Provider 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 Provider 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).
- Expiration of required professional liability insurance (must be notified at least thirty (30) calendar days before the expiration, termination, or material change to such coverage).
- Expiration of professional license/certification, DEA certificate, CDS certificate, board certification and malpractice insurance.

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 their 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
- Tax identification number
- 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*** **form.** 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

FHC will conduct site visits to a facility or practitioner's office(s). The criteria for selection of Providers to whom site visits are made may include:

- Initial credentialing
- High-volume Provider
- Recredentialing (at FHC discretion)
- Between recredentialing processes when adding a new practice location or changing group affiliations since the previous credentialing decision.
- 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

The Provider will be contacted by FHC to arrange a mutually convenient time for the site visit. The site visit will take between 60 and 130 minutes for individual practitioners, and as much as several days for facilities or programs. 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. Peer-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 of performance

L. Appeal rights

FHC has established an Appeals Committee to ensure a fair appeal process for practitioners to present written or oral testimony in the event an adverse participation decision is made against a practitioner that does not meet quality standards. Providers have the right to appeal certain adverse credentialing decisions regarding network participation initiated by the Credentialing Committee because of a quality-of-care issue.

The Appeals Committee includes representatives of major clinical disciplines, including network Providers and clinical representatives from FHC, none of whom compete or have a conflict with the appealing Provider. Members of the Appeals Committee must not have participated in the Credentialing Committee decision.

1. Appeal Process

- Providers are given written notice of the proposed actions within ten (10) business days of the decision.
- The notification must include information about the rights to appeal and to request a hearing, the reason(s) for the decision, the process and timing to exercise the appeal, and the practitioner’s right to be represented by an attorney or another person of the Provider’s choice.
- Providers have thirty (30) calendar days following the date of the notice to appeal the action and to file a request for a fair hearing. Failure to submit the FHC Appeal form in a timely manner shall constitute a waiver of the right to appeal and consent to the action or proposed action.
- The Appeals Committee shall examine the new evidence presented by the practitioner by written or oral testimony and shall determine through the added information received whether the practitioner meets the credentialing criteria and qualifications.
- The Appeals Committee shall review all relevant evidence and decide the matter by majority vote within thirty (30) calendar days of the date of the hearing.

- The written decision shall be sent to the Provider by mail and/or e-mail within ten (10) business days from the date of the decision, setting forth:
  - The decision of the hearing panel
  - The basis for the decision

The determination of the Appeals Committee constitutes the final action of the appeal process.

2. Exceptions to the Right of Appeal

- The appeal process and fair hearing rights described in this Handbook shall not apply in cases involving specific circumstances not classified under quality-of-care issue.
- Quality of care issues include, but are not limited to:
  - Medication errors
  - Unnecessary or inappropriate treatment
  - Transition of care
  - Health or drug plan
  - Customer service
  - Access to care
  - Improper care or unsafe conditions
  - Facility conditions
  - Ethics

- FHC shall have the right to deny the credentials or terminate the agreement without offering the Provider the due process rights described in this Handbook for, but not limited, to the following circumstances:
  - The Provider's professional license or legal credential to practice has been revoked or suspended.
  - The Provider's authority to prescribe, including but not necessarily limited to the DEA certification, has been revoked or suspended.
  - Failure to comply with the credentialing standards.
  - Provider is indicted, arrested, or convicted of a felony or any criminal charge.
  - Provider becomes the target of a federal investigation and/or federal agents execute a search warrant at their home or place of business.
  - The Provider has been debarred or excluded from participation in federally funded programs by the federal government.
  - The Provider is included in the LEIE and SAM exclusion lists, or similar official exclusion listings.

SECTION 6: PROVIDER AGREEMENT

A. Term and Termination

1. **General Term** – The Provider Agreement is effective from the date specified on the execution page of the Provider 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 Provider 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 Provider agree that there will be no requirement or obligation to provide a reason for exercising their 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 or for ninety (90) calendar days, whichever is less.

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 Practitioner including, but not limited to, the following reasons:
   - Failure to comply with the code of professional ethics.
   - Breach of contract.
   - The practitioner has made a misrepresentation or a false, misleading inaccurate or incomplete statement in his/hers/theirs application.
   - The practitioner has been voluntarily or involuntarily suspended or expelled from any hospital medical staff, has had his/hers/theirs hospital privileges suspended, revoked, or limited, or has had action by a managed care organization that affected his/hers/theirs participation.
   - 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 compliance audits
- Noncompliance with the site visit criteria

- Fraud, waste, and abuse issues
- The Provider fails to comply with the recredentialing process
- Nonrenewal of the Provider Agreement
- The Provider is unable to be located
- 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's 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, waste 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 agencies.
    - 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, practitioners 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 practitioner's license or credentials to provide any covered services he/she/they were previously licensed to provide.
    - 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.
    - The Provider becomes the target of a federal investigation and/or federal agents execute a search warrant at their home or place of business.
    - Practitioner's indictment, arrest, or conviction whether because of a guilty plea or a verdict of guilty of a felony, any offense involving moral turpitude, and any offense related to the practice or with the ability to practice.

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

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 this Provider Handbook, Section 3. Provider Agreements, G. Adverse Incidents Reporting.

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 suspected fraud, waste, or abuse.

B. Fraud, waste, and abuse

It is the responsibility of Providers 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 has not knowingly or intentionally misrepresented facts to obtain payment.

If FHC identifies that potential 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.

C. Compliance Audits

The Special Investigations Unit (SIU) is a part of the Compliance Department that reviews and monitors claims and billing practices of Providers. SIU/Compliance auditing is considered a health care operation permitted by the HIPAA Privacy Rule for fraud, waste, and abuse detection (see 45 CFR 164.501 and 506). Providers agree to allow oversight and to cooperate with Compliance audits as a condition of network participation.

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

Providers will be required to either scan or copy the medical records before submitting them to FHC for review. Providers must supply the requested documents to FHC within the required timeframe. The required timeframe will be specified in the record request letter.

Providers can submit the documentation in person at FHC offices, by mail or electronically. FHC will not reimburse Providers for copying fees related to providing documents or records requested during an audit, unless otherwise specifically required by applicable state or federal law. FHC will manage medical records in accordance with FHC's privacy policies and in compliance with HIPAA Privacy rules.

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

For the purposes of Compliance audits, the "medical record" includes, but is not limited to: patient assistance sheets or signature logs, signed patient consent forms, progress notes, medication prescriptions, results of clinical tests, documentation of counseling sessions or therapeutic interventions, treatment plans, and referrals. A member's medical record must include the following core elements: member name, date of service, rendering Provider signature and/or rendering Provider name and credentials, member diagnosis, start and stop times for time-based services (i.e.., 9:00 a.m. to 9:50 a.m.), and descriptive documentation of the services rendered to substantiate the Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) codes, the place of service (POS) codes and the modifier codes reported on the claims submitted for payment. Documentation must also meet the requirements outlined in Section 8.G General Guidelines for Documentation and Section 8.I Treatment Record Standard Tool of this Handbook.

During a Compliance audit, documents and records provided are compared against the claims submitted by the Provider. 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 Determinations (NCD) and Local Coverage Determinations (LCD) as well as the nationally recognized criteria found in the HCPCS or CPT Manuals published by the American Medical Association (AMA). Providers' strict adherence to these guidelines is

required. The lack of proper documentation for services rendered could result in denial of payment, or, if payment has already been issued, a financial recovery.

Following completion of the review, the Compliance Department will provide a written report of the findings to the Provider. In some instances, such report of the findings may include a request for additional records. The Compliance Department's report of findings may include specific requirements for corrective action to be implemented by the Provider 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.

If the Provider disagrees with a report's findings, the Provider 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 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 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 or other sources. The appeal results will be documented and communicated to the Provider 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 requesting any additional information required of the Provider and estimating a time of completion. If financial recovery is required after the appeal review, the Provider must submit the required repayments within sixty (60) calendar days of receiving the Recovery letter from FHC's Finance Department, unless the Provider has an approved extended repayment schedule (ERS) or installment payment plan.

FHC will take appropriate legal and administrative action in the event a Provider 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 Provider Agreement and actions to recover amounts previously paid on claims involved in the investigation. FHC will report any suspicion of potential fraud, waste or abuse to the appropriate regulatory agencies or law enforcement as required by local and federal regulation, or when appropriate.

D. Reporting fraud, waste, and abuse

Providers 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 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 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 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.

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 practitioners and 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 practitioners 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)
- 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. General guidelines for documentation

- All members' treatment records must contain a bio-psychosocial assessment, treatment plan; follow up assessments, focus of treatment, and disposition/discharge plan. Medical and psychological treatment documentation and progress notes must be current and treatment plans shall be updated as necessary, among other elements.
- Upon starting treatment, the Provider must document an initial treatment plan that describes the active target interventions with specific, measurable goals at the proposed level of care, stated in behavioral terms.

H. Treatment record review

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
- To meet the health plan or accreditation agency, such as NCQA, requirement mandating review on a periodic basis or upon request, and/or
- As part of the yearly audit schedule (which is randomly selected).

FHC scans or photocopies medical records for review during its visit to the Providers office. The office-site adequacy portion of the audit is conducted on-site. Medical record review audits entail requesting a sample of records from the Provider. Selected Provider offices will be contacted and requested to assist in these medical record collections. Following the review of the sample, FHC may request additional records and pursue a more comprehensive audit, if necessary.

FHC will manage treatment records in accordance with FHC's privacy policies and in compliance with HIPAA Privacy rules. Treatment record review is considered a quality-related health care operation activity and is permitted by the HIPAA Privacy Rule (see 45 CFR 164.501 and 506).

Records reviewed may include, but are not limited to, treatment and administrative, records. For the purposes of FHC audits, the "treatment record" includes, but is not limited to, progress notes, medication prescriptions and monitoring, documentation of counseling sessions (for example initial evaluation, chief complaint, family history, etc.), the modalities and frequency of treatment furnished, and results of clinical tests. It may also include the: clinical history; diagnosis; functional status; referrals; treatment plan; symptoms; prognosis; progress to date, and patient assistance sheets or signature logs, as well as signed consents.

Records are reviewed by licensed clinicians. Following the treatment record review, the Provider will receive a written report that details the findings. If applicable, included in the report will be an Action Plan with specific recommendations that will enable the Provider to comply with FHC's standards for treatment records.

Treatment records are reviewed utilizing an objective audit tool instrument. The instrument is continuously under study and revision. FHC reserves the right to alter it as needed. To conduct retrospective case reviews, clinical files pertaining to FHC members should be maintained for ten (10) years.

I. Treatment Record Standard Tool

The treatment record is a reciprocal description of the interactions of a patient with a health professional. It is the evidence that a medical service was offered, which will be billed to the health plan. It is a communication tool to promote continuous care of a patient.

The following is the treatment record standard tool to assure compliance with its requirement:

Identification and/or legibility

- Each page contains the patient's name and identification number.
- Each record includes the patient's address, employer or school, home and work telephone numbers, emergency contacts, marital/legal status, appropriate consent forms, including HIPAA, and guardianship information, if relevant.
- Every record has an attendance/contact sheet.
- All entries include the responsible clinician's name, professional degree, and relevant identification number, if applicable.
- All entries are dated.
- The record is legible to someone other than the writer.

Informed consents

- Informed consent for medication and the patient's understanding of the treatment plan are documented. Consents address:
  - Diagnosis and clinical description of the medical condition
  - Recommended treatment
  - Risks and consequences of accepting or refusing treatment
  - Other treatments, although less indicated, are available
  - Benefits, risks and consequences of treatment alternatives
  - Corresponding prognostic
  - Possibility of side effects and irreversible damage as a result of treatment or use of particular recommended drugs (prescribers)

Histories documentation

- A family history is documented in the treatment record.
- A psychiatric history is documented in the treatment record.
- Relevant medical conditions are listed, prominently identified, and revised.
- Presenting problems and identified strengths along with relevant psychological and social conditions affecting the patient's medical and psychiatric status are documented.
- Past and current medication are documented in the record.

- Allergies and adverse reactions are clearly documented as present or absent. A lack of known allergies and sensitivities to pharmaceuticals and other substances is prominently noted.
- For patients 12 and older, documentation includes past and present use of cigarettes and alcohol, as well as illicit, prescribed, and over-the-counter drugs.
- Treatment record evidence collection of culturally relevant information, such as religion, age gender, sexual orientation, literacy, socioeconomic status, etc.

Mental status evaluation

- A mental status evaluation documents the patient's affect, speech, mood, thought content, judgment, insight, attention/concentration, memory, and impulse control.

Safety

- Record reflects that patients who become homicidal, suicidal, unable to conduct activities of daily living are promptly referred to the appropriate level of care.
- Situations when member, third parties or property are at-risk, such as imminent menace of harm or suicidal ideation, or elopement potential are prominently noted, documented, and revised in compliance with written protocol.

DSM-V / ICD-10 diagnosis

- An ICD-10 or DSM V diagnosis consistent with the presenting problems, history, mental status examination and/or other assessment data is documented in narrative in the initial evaluation and each progress note.

Prescribed Medications

- As applicable, each record indicates what medications have been prescribed, the dosages of each and the dates of initial prescription or refills.

Treatment Plan

- Treatment plans are updated as necessary and consistent with diagnoses and have both objective, measurable goals and estimated timelines for goal attainment or problem resolution, and the focus of treatment interventions is consistent with the treatment plan goals and objectives.
- Treatment plan should include a mechanism for measuring objectively treatment plan progress and/or goal attainments. For example, using a validated instrument, such as assessment tool, questionnaire, survey and/or checklist. FHC does not prescribe any mechanism. This must be determined by the provider based on circumstances and the provider clinical judgement.
- The focus of treatment interventions is consistent with the treatment plan goals and objectives.

Progress notes

- Progress notes include a detailed chief complaint evidencing symptoms, complaints, changes in behavior, and/or other clinical circumstances.
- Progress notes include documentation on the assessment/impression performed by the practitioner including problem, diagnosis (in narrative) and the clinical reasoning.
- Describe the patient's strengths and limitations in achieving treatment plan goals and objectives and reflect treatment interventions that are consistent with those goals and objectives.

- Reflect an ongoing assessment of patient safety issues (e.g., dangerous to self or others) and how these have been addressed.
- The treatment record documents preventive and recovery-focused services as appropriate, such as relapse prevention, stress management, wellness programs, lifestyle changes and referrals to community resources.
- The treatment record reflects continuity and coordination of care between the primary clinician, consultants, ancillary Providers, and health care institutions.
- The treatment record documents dates of follow-up appointments or, as appropriate, discharge plans.

Departures from treatment plan

The rationale for any departure from the plan or extension of therapy is documented in the medical record. The practitioner documents patient/therapist interaction in addition to an assessment of the patient's problem(s).

J. Behavioral Health Screening Programs descriptions

FHC of Puerto Rico (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 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 one 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 obtained appropriate practitioner and 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 program design.

FHC will review available scientific evidence and update these programs every two years or more often when applicable. This revision is performed by members of FHC's Clinical Advisory Committee (CAC) and representatives of network practitioners and providers.

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

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

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), the coexistence of both a mental health and a substance use disorder is referred to as co-occurring disorders. SAMHSA reports that for the 2021 in the Unite States (US), approximately 19.4 million adults have co-occurring disorders, and only 6.6% of these individuals receive treatment for both conditions (SUD treatment at specialty facility and Mental health treatment). These percentages in 2021 are higher than in previous years. For Hispanics, similar needs were identified, for which approximately 15% adults have a SUD needing treatment, but only 1% of the individuals receive any substance use treatment.[i]

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 (e.g., 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 diagnose of Bipolar Disorder or SUD. Patients are eligible for screening if they present an already existing bipolar disorder or SUD diagnosis, or during the course of treatment, upon diagnosis of the condition and when they are first diagnosed. Patients will be screened within the next three (3) sessions after notification is received. Follow up screens must not span longer than a year after last screening.

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 allows 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 practitioner must administer the Audit- C. The minimum score (for nondrinkers) is 0 and the maximum possible score is 12. Consider a screen positive for unhealthy alcohol use if AUDIT-C score is ≥ 5 [III]. For substance use disorder screening, ask for lifetime use of cannabis, solvents, tranquilizers, barbiturates, cocaine, stimulants, or narcotics (do not include alcohol or tobacco). If patient has used any of the drugs mentioned in the established frequency, clinician must administer the Drug Screening Questionnaire (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.

Screening for a Depressive Disorder in patients with SUD

FHC requires practitioners to screen for Major Depressive Disorder using the PHQ-9 since it is the most prevalent diagnosis seen in the population served by FHC. Major depression is diagnosed if 5 or more of the 9 depressive symptom criteria have been present at least "more than half the days" in the past 2 weeks, and 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 2 weeks, and 1 of the symptoms is depressed mood or anhedonia. One of the 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 practitioner 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 0 to 27, since each of the 9 items can be scored from 0 (not at all) to 3 (nearly every day) [IX].

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

Second Generation Antipsychotics 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.

Taking into account 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 refer laboratory orders and physical examination to assess all the factors for the diagnosis of the syndrome, or confirm assessments performed by primary care physicians. 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. Psychiatrists are required to refer those patients who are on an active prescription of SGAs, notwithstanding a specific psychiatric diagnosis, to perform the Metabolic Panel Laboratory Tests. An active prescription refers to a prescription that the patient is currently using, and that is documented by the psychiatrist in the patient's medical record. Psychologists and Social Workers who have patients on SGAs are required to educate patients and refer them to their psychiatrists or primary care physicians for further action. 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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K. 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 and manage 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.

L. 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 practitioners and 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 practitioners 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 organization 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 practitioners and Providers need to provide care.
- Responsibility to follow plans and instructions for care that they have agreed to with their practitioners.
- 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.

M. 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's 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 believes 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 they practice. 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/their duty-to-warn obligations.

N. 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, practitioners, 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 or practitioners 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.

O. 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: 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 and practitioners 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
- Face-to-face evaluations by contracted Providers
- Psychiatric Hospitals
- Partial Hospitalization facilities
- Home Health Services
- 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	For concurrent inpatient review, within 72 hours of receipt request. 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/she/they 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 practitioners: 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 practitioners can also contact FHC by telephone to complete the referral process, through the toll-free line for Medicare Advantage: **1- 800-760-5691**.
c. Member or caregiver referral: Members are informed of their ability to self-refer to the Case Management Program or caregivers may refer their family member through the website using the following form: **Referral Form.** Additionally, they 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/their 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 discharged 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/their 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/practitioners 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, use of multiple central nervous system, concurrent use of opioids and benzodiazepines, inappropriate diagnosis based on treatment, and uses of potentially inappropriate medications as high-risk medications (HRM) to the elderly population. In addition, the Pharmacy Management Program's efforts include medication adherence strategies to encourage patients take medications as prescribed by their providers.

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 Provider 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.

FHC must not disrupt or require preauthorization for an active course of treatment for new plan enrollees and enrollees new to Medicare for a period of at least 90 days. For new members who are undergoing an active course of treatment; (i) approval of a prior authorization request for a course of treatment must be valid for as long as medically necessary to avoid disruptions in care, in accordance with applicable coverage criteria, the individual patient's medical history, and the treating provider's recommendation; and (ii) there will be a minimum ninety (90) days transition period for any active course(s) of treatment when the member has enrolled in an MA plan after starting a course of treatment.

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 10: 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 Provider Agreement (along with this Provider 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 forty-five (45) 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 Provider 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. ACH Payment

The Automated Clearing House (ACH) is an electronic fund transfer made between one bank account to another using the customer's routing and bank account information. It facilitates operational efficiency, cost reduction and effectiveness in payment processing.

Other benefits and advantages of receiving payment through ACH are:

- Speed and accessibility
- Privacy and security
- Beneficial to the environment and your practice

To begin receiving your payments by ACH you must complete the authorization form Formulario Depósito Directo and send it to:

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

F. 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 as long as 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.

G. 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 provides 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.

H. Participating Provider coverage during absences

A participating Provider must contact FHC to discuss alternative Provider coverage arrangements in any situation when he/she/they is unable to treat FHC beneficiaries in active treatment. Notification to FHC is required regardless of the reasons for utilizing an alternative Provider (i.e., coverage while on vacation).

Any Provider leaving another Provider to cover their services while they are away from their office, should use the Q5 modifier code when billing. To use the Q5 modifier the following requirements must be met:

- The Provider is unavailable to provide the services;
- The FHC member seeks to receive services from the Provider; and
- The substitute Provider does not offer the services to the FHC members over a continuous period longer than 60 days.
- The substitute Provider must also be a FHC participating Provider.

Substitute billing services should be billed as follows:

- Modifier Q5 must be entered on the CMS-1500 form after the procedure code.
- A record of each service provided by the substitute Provider must be kept on file by the regular Provider and associated with the substitute Provider's NPI when required.
- The Provider by whom the substitution services are furnished must be identified by his/hers/their NPI when required in block 24J of the appropriate line item on the CMS 1500 form.

I. 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 in Section9: Utilization Management Program of 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

FULL

ACCREDITED
Case Management
07/01/2026

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DESIGNATION
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