ACHP
By Sendero

Provider Manual

Service Area: Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis & Williamson Counties

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1.0 – Introduction

1.1 Background of ACHP

Access to Care Health Plan (ACHP) is a local non-profit corporation based in Austin, Texas and licensed as a community-based Health Maintenance Organization (HMO) that serves Central Texas. ACHP is sponsored by the Travis County Healthcare District, doing business as Central Health, which is providing organizational and financial resources to enable ACHP to become a major player in improving health care access for people in Central Texas. State-based health insurance exchanges, or Marketplaces, are a key component of the ACA and enable consumers to compare a selection of qualified health insurance options in order to find the plan that best meets their needs and budget. ACHP leases the network from Sendero Health Plans and began providing services to the Marketplace population in Travis and surrounding counties of Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, and Williamson.

Mission Statement
ACHP is committed to providing comprehensive healthcare coverage and to arrange for innovative, high quality and cost-effective medical services for health plan Members within Central Texas.

Provider Network
ACHP has developed collaborative relationships with physicians, hospitals and other healthcare providers to improve access, efficiency and quality of care for our Members. We are committed to understanding local provider's requirements. As a non-profit corporation, ACHP will reinvest any surplus earnings to strengthen local healthcare infrastructure and improve healthcare for people living in Central Texas. We are based in Austin with a local management team to serve Members and providers. We work collaboratively with physicians and other providers to facilitate access and continuity of care.

Products
Under a contract with the Centers for Medicare and Medicaid Services (CMS), ACHP is contracted to provide services for the Texas federal health insurance exchange, or Marketplace, in the eight county Travis Service Delivery Area under the plan name ACHP Health Plan.

1.2 ACHP's Philosophy of Business

ACHP has established a working collaboration with its provider network; one that strives to improve access to care, efficiency in care and continued quality of care for our Members. We endeavor to make this approach gain ACHP the respect and cooperation of the provider community throughout the Travis Service Delivery Area (SDA). ACHP encourages providers to be very involved, through the Medical Directors and the Medical Management Department, in review of clinical guidelines and in creating programs to benefit the Service Delivery Area. These strong and mutually beneficial relationships ensure excellence in the delivery of health care services to ACHP Members and the community at large.

1.3 ACHP's Program Objectives

The program objectives of ACHP focus on:

- Comprehensive well-child care, including childhood immunization
- Case management opportunities to coordinate care
- Cancer and diabetes care management programs to collaboratively improve control of these chronic conditions with affected ACHP Members
- Early and continuous prenatal care for pregnant ACHP Members geared to improve birth outcomes
- Effective behavioral health and substance use disorder care management

1.4 Role of Primary Care Provider

The primary care provider is the cornerstone for ACHP. The primary care provider is responsible for the provision of all primary care services for the ACHP Member. In addition, the primary care provider is responsible for facilitating referrals and authorization for specialty services to ACHP network providers, as needed. For more information on the responsibilities of the primary care provider, see "*3.0 Guidelines for Providers*" in this manual.

1.5 Role of the Specialty Care Provider

The Specialty Care provider collaborates with the primary care provider to deliver specialty care to ACHP Members. A key component of the Specialist's responsibility is to maintain ongoing communication with the Member's primary care provider. Specialty providers are responsible to ensure necessary referrals/authorizations have been obtained prior to provision of services. For more information on the responsibilities of the Specialty Care provider, see "*3.0 Guidelines for Providers"* in this manual.

1.6 Role of the Pharmacy

The role of the pharmacy benefits manager for ACHP, is to provide a robust network of sites and pharmacies to ensure medication access. ACHP's pharmacy benefits manager is fully compliant with NCPDP E.1 electronic eligibility verification.

1.7 Network Limitations (e.g. Primary Care Providers, Specialists, OB/GYN)

Members are limited to the use of providers that are contracted with ACHP. Exceptions can be made temporarily when continuity of care would be disrupted if the ACHP Member did not continue with an out-of-network provider. All out-of-network referrals must be approved by the Medical Management department. For more information on referrals to out-of-network providers, see "*3.0 Guidelines for Providers"*.

ACHP Members who are involved in an "active course of treatment" have the option of completing that course of treatment with their current provider regardless of whether the current provider is contracted with ACHP or terminates their contract with ACHP during the treatment phase. This option applies to Members who:

- Have pre-existing conditions
- Are 24 weeks or further along in their pregnancy
- Are receiving care for an acute medical condition
- Are receiving care for an acute episode of a chronic condition
- Are receiving care for a life threatening illness, or
- Are receiving care for a disability

Members who fall into these categories will work with a ACHP Case Manager to transition services when it is appropriate to do so over a reasonable period of time as determined by the individual member's situation. To contact a Nurse Case Manager call Medical Management at 1-855-297-9191.

2.0 – Guidelines for Providers

2.1 The Role and Responsibilities of the Primary Care Provider

Each ACHP Member must select a primary care provider. The role of the primary care provider is to render the following minimum set of primary care services in his/her practice, in conjunction with providing a medical home:

1. Routine office visits
2. Care for colds, flu, rashes, fever, and other general problems
3. Urgent Care within the capabilities of the Physician's office
4. Periodic health evaluations
5. Well baby and child care
6. Vaccinations, including tetanus toxoid injections
7. Venipuncture and other specimen collection
8. Eye and ear examinations
9. Preventive care and education / access to second opinion for services
10. Hospital visits if the physician has active hospital admitting privileges and/or if there is a hospital facility available in the immediate geographic area surrounding the physician's office
11. Other covered services within the scope of the Physician provider's Medical Practice
12. Based on evaluation and assessment, coordinate referrals to in network specialty care
13. Behavioral health screening and help to access to care if Member requests
14. May provide behavioral health related services within the scope of his/her practice

The physician provider must deliver the services listed above to ACHP Members, unless specifically waived by the Health Plan. In addition to the above services, the primary care provider is required to:

- Coordinate all medically necessary care with other ACHP network providers as needed for each Member, including, but not necessarily limited to:
  - specialist physicians and ancillary providers
  - outpatient surgery
  - dental care
  - hospital admission
  - other medical services
- Follow ACHP procedures with regard to non-network provider referrals (see below) and applicable aspects of the ACHP medical management program outlined in "*6.0 Medical Management*" in this manual
- Be available to ACHP Members for urgent or emergency situations, either directly or through an on-call physician arrangement, on a 24 hours a day/7 days a week basis

- Have admitting privileges at an in-network hospital and/or coordinate inpatient care and services through admitting arrangements with hospitalists, laborists, neonatologists and other hospital based providers
- Maintain a confidential medical record for each patient
- Educate Members concerning their health conditions and their needs for specific medical care regimens or specialist referral and give information regarding advance directive as required
- Help ACHP in identifying and referring Members who would benefit from ACHP's care management program or who are pregnant and would benefit from ACHP's case management programs. Referrals can be called in to Medical Management at 1-855-297-9191.
- Cooperate with ACHP 's case management team by providing clinical information and collaborating with ACHP on case management efforts (such as education and provider follow up) to help members at risk for exacerbation, for compliance barriers or for unplanned hospitalizations when Members are determined appropriate for case management services.
- Maintain an open panel and accept new Members unless prior arrangements have been made with ACHP
- Inform member of their right to obtain medication from any Network pharmacy

Other Primary Care Provider Responsibilities

The primary care provider is responsible for collection of co-payments at the time of service for ACHP Members. ACHP Members are to be responsible for office co-payments and non-covered services (as applicable) at the time of service. According to the level of benefits, the amount of a Member's co-payment will vary. The Member's Identification Card will list the co-payments to be collected at the time of service. In no event shall the Member be billed for the difference between billed charges and fees paid by ACHP.

The primary care provider is responsible for verifying Member eligibility at the time of the office visit. This includes verification that the Member is seeing the primary care provider designated on their ACHP Member ID card.

ACHP requests that Members notify us in writing if they move, change their address or phone number – even if these are temporary situations. If a Member leaves the Travis Service Delivery Area, they may no longer be eligible. The Travis Service Delivery Area includes the counties of Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis, and Williamson.

ACHP does not impose any pre-existing condition limitations or exclusions, nor is there a requirement for Evidence of Insurability to join the Health Plan.

If the primary care provider employs, supervises, collaborates with or directs physician assistants, advanced practice nurses, or other individuals who provide health care services to Members, the primary care provider must have written policies in place that are implemented, enforced, and describe the duties of all such individuals in accordance with statutory requirements for licensure, delegation, collaboration, and supervision as appropriate.

Interpreter/Translation Services

If you have a Member who needs help with special language services including interpreters, please call Customer Service at 1-844-800-4693 and provide the customer service representative with the following:

- Language needed

- Member ACHP ID number
- Physician's first and last name

If you need an interpreter in the office when the Member sees you, please call, or have the Member call Customer Service at least 48 hours before his/her appointment to schedule these services.

You can also contact Relay Texas for telephone interpreter service for deaf or hard of hearing ACHP Members by dialing 711 and requesting to communicate with the Member. This service is available for Texans 24 hours a day, 365 days a year. There are no restrictions imposed on Relay Texas calls. TTY services are also available for ACHP members at 1-800-855-2880.

2.2 Who Can Be a Primary Care Provider?

The following ACHP network provider types are eligible to serve as a primary care provider for ACHP Members:

- Pediatrician
- Family or General Practitioner
- Internist
- Rural Health Clinic (RHC)
- Federally Qualified Health Center (FQHC)
- Pediatric and Family Nurse Practitioners (PNP and FNP)
- Physician Assistants (PA) (under the supervision of a licensed practitioner)
- Specialists, as approved by ACHP, willing to provide a medical home for specific Members with certain special health care needs or illnesses (see below)

2.3 OB/GYN Physician

ACHP Members are allowed to self-refer to a network OB/GYN for any of the well-woman services stated below. This information is clearly communicated to the Members in the Member Handbook. No referral is required.

> *ACHP allows you to pick an OB/GYN without a referral, but this doctor must be from within the ACHP network of providers.*
>
> *ATTENTION FEMALE MEMBERS: You have the right to pick an OB/GYN without a referral from your Primary Care Provider. An OB/GYN can give you:*

- *One well-woman check-up each year*
- *Care related to pregnancy*
- *Care for any female medical condition*
- *Referral to specialist doctor within the ACHP network*

OB/GYN Responsibilities

Once the obstetrical services provider diagnoses a Member's pregnancy, the provider must notify ACHP within 3 days of making the diagnosis by using one of the following methods:

- completing the ACHP Pregnancy Notification Form
- completing a similar form containing the required information
- Notifying Medical Management Case Management with the required information by calling 1-855-297-9191 or faxing ACHP at 512-901-9724.

Providers are not required to use the ACHP Pregnancy Notification form itself, but may provide the same information via some other form, such as the American College of Obstetricians and Gynecologists (ACOG) or Hollister high risk forms or other similar forms. If a health condition develops or is discovered during the self-referral episode of care that is likely to have an ongoing effect on the Member's health and/or the Member's relationship with or care from her primary care provider, the OB/GYN provider should provide a written report to the Member's primary care provider unless the Member specifically requests that no such report be made.

ACHP will make every effort not to disrupt an existing relationship for pregnant women who have already established a relationship with an OB/GYN provider at the time of their enrollment with the Health Plan. If a member requests to change OB/GYN providers, she will be allowed to choose from any of ACHP's in-network provider panel.

ACHP's Case Managers are available to provide services to high risk pregnant women, and to be a resource for educational needs. If notified timely, the Case Managers can more effectively assist pregnant Members who have high risk pregnancies, these women frequently have premature births or newborns with complications.

Contact Case Management at **1-855-297-9191** if a high risk pregnant Member is identified.

2.4 Other Specialists as Primary Care Provider

ACHP allows Members with chronic, disabling, or life-threatening illnesses to select a Specialist as their Primary Care Provider following a review and authorization by ACHP's Medical Director. The request to utilize a Specialist in the capacity of a PCP must contain the following information:

- Certification by the Specialist of the medical need for the Member to utilize the Specialist as a PCP
- A Statement signed by the Specialist that he/she is willing to accept responsibility for the coordination of all of the Member's health care needs, and
- Signature of the Member on the completed Specialist as a PCP Request form

To be eligible to serve as a PCP, the Specialist must meet ACHP's Network requirements for PCP participation. A decision will be given to the requesting Specialist physician and Member in writing, within thirty (30) days of original request. If approved, the Specialist physician may serve as a primary care provider for specific Members and must be willing to provide all the services outlined above in ***The Role and Responsibilities of the Primary Care Provider*** paragraphs of this section, and if they meet the criteria stated below. Network Management will work with the specialty PCP to re-define their service agreement to reflect their new role as a PCP and will provide the specialist serving as a PCP with a copy of the current directory of participating specialist physicians and providers. If denied for any reason other than Provider's failure meet eligibility to serve as a PCP or to accept "The Role and Responsibilities of the Primary Care Provider", the Member may appeal the decision following the appeal process defined in Appendix C of this manual.

The Specialist that has been chosen as a primary care provider by the Member must meet and agree to the following criteria:

1. The Specialist must be board certified or board eligible in their specialty and licensed to practice medicine or osteopathy in the State of Texas.

2. The Specialist must have admitting privileges at a network hospital.

3. The Specialist must agree to be the primary care provider for the Member. He/she will be contacted and informed of the Member's selection. The Specialist must then sign the Specialist as a PCP Referral form (available by calling Network Management) for the Member that has made the request.

4. The Specialist must agree to abide by all the requirements and regulations that govern a primary care provider, including but not limited to:

    a. being available 24 hours a day, 7 days a week,
    b. administering immunizations as required, and
    c. acting as the medical home and coordinating care for this Member

The effective date of the Specialist functioning as the Member's primary care provider will be the first of the month following the date the Specialist as a PCP Referral form is signed by the Medical Director. The effective date of the designation of the specialist as the member's PCP may not be applied retroactively. ACHP will not reduce the amount of compensation owed to the original primary care physician for services provided before the date of the new designation.

2.5 Primary Care Provider Panel of Members

Open Panel of Members

ACHP asks that all primary care providers maintain an open panel and accept new Members that may select the primary care provider for medical care. ACHP understands that, a primary care provider's panel may become full and necessitate the primary care provider to close his or her panel.

Closing Primary Care Provider Panel of Members
Primary care providers must notify ACHP's Network Management representative in writing if the primary care provider's panel needs to be closed. The primary care provider's written notice should include an explanation of why his/her panel needs to be closed. ACHP requests that primary care providers provide at least 30 days' notice of the closure of their panel. Once the panel is closed, ACHP will not allow the primary care provider to selectively accept new Members unless the Member or siblings of the Member were existing Members of the primary care provider.

2.6 Primary Care Provider Panel Changes

Primary Care Provider Changes
ACHP Members have a right to change primary care providers. ACHP closely monitors primary care provider changes because such changes may disrupt the continuity of care and/or may indicate Member dissatisfaction with aspects of their care. ACHP will make every attempt to address a Member's concerns prior to their making a primary care provider change and may even contact the primary care provider for help in resolving the Member's issue if dissatisfaction with the current primary care provider is the cause for the Member requesting a primary care provider change.

If a Member requests to change primary care providers, the change will be effective on the date the change is requested. The change of primary care provider can be made by the Member or the Member's parent/guardian by calling the ACHP Customer Service line at 1-844-800-4693.

ACHP reserves the right to reassign a Member's primary care provider or close a provider's panel if, in ACHP's sole determination, it is in the best interest of the Member.

Primary Care Provider-requested Removal of a Member from Panel
Primary care providers may request the removal of a Member from their panel in select situations. ACHP will work to resolve problems between the Member and the primary care provider before making the change. The following may be reasons for a primary care provider to request that a Member be removed from his/her panel:

- Member is consistently non-compliant with the primary care provider's medical advice
- Member is consistently disruptive in the office
- Member consistently misses scheduled appointments without cause and/or without notice to the office

2.7 Primary Care Provider & Specialist Accessibility and Appointment Standards

Accessibility Standards
Primary care providers and Specialists serving as a primary care provider for certain Members must be available to Members 24 hours a day, 7 days a week. Your office is expected to answer phone calls during your routine office hours with after-hours telephone availability or arrangements as follows:

- Access to covering physician, or
- Answering service, or
- Triage service, or
- A voice message in English and Spanish that provides a second phone number that is answered or returned within 30 minutes of the Member leaving a message.

Appointment Standards

Primary care providers, Specialists serving as a primary care provider for certain Members, and Specialists must make appointments available to Members as follows:

Event	Requirement
Emergency Services	Emergency Services must be provided upon Member presentation at the service delivery site, including at non-network and out-of-area facilities;
Behavioral Health – non-life threatening emergency care	Behavioral Health non-life threatening emergency care must be provided within 6 hours of request or redirected to the Emergency Room
Urgent Care, including Urgent Specialty Care	Urgent care, including urgent specialty care must be provided within 24 hours of request;
Urgent Care – Behavioral Health	Behavioral Health Urgent care must be provided within 48 hours of request;
Routine Primary Care	Routine primary care must be provided within 15 calendar days of request;
Specialty Care (Non-Urgent)	Specialty Care (Non-Urgent) must be provided within 30 calendar days of request;
Outpatient Behavioral Health Visits – Prescriber and Non-prescriber Follow-up Routine Care	Behavioral Health routine care must be provided within 30 calendar days of request;
Initial Primary Care Visit	Initial Primary Care Visit must be provided within with 90 calendar days of request;
Initial Outpatient Behavioral Health Visits – Routine Care	Initial outpatient behavioral health visits for routine care must be provided within 10 business days of request;
Outpatient Behavioral Health Treatment following a Behavioral Health Inpatient Admission	Behavioral Health outpatient treatment must occur within 7 calendar days from the date of discharge following an inpatient Behavioral Health stay.
Initial Prenatal Visits	Prenatal care must be provided within 14 days of request, except for high-risk pregnancies or new Members in the third trimester, for whom an appointment must be offered within five days or immediately, if an emergency exists, or within 24 hours if an urgent condition exists;
Preventive Health Services	Preventive Health visits must be provided within 60 calendar days of request;

Event	Requirement
Member Access to Primary Care Provider	Members are able to reach their primary care provider twenty-four (24) hours a day, seven (7) days a week, either by answering service or by coverage of another physician. Primary care provider (or covering physician) should call the Member within 30 minutes of the Member contacting the answering service.
A Member's Travel Requirements to Reach a Primary Care Provider or General Hospital	A Member is not required to travel in excess of thirty (30) miles to reach a primary care provider or general hospital.
A Member's Travel Requirements To Secure An Initial Contact With A Referral Specialist, Specialty Hospital, Psychiatric Hospital, Or Diagnostic And Therapeutic Services	A Member is not required to travel in excess of seventy-five (75) miles to secure an initial contact with a referral specialist, specialty hospital, psychiatric hospital, or diagnostic and therapeutic services (if one is available).
Wait Times	Members should not wait longer than 45 minutes in the office waiting room prior to being taken to the examination room. Members should not wait more than 15 minutes to be seen by a provider after being taken to an examination room.

2.8 Primary Care Provider Referrals to Other Providers

Primary Care Provider Referrals to Network Providers

The Texas Standard Preauthorization Request Form for Health Care Services should be filled out and given to the Member when referring the Member to specialists or other ancillary providers for medically necessary services within the ACHP Plans' network. You should explain to the member that the specialist may not see the member without this form. The member needs to give this form to the specialist so that the specialist knows that the member is being referred by you, why the member is being referred, what the expectations are for the visit, and how many visits are being allowed. Script pad referrals are acceptable, if accepted by the specialist. Primary Care Providers are responsible for assuring that appropriate communication and coordination of care occur with all specialty referrals.

Primary Care Provider Referrals to Non-network Providers

In rare situations, the primary care provider may believe that the most medically appropriate referral for a specific Member with a unique medical condition is to a non-network provider. Referral to non-network providers must be referred to the Medical Management department for review and preauthorization. Medical Management must

be given a written justification stating member specific reasons for out-of-network care. For preauthorization of a non-network referral, the primary care provider must contact the Medical Management Department by calling 1-855-297-9191, faxing a request to 512-901-9724, or complete an online Preauthorization request using the ACHP provider portal at https://providers.accesstocarehealth.com/. Once the request for out-of-network care is received, it will be reviewed by a ACHP Medical Director and sent to Network Management.

2.9 Members Right to Self-Referral

ACHP Members have the right to make a self-referral for certain services. Unless otherwise specified, self-referral is permitted for ACHP Members. Members may self-refer for:

In-network-only Self-referral for Covered Services

- Behavioral health services
- Obstetric services
- Well-woman gynecological services
- Vision care, including covered eye glasses

2.10 Responsibilities of Specialists

Specialists' Responsibilities
Except as outlined above in the ***Members Right to Self-Referral*** paragraphs of this section, specialists should provide only the services outlined in a valid referral from the Member's primary care provider or other authorized provider. Non-network specialists must have received preauthorization from the Medical Management department of ACHP.

When rendering services pursuant to a valid referral, the specialist is responsible to:

- provide the services requested in the referral
- educate the Member with regard to findings and/or next steps in treatment
- coordinate further services with the Primary Care Physician or provider and provide such services as authorized
- provide a written report of findings and recommendations to the Primary Care Physician or provider within 7 working days of the referral evaluation
- submit a claim for services to ACHP within 95 days of the date of service

If the Specialist provider employs, supervises, collaborates with or directs physician assistants, advanced practice nurses, or other individuals who provide health care services to Members, the Specialist provider must have

written policies in place that are implemented, enforced, and describe the duties of all such individuals in accordance with statutory requirements for licensure, delegation, collaboration, and supervision as appropriate.

Before seeing any ACHP Member, the Specialist provider is obligated to:

- Confirm that the Member is an eligible Member and has a valid referral form from the primary care provider.
- Adhere to the ACHP accessibility standards for obtaining appointments.
- Collect the applicable co-payment for office visit from the ACHP Member.
- Send a report to the Member's Primary Care Provider within seven (7) working days after the date of the member's evaluation or service.
- Consult with the Member's Primary Care Provider concerning any additional specialty care or service needed by the Member that is not included with the referral. This can be done during or after the Member's visit to the Specialist, but must be done prior to providing any additional specialty care or service that is not included on the Referral Form.

If the Member needs mental health or substance use disorder services, the Specialist may refer to an in-network provider for the mental health benefits. Preauthorization may be required prior to seeing this Behavioral Health provider. Call ACHP's Medical Management line at 1-855-297-9191 for authorization requests or ACHP's Customer Service line at 1-844-800-4693 for questions regarding mental health benefits for ACHP Members.

Specialist providers must also comply with the ACHP policies and procedures included in this Manual.

Hospital Responsibilities
There is a list of planned hospital admissions that require preauthorization. Admissions will be coordinated by the Member's primary care provider or a network specialty provider involved in the Member's care.

Hospital admission for Emergent services should be communicated to ACHP within 24 hours of the admission by calling or faxing the Medical Management Department at the numbers listed below. The Medical Management Department may request specific clinical information for discharge planning activities and/or for review.

Ancillary Provider Responsibilities
Ancillary providers such as home health agencies, rehabilitative services providers, durable medical equipment providers, and similar providers may only supply services as authorized by ACHP. It is the responsibility of the referring physician to provide any required physician orders to the ancillary provider.

2.11 Pharmacy Provider Responsibilities

Pharmacy providers provide services to members according to these responsibilities:

- Adhere to the Formulary
- Coordinate with the prescribing physician

- Ensure Members receive all medications for which they are eligible
- Coordination of benefits when a Member also receives Medicare Part D services or other insurance benefits

2.12 Credentialing and Responsibilities of Mid-Level Practitioner

Mid-level practitioners include nurse practitioners and physician assistants and are credentialed by ACHP and consistent with NCQA criteria. Mid-levels must follow all regulations required by the State of Texas regarding collaborating physician oversight.

Mid-level practitioners may be primary care providers if they meet all the requirements as directed by their Texas licensing board to be an independent practitioner. Questions regarding the practitioner services may be directed to the Network Management number below.

2.13 Medical Records

Maintenance of Records
All ACHP providers are required to maintain a written or electronic medical record that complies with the standards of the health care industry and with the requirements of applicable federal, state and local laws, rules and regulations. Records must be:

- Individual to each patient
- A complete and accurate representation of all medical services, counseling and patient education provided by the provider including ancillary services
- Maintained in an orderly and legible fashion
- Kept secured to ensure the maintenance of confidentiality and be accessible only to practice employees and eligible persons as permitted by law
- Maintained pursuant to procedures of confidentiality that comply with the Health Insurance Portability and Accountability Act (HIPAA)
- Made available to the patient according to the written policies and procedures
- Made available to appropriate parties allowed to view such records pursuant to HIPAA and other relative federal, state and local laws, rules and regulations

Electronic Medical Records
Providers who use electronic medical records within their office must have a system that conforms to all the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) provisions of the American Recovery and Reinvestment Act (collectively referred to as "HIPAA Requirements") and other federal and state laws.

Forms Required by ACHP
ACHP does not require any health-plan-specific forms to be maintained in a provider's medical records. The forms used by each provider are determined solely by the provider, but must be sufficient to document all treatment, counseling and education services to Members in an orderly, efficient and complete manner.

ACHP Requests for Medical Records
ACHP may from time to time request copies of medical records related to the treatment of ACHP Members. Such requests for records will generally be for the purposes of (1) responding to legislative or regulatory inquiries or purposes, (2) responding to complaints or appeals filed by Members or providers, or (3) quality improvement and/or utilization management functions. All providers are required to make available copies of applicable records at no cost to ACHP if the request comes from:

- Federal or state entities of competent jurisdiction.
- ACHP as a direct result of a request for records from federal or state entities of competent jurisdiction.
- ACHP pursuant to the health plan's utilization management preauthorizations requested by the provider.
- ACHP in relation to a quality review.
- ACHP or the State as a direct result of a Fraud, Waste, and Abuse investigation.

Confidentiality
All providers must maintain written policies and procedures with regard to maintaining the confidentiality of medical records in a manner consistent with federal, state and local laws, rules and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) provisions of the American Recovery and Reinvestment Act.

ACHP will maintain complete confidentiality with regard to medical records that may be requested from providers. ACHP's policies and procedures for confidentiality shall at all times be compliant with federal, state and local laws, rules and regulations, including HIPAA and HITECH.

2.14 Changes in Provider Addresses or Contact Information or Opening of New Office Locations

All network providers are required to notify ACHP in writing of any changes in office address or in relevant contact information. Changes in office address should be received by ACHP at least thirty (30) days prior to the change. This includes notifying ACHP when a provider is leaving a group practice or joining another group practice or an employed provider is leaving a group practice.

In addition, all network providers must notify ACHP upon opening of new offices where ACHP's Members may be treated OR upon engaging new physician or mid-level practitioners who may be involved in the treatment of ACHP's Members. New office locations are subject to site review before they are eligible to receive reimbursement. New providers or mid-level practitioners joining an existing group practice may have expedited credentialing and will be reimbursed at the rates of the contracted group.

The ACHP Provider Information Form (PIF) can be located on the ACHP website and used for notification of changes to practice location or panel.

2.15 Cultural Sensitivity

ACHP places great emphasis on the wellness of its Members and recognizes that a large part of health care delivery is treating the whole person and not just a medical condition. Sensitivity to differing cultural influences, beliefs and backgrounds can improve a provider's relationship with Members and in the health and wellness of the patients themselves. ACHP encourages all providers to be sensitive to varying cultures in the community. Following is a list of principles for ACHP's network providers demonstrating the knowledge, skills and attitudes related to cultural sensitivity in the delivery of health care services to ACHP members:

KNOWLEDGE of cultural sensitivity:

- Provider's self-understanding of race, ethnicity and influence.
- Understanding historical factors impacting the health of minority populations
- Understanding the particular psycho-social stressors relevant to minority patients.
- Understanding the cultural differences within minority groups.
- Understanding the minority patient status within a family life cycle and inter-generational conceptual framework in addition to a personal developmental network.
- Understanding the differences between "culturally acceptable" behaviors of psycho-pathological characteristics of different minority groups.
- Understanding indigenous healing practices and the role of religion in the treatment of minority patients.
- Understanding the cultural beliefs of health and help seeking patterns of minority patients.
- Understanding the health service resources for minority patients.
- Understanding the public health policies and its impact on minority patients and communities.

SKILLS for demonstrating cultural sensitivity:

- Ability to interview and assess minority patients based on a psychological, social, biological, cultural, political, and spiritual model.
- Ability to communicate effectively with the use of cross-cultural interpreters.
- Ability to diagnose minority patients with an understanding of cultural differences in pathology.
- Ability to avoid under diagnosis or over diagnosis.
- Ability to formulate treatment plans that are culturally sensitive to the patient and family's concept of health and illness.
- Ability to utilize community resources (churches, community based organizations, self-help groups, school programs)
- Ability to provide therapeutic and pharmacological interventions, with an understanding of the cultural differences in treatment expectations and biological response to medication.
- Ability to ask for consultation.

ATTITUDES demonstrating cultural sensitivity:

- Respect the "survival merits" of immigrants and refugees.
- Respect the importance of cultural forces.
- Respect the holistic view of health and illness.
- Respect the importance of spiritual beliefs.
- Respect and appreciate the skills and contributions of other professional and paraprofessional disciplines.
- Be aware of transference and counter transference issues.

2.16 Termination of Provider Participation

Provider Requested Termination

As outlined in each provider's contract, a provider retains the right to terminate his/her participation in the ACHP network for any reason. If a provider desires to terminate his/her service agreement with ACHP, a written notice to ACHP is required either ninety (90) days prior to the desired effective date of the termination or in accordance with the time frames outlined in the provider's contract with ACHP. ACHP will honor requests for termination, but may work with the provider to see if some other alternative can be identified to prevent network termination. In the event of a conflict between this rule and the provider's contract, the contract will prevail.

ACHP Requested Termination

ACHP will follow the procedures outlined in §843.306 of the Texas Insurance Code if terminating a contract with a provider. At least 30 days before the effective date of the proposed termination of the provider contract, ACHP will provide a written explanation to the provider indicating the reasons for termination. ACHP may immediately terminate a provider contract if the provider presents imminent harm to Member health, actions against a license or practice, fraud or malfeasance.

Within 60 days of the termination notice date, the provider may request a review of ACHP's proposed termination by an advisory review panel, except in a case in which there is imminent harm to Member health, an action against a private license, fraud or malfeasance. The advisory review panel will be composed of physicians and providers, as those terms are defined in §843.306 Texas Insurance Code, including at least one representative in the provider's specialty or a similar specialty, if available, appointed to serve on ACHP's Quality Improvement Committee or Credentials Committee. The decision of the advisory review panel must be considered by ACHP but is not binding on ACHP. ACHP must present to the provider, on request, a copy of the recommendation of the advisory review panel and ACHP's determination.

According to the provider's agreement with ACHP, the provider is entitled to sixty (60) days advance written notice of ACHP's intent to terminate the provider's agreement for cause. The agreement also states that it will terminate immediately and without notice under certain circumstances. If ACHP gives the provider a sixty (60) day notice of intended termination or if the provider's agreement terminates immediately without notice, and the cause for termination is based on concerns regarding competence or professional conduct as the result of formal peer review, the provider may appeal the action pursuant to this procedure. This procedure is available only if ACHP is terminating the provider's agreement for the reasons stated above.

The provider may not offer or give anything of value to an officer or employee of Federal or state entities in violation of state law. A "thing of value" means any item of tangible or intangible property that has a monetary

value of more than $50.00 and includes, but is not limited to, cash, food, lodging, entertainment and charitable contributions. The term does not include contributions to public office holders or candidates for public office that are paid and reported in accordance with state and/or federal law. ACHP may terminate this Network Provider contract at any time for violation of this requirement.

Notice of Proposed Action
ACHP will give the provider notice that their agreement has terminated or is about to terminate, and the reason(s) for the termination. The notice will either accompany the provider's sixty (60) day notice of termination, or be given at the time the provider's agreement terminates immediately without notice.

Upon termination of the provider's agreement with ACHP, the provider may request reinstatement by special notice (registered or certified mail) within thirty (30) days of receiving the notice of termination to ACHP's Medical Director. The provider should include any explanation or other information with their request for reinstatement. ACHP's Medical Director will appoint a committee to review the provider's request and any information or explanation provided within thirty (30) days of receipt. The committee will recommend an initial decision to the ACHP Board of Directors to reaffirm the provider's agreement, reaffirm with sanctions, or to revoke the provider's contract as a ACHP network provider.

Decision
Within ten (10) days of receiving the committee's recommendations, ACHP will, by special notice in registered or certified mail, inform the provider of ACHP's decision on the provider's request for reinstatement. This decision will be final.

ACHP will work with Members currently receiving care from the provider to transition to other providers within the ACHP network pursuant to the Transition of Care policy. This transition will occur based on the individual termination situation (upon completion of the Notice of Action process, the provider's appeal or immediately) depending on the reasons for termination of the contract.

2.17 Member/Provider Communications

ACHP shall not impose restrictions upon Provider's free communication with Members about Member's medical conditions, treatment options or their costs, referral policies, and other managed care policies, including financial incentives or arrangements.

3.0 – Emergency Services

3.1 Definitions: Routine, Urgent and Emergent Services

Routine
Routine care is defined as health care for covered preventive and medically necessary Health Care Services that are non-emergent or non-urgent, such as a well-child visit, a chronic condition status visit or an annual physical examination.

Urgent Care
Urgent care is defined as when a Member needs to be seen, evaluated and treated within 24 hours. An urgent need may be for illness or injury that is non-life threatening.

Emergent Care
Emergency care is defined as health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, serious dysfunction of any bodily organ or part, serious disfigurement, or in the case of a pregnant woman, serious jeopardy to the health of the fetus.

"Emergency services" and "emergency care" means health care services provided in an in-network or out-of-network hospital emergency department or other comparable facility by in-network or out-of-network physicians, providers, or facility staff to evaluate and stabilize medical conditions. Emergency services also include, but are not limited to, any medical screening examination or other evaluation required by state or federal law that is necessary to determine whether an emergency condition exists.

Some conditions that may require taking the Member to the Emergency Room include:

- Incessant infant crying
- Excessive, uncontrolled bleeding
- Epiglottitis
- High fever
- Pneumonia
- Loss of consciousness
- Kidney stones
- Referral from primary care provider to ER (regardless of diagnosis)
- Mental Health conditions where the Member is a threat to themselves or others
- Fracture
- Severe laceration
- Status asthmatic
- Urinary tract infection, pyelonephritis
- Concussion
- Loss of respiration
- Convulsions
- Poisoning
- Overdose situations
- Severe abdominal pain
- Chest pain

3.2 Prudent Layperson Standards at ACHP

ACHP standards regarding Prudent Layperson comply with the Texas Administrative Code definition for emergency services. See definition of Emergent Care above.

3.3 Out of Network Emergency Services

Out of network emergency services are covered by ACHP. Any services rendered are reimbursed at the usual and customary rate. Members who must use emergency services while out of the service area are encouraged to contact their primary care provider as soon as possible and advise them of the emergent situation.

3.4 Emergency Transportation

Emergency transportation, such as ambulance service, is covered by ACHP. Emergency transportation is defined as transportation to an acute care facility, when there is a life and death situation. Ambulance service companies are to submit claims to ACHP for reimbursement.

3.5 Emergency Services Outside the Service Area

If a Member is injured or becomes ill while temporarily outside of the service area, the Member should contact his / her primary care provider and follow his / her or the covering physician's instructions, unless the condition is life-threatening. If the condition is life-threatening, as determined by a prudent layperson, the Member may go to the nearest emergency facility. The Member should notify ACHP of the incident within 48 business hours (or the primary care provider should notify the ACHP within 24 hours or the next business day) after learning of the out-of-area emergency. An authorization number will be issued based on medical criteria, for inpatient services. Emergency room services do not require authorization. If the Member is admitted to an out-of-area hospital, the ACHP Medical Management Department, in conjunction with the primary care provider, will monitor the Member's condition with the out-of-area attending physician. ACHP will help the primary care provider in arranging for follow up care upon the member's return to the service area when medically appropriate.

4.0 – Preauthorization and Notification

ACHP's Medical Management Program includes the following:

- ACHP operating hours are 8:00 a.m. and 5:00 p.m., Central Time, Monday through Friday on each day that is not a legal holiday and between 9:00 a.m. and noon, Central Time, on Saturday, Sunday, and legal holidays.
- Prior Authorization of certain medical and behavioral health services is required. See list of categories in ACHP's Quick Reference Guide, below and online. Alternatively, refer to ACHP's online provider page

for the latest version of this tool, https://www.accesstocarehealth.com/. This tool also provides an online interactive lookup tool for providers to query if a particular code requires preauthorization or not.
- Notification of certain services may also be required. See Quick Reference Guide below.
- Concurrent Review of members in hospitals, SNF, LTAC are managed telephonically.
- Providers may call ACHP's Medical Management line at 1-855-297-9191 for an authorization, or for any questions regarding benefits for ACHP Members.

The Medical Management department maintains a toll-free fax line 24 hours daily and utilizes HIPAA encrypted secure email. All faxes and emails are responded to the next business day. That fax number is 512-901-9724.

4.1 Preauthorization Process

- Review Criteria Source: Prior Authorization requests are reviewed using decision guidelines, based on reasonable evidence. ACHP uses a mix of InterQual and internal policies to support prior authorization functions.
- Contact Information: The Utilization Management team may receive prior authorization requests via telephone, fax or HIPAA secure encrypted email from the Provider's office. The guidelines are applied and the services are authorized by the Utilization Management Registered Nurse, or referred to the Medical Director or Physician Reviewer for approval.
- Physician Review: The Physician Reviewer reviews all cases where the potential for denial is possible. In any instances where the medical necessity or appropriateness of the requested service is questioned, the Medical Director or Physician Reviewer will make every reasonable effort, following statutory and regulatory guidelines, to contact the requesting Provider in order to afford her/him the opportunity to discuss the plan of treatment and the clinical basis for the decision, prior to a final determination.
- Adverse Determination: Any Adverse Determinations will follow established policies, statute, and regulatory guidelines prior to final determination and communications of the Adverse Determination to the Member and Providers.
- Preauthorization Numbers: ACHP will provide preauthorization numbers that fully comply with the format for federal and state requirements and currently utilizes ANSI ASC X12 837 format.

4.2 Notification

Certain services, such as emergency admissions, maternity admissions, and other services listed on the ACHP Preauthorization List Guidance, "Required Notifications", only require notification to ACHP.

ACHP's Preauthorization List Guidance serves as a job aid to explain the categories of services that require prior authorization. Please refer to ACHP's online provider page for the latest version of this tool, https://www.accesstocarehealth.com to ensure you are using the most up to date version throughout the year.

4.3 Preauthorization Form

TEXAS PRIOR AUTHORIZATION REQUEST FORM

Sendero Medical Management
Phone: 1-855-297-9191
Fax: 512-901-9724

SENDERO HEALTH PLANS | ACHP

Web Authorizations may be completed at **www.senderohealth.com**

SECTION I – SUBMISSION

Issuer Name:	Phone:	Fax:	Date:

SECTION II — GENERAL INFORMATION

Review Type: ☐ Non-Urgent ☐ Urgent		Clinical Reason for Urgency:	
Request Type: ☐ Initial Request ☐ Extension/Renewal/Amendment		Prev. Auth. #:	

SECTION III — PATIENT INFORMATION

Name:	Phone:	DOB:	☐ Male ☐ Female ☐ Other ☐ Unknown
Subscriber Name (if different):	Member or Medicaid ID #:	Group #:	

SECTION IV — PROVIDER INFORMATION

Requesting Provider or Facility		**Service Provider or Facility**	
Name:		Name:	
NPI #:	Specialty:	NPI #:	Specialty:
Phone:	Fax:	Phone:	Fax:
Contact Name:	Phone:	Primary Care Provider Name (see instructions):	
Requesting Provider's Signature and Date (if required):		Phone:	Fax:

SECTION V — SERVICES REQUESTED (WITH CPT, CDT, OR HCPCS CODE) AND SUPPORTING DIAGNOSES (WITH ICD CODE)

Planned Service or Procedure	Code	Start Date	End Date	Diagnosis Description (ICD version___)	Code

☐ Inpatient ☐ Outpatient ☐ Provider Office ☐ Observation ☐ Home ☐ Day Surgery ☐ Other: _____

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Cardiac Rehab ☐ Mental Health/Substance Abuse
Number of Sessions:_____ Duration:_____ Frequency:_____ Other: _____

☐ Home Health (MD Signed Order Attached? ☐ Yes ☐ No) (Nursing Assessment Attached? ☐ Yes ☐ No)
Number of Visits:_____ Duration:_____ Frequency:_____ Other: _____

☐ DME (MD Signed Order Attached? ☐ Yes ☐ No) (Medicaid Only: Title 19 Certification Attached? ☐ Yes ☐ No)
Equipment/Supplies (include any HCPCS Codes):_____ Duration: _____

SECTION VI — CLINICAL DOCUMENTATION (SEE INSTRUCTIONS PAGE, SECTION VI)

An issuer needing more information may call the requesting provider directly at: _____

4.4 Concurrent Review

ACHP performs concurrent review and discharge planning on inpatient admissions and observations, consistent with health plan benefits. ACHP will work closely with the attending physician and hospital discharge planners to coordinate the use of home health care, home infusion therapy and other health care alternatives, which may decrease a hospital length of stay.

4.5 Out of Network Referrals

As an HMO, the benefit plans have limited out of network services, therefore, ACHP will consider out of network referrals if requested for the following reasons:

- There is no in-network specialist that may be specifically indicated to address the unique clinical need of a Member.
- There are no in-network physicians for the requested specialty who performed a prior surgery and care is now medically necessary for continuity of care.

Any denial for an out of network / out of plan referral will be managed consistent with ACHP policy and procedures on adverse determinations.
All elective out-of-network services are considered Excluded Services and are not covered by ACHP unless approved through preauthorization.

4.6 Care Management

Care Management is available for Enrollees with high-risk issues, non-compliance or multiple acute or chronic uncontrolled disease processes. ACHP's Care Management utilizes close monitoring, patient / family education, and knowledge of local community health system and resources to help meet our members where they are, by setting individually directed care goals and supporting members to achieve those goals. Care Management actively involves the interventions of other health care providers, social services and other resources as indicated. The Care or Case Manager works closely with the physician and full range of allied health professionals and community based organizations involved in the Member's care to assist the patient and family in understanding the care needs and limitations of the patient. If a Provider identifies a Member that may be a candidate for Care Management services, please notify our Clinical Care Management department at 1-855-297-9191. ACHP also provides a behavioral health hotline for its members, available 24 hours a day / 7 days a week**:**1-855-765-9696.

4.7 Complex Case Management

ACHP also provides case management services for catastrophic medical cases or for specific types of highly complex health care needs through the Complex Case Management Program. Complex Case Management activities are performed by ACHP Medical Management' RN Case Managers. The RN Case Manager works closely with the Member's primary care provider to monitor the Member's health by tracking and reviewing the Member's utilization trends (inpatient admissions, office visits, pharmacy, etc.). The RN Case Manager determines whether coordination of services will result in more appropriate and cost-effective care through treatment plan intervention and helps develop a proposed treatment plan. Members may be referred to the Complex Case Management program by calling Medical Management at 1-855-297-9191. Referrals are also accepted from entities such as community based organizations, allied health professionals, and government agencies involved in the member's care, as well as the member or family.

4.8 Quality Improvement and Population Health Programs

ACHP implements numerous quality improvement and population health programs and initiatives. These programs are aligned with ACHP's participation in HEDIS and QHP programming. In a given year, Members may be eligible for programs that incentivize evidence-based, proactive and preventive health care seeking. In a given year, Providers may also be eligible for programs that incentive a focus on evidence-based, desirable preventive health care. ACHP also encourages our In-Network Providers to consider entering into a quality contracting arrangement with ACHP. Provider practices who are interested in learning more about these programs can inquire through their Network Representative, who will facilitate a connection to the appropriate Quality Improvement and Population Health leadership.

4.9 Clinical Practice Guidelines

ACHP collates recommended clinical practice guidelines relevant to the medical and behavioral health conditions commonly experienced by our membership. Providers can access this content through the ACHP website at https://www.accesstocarehealth.com.

4.10 Discharge Planning

Discharge Planning is available to provide assistance to any Member being discharged from a facility while assuring quality and continuity of care. ACHP evaluates and assists in identifying the patient's needs for transition from the acute hospital to home or to the most appropriate setting. This support is coordinated with the patient and their family, Case Manager, PCP and attending physician working as a team to identify the needs of the Member. To facilitate discharge planning for a ACHP member currently admitted to an acute care setting, providers may call the Medical Management at 1-855-297-9191.

4.11 Management of Enrollees with Special Circumstances

Some Members may require services that fall outside of the ordinary scope of Medical Management or outside the scope of standard screening guidelines. Under these special circumstances, ACHP may identify the Member's special circumstances which include, but are not limited to, an individual who has a disability, acute condition, or life-threatening illness. In these circumstances, ACHP will gather the facts of the case and forward to the Medical Director and Care Management team lead, who will develop a plan of action to assist the Enrollee with special circumstances.

4.12 Adverse Determination

Contact Information
If you have questions and/or require clarification regarding an adverse determination and/or the appeal process, please do not hesitate to contact ACHP's' Medical Management Department at:

Medical Management:
PHONE: 1-855-297-9191
FAX: 512-901-9724

An Adverse Determination is an instance where ACHP is questioning the medical necessity or appropriateness or the experimental or investigational nature of health care services.

All ACHP authorization requests will be reviewed for medical necessity. Requests for services may be denied for the following reasons:

- Not medically indicated (Adverse Determination)
- Services are considered experimental or investigative (Adverse Determination)
- Services can be safely provided in an alternative setting or level of care (Adverse Determination)
- Services rendered were not determined to meet the definition of emergency care (Adverse Determination)

Adverse Determinations may only be issued by the Medical Director or Physician Reviewer. All requests for services that do not meet the predetermined criteria are forwarded to the Medical Director or Physician Reviewer for consideration. ACHP adheres to statutory and regulatory requirements governing offer of peer to peer discussion ahead of an adverse determination. The Medical Director or Physician Reviewer will make every reasonable effort to discuss the case with the requesting physician prior to issuing an Adverse Determination.

4.13 Administrative Denial

Administrative Denials may be issued by Utilization Management Registered Nurse which relate to cases, such as Member is not eligible, benefits are not a covered service, or provider is not in ACHP network.

4.14 Notification of Denial of Service

Provider Notification: The requesting Provider shall be notified via phone call or fax. The written notification will be provided no later than the third (3) working day after the date of the phone call or email. If related to acquired brain injury, Member notification with be via phone . All other notifications will be in writing. Such communications will include the following:

- A clear and concise statement of the specific medical or contractual reasons for the resolution shall be sent to the requesting Provider and include a request for further information or action.
- The information regarding the appeal process and the right to appeal the decision, including instructions and how to file a complaint to ACHP.

Member Notification: Member will be notified of the denial of services via the United States Postal Service or HIPAA encrypted secure email. Notification will include a description of the procedure for filing a complaint and for filing an appeal. It will include a notice to the Member of the Member's right to appeal an adverse determination to an IRO and of the procedures to obtain that review, including a copy of the form prescribed by the Texas Department Insurance.

ACHP will use the following notifications:

HOSPITALIZATION
If a patient is hospitalized at the time of the adverse determination, ACHP will notify the Provider of record:

- Within one (1) working day by phone,
- Will follow with a letter within three (3) working days to notify the Member, the facility, and the admitting/attending physician of this determination.
- The letter shall state that benefits will be terminated at a stated date and time after notification.
- The notification letter will also inform as to the right of appeal and the process to follow.

MEDICAL (NO HOSPITALIZATION)
If the patient is not hospitalized at the time of the adverse determination, ACHP will notify the Member and the Provider of record within three (3) working days in writing@.

POST STABILIZATION
If the adverse determination is related to denying post stabilization care subsequent to emergency treatment as requested by a treating physician or other health care provider, ACHP shall provide the notice to the treating

physician or other health care provider no later than one (1) hour after the time of the request followed by a letter within three (3) working days to all parties.

RETROSPECTIVE REVIEW

If an adverse determination is related to a retrospective review, ACHP will notify the Provider of record and the Member within a reasonable period, but not later than thirty (30) days after the date on which the claim was received.

ADVERSE DETERMINATIONS APPEAL

A Member, a person acting on behalf of the Member, or the Member's Provider may appeal an adverse determination orally or in writing for an adverse determination for a prior authorization, concurrent review, retrospective review, or any appeal of an adverse determination made by ACHP.

All appeals for reconsideration of an adverse determination will be processed within set time frames and must fulfill the requirements as follows:

- All appeals must be submitted to ACHP orally or in writing.
- The appealing party will be allowed not less than one hundred and eighty (180) calendar days after the date of issuance of written notification of an adverse determination to file an appeal.
- In a circumstance involving a Member's life-threatening condition, the Member is entitled to an expedited appeal or an immediate appeal to an IRO and is not required to comply with procedures for an internal review by ACHP.
- ACHP may not require exhaustion of internal appeals prior to external review if:
  - ACHP fails to meet its internal appeal process timelines as above, or
  - The claimant with an urgent care situation files an external review before exhausting ACHP's internal appeal process.
- Within five (5) working days from the receipt of the appeal, ACHP will send an acknowledgment letter to the patient or a person acting on the patient's behalf and the patient's physician or other health care provider.
- Appeal decisions will be made by a Physician who has not previously reviewed the case.
- Once a determination of an appeal is made, written notice will be sent to all relevant parties of the determination of the appeal as soon as practicable, but not later than the thirtieth (30^{th}) calendar day, after the date ACHP receives the appeal.
- If an appeal is denied and, within ten (10) working days from the denial, the Provider sets forth in writing good cause for having a particular type of specialty provider review the case, the denial will be reviewed by a health care provider in the same or similar specialty that typically manages the medical, dental, or specialty condition, procedure, or treatment under discussion. The specialty review must be completed within fifteen (15) working days of receipt of the request.
- After ACHP has reviewed the appeal of the adverse determination, a letter will be sent to the Member or an individual acting on behalf of the Member, and the Provider of record, explaining the resolution of the appeal.

ADVERSE DETERMINATIONS EXPEDITED APPEAL PROCESS

ACHP provides a method for expedited appeals for emergency care denials, care for life-threatening conditions denials, and/or continued stays for hospitalized Member denials.

- Expedited appeals will be reviewed by a Specialist who has not previously reviewed the case and is of the same or similar specialty, as would manage the Member condition under review. In addition, the Specialist Reviewer may interview the Member, an individual acting on behalf of the Member, or the Provider to make a decision.
- The expedited appeal will be completed based on the immediacy of the condition and not later than one (1) working day for the date all the information necessary to complete the appeal is received and communicated by phone. A letter will always follow up oral notification of the expedited appeal decision within three (3) working days from the date of the decision.
- All correspondence with the appealing party/parties will be in writing and signed by the Medical Director or designee.
- In any circumstance involving an Member's life-threatening condition, the Member is entitled to an immediate appeal to an independent review organization and is not required to comply with procedures for an internal review or expedited appeal.

LIFE THREATENING CONDITION ADVERSE DETERMINATION APPEAL

The Member, individual acting on behalf of the Member, or the Member's Provider may determine the existence of a life-threatening condition and initiate an appeal.

Any party who receives an adverse determination involving a life-threatening condition or whose appeal of an adverse determination is denied by ACHP may seek review of that determination or denial by an IRO assigned by Texas Department of Insurance (TDI).

ACHP must provide the IRO notification to the Provider of record or other health care provider no later than one (1) working day from the date the request is received.

INDEPENDENT REVIEW ORGANIZATION (IRO) OF ADVERSE DETERMINATION

At the time of notification of all adverse determinations, ACHP will provide to the Member and related parties, the notice of the IRO process and a copy of the Texas Department of Insurance Request for a Review by an IRO form. ACHP will fully cooperate and facilitate the IRO review. ACHP will comply with the IRO's determination with respect to the medical necessity or appropriateness, or the experimental or investigational nature of the health care items and services for a Member.

SPECIALTY REVIEW APPEALS FOR ADVERSE DETERMINATIONS

A Provider of record may request that a particular type of specialist review an adverse determination.

5.0 – Billing and Claims

5.1 What is a Claim?

A claim is a request for payment. ACHP uses the standard CMS-1500 (professional) and CMS-1450 (UB04 institutional) paper claim forms **OR** the ANSI-837 format for electronic claims submission for medical and behavioral health claims.

5.2 What is a Clean Claim?

A clean claim is defined as a claim submitted by a physician or provider for medical care or health care services rendered by a provider to a ACHP Member, with the data necessary for ACHP to adjudicate and accurately report the claims. A clean claim must meet all requirements for accurate and complete data as defined in the 837 transaction guide.

Once a clean claim is received, ACHP is required, within the thirty (30) day claim payment period to:

- Pay the claim in accordance with the provider contract, or
- Deny the entire claim, or part of the claim, and notify you why the claim or part of the claim was not paid.

5.3 Electronic Claims Submission: ANSI-837

ACHP accepts claims via 837 electronic claims submission utilizing Cognizant/Trizetto as our clearinghouse. Cognizant/Trizetto EDI Payor ID = ACHP1. Please verify that Cognizant/Trizetto can accept your electronic claims or contact your Provider Relations Representative for assistance.

5.4 Submitting Paper Claims to ACHP

Paper claim forms should be mailed to:

ACHP
Attn: Claims
1111 E. Cesar Chavez St.
Austin, TX 78702

In compliance with CMS 5010 billing guidelines, all submitted CMS-1500 paper claims must provide a physical address for the provider's billing location in Box 33. Any paper claim submitted with a P.O. Box as the provider's billing address in Box 33 will be rejected and sent back to the provider for update and resubmission.

5.5 Timeliness of Billing

Initial claims and/or encounters must be submitted as follows:

Type of Claim	Timely Billing Parameter
Professional Claims submitted on a CMS-1500 or using the professional ANSI-837 electronic claim format	95 days from **DATE OF SERVICE**
Ancillary Services Claims submitted on a CMS-1500 or using the professional ANSI-837 electronic claim format	95 days from **DATE OF SERVICE**
Ancillary Services Claims for services that are billed on a monthly basis submitted on a CMS-1500 or using the professional ANSI-837 electronic claim format (e.g. home health or rehabilitation therapy)	95 days from the **LAST DAY OF THE MONTH** for which services are being billed
Outpatient Hospital Services billed on the CMS-1450 (UB04 institutional claim form) or using the institutional ANSI-837 electronic claim format	95 days from the **DATE OF SERVICE**
Inpatient Hospital Services claims billed on the CMS-1450 (UB04 institutional claim form) or using the institutional ANSI-837 electronic claim format	95 days from the **DATE OF DISCHARGE**

CORRECTED claims must be submitted as follows:

Type of Claim	Timely Billing Parameter
Professional Claims submitted on a CMS-1500 or using the professional ANSI-837 electronic claim format	120 days from **DATE OF SERVICE**
Ancillary Services Claims submitted on a CMS-1500 or using the professional ANSI-837 electronic claim format	120 days from **DATE OF SERVICE**
Ancillary Services Claims for services that are billed on a monthly basis submitted on a CMS-1500 or using the professional ANSI-837 electronic claim format (e.g. home health or rehabilitation therapy)	120 days from the **LAST DAY OF THE MONTH** for which services are being billed

Outpatient Hospital Services billed on the CMS-1450 (UB04 institutional claim form) or using the institutional ANSI-837 electronic claim format	120 days from the **DATE OF SERVICE**
Inpatient Hospital Services claims billed on the CMS-1450 (UB04 institutional claim form) or using the institutional ANSI-837 electronic claim format	120 days from the **DATE OF DISCHARGE**

Claims not submitted in accordance with the above noted deadlines may be denied. If a claim submitted electronically is rejected, the provider is responsible for reviewing any acceptance/rejection reports from their clearinghouse and submitting the initial claim within 95 days from the date of service. Providers are responsible for following up to ensure initial paper claims are received and accepted timely for processing within 95 days from the date of service.

Please do not submit a duplicate claim from original submission date prior to thirty (30) days for electronic claims, and forty-five (45) days for paper claims.

Acceptable proof of timely filing includes:
- Remittance report from wrong/primary payer within 95 days of the disposition
- Certified receipt showing delivery of claim to the correct claims address AND/OR
- Copy of the electronic acceptance report with the patient information and claims information from the clearinghouse.

Delays cannot be the result of neglect, indifference, or lack of diligence on the part of the provider or the provider's employee or agent. Exceptions are considered but limited to:
- Catastrophic events that substantially interfere with normal business operations
- Delays or errors in the eligibility determination
- Delays due to electronic claim or system implementation
- Client eligibility is determined retroactively and provider not notified

5.6 Timeliness of Payment

ACHP will pay all clean claims submitted in the acceptable formats as previously detailed within thirty (30) days from the date of receipt or the date that the claim is deemed "clean". Should ACHP fail to pay the provider within the thirty days, ACHP follows the Texas Administrative Code Title 28, Part 1, Chapter 21, Subchapter T, Rule 21.2815 for interest and penalty payments to providers.

ACHP will pay all clean electronic pharmacy claims submitted in the acceptable format within eighteen (18) days from the date of receipt or the date that the claim is deemed "clean".

5.7 Coding Requirements: ICD10 and CPT/HCPCS Codes

Professional Medical Claims: ACHP requires the use of ICD10 diagnosis codes and CPT or HCPCS procedure codes.

Emergency Professional Services Claims: ACHP requires the use of ICD10 diagnosis codes and CPT or HCPCS procedure codes.

Inpatient Institutional Claims: ACHP requires the use of ICD10 diagnosis codes and either ICD10 or CPT surgical procedure codes. Line item charges must be coded with UB04 Revenue Codes.

Outpatient Institutional Claims: ACHP requires the use of ICD10 diagnosis codes, HCPCS codes for applicable line item charges and the corresponding UB04 Revenue Code, and either ICD10 or CPT surgical procedure codes.

Emergency Institutional Claims: ACHP requires the use of ICD10 diagnosis codes, HCPCS codes for applicable line item charges and the corresponding UB04 Revenue Code, and either ICD10 or CPT surgical procedure codes.

Prescription Drug Claims: All pharmacy / drug claims should be submitted thru Navitus Health Solutions or call Navitus Customer Care at 1-877-908-6023. Claims forms are available at www.navitus.com.

5.8 Billing Requirements

ACHP follows standard E&M coding and billing guidelines as promulgated by the Centers for Medicare and Medicaid Services (CMS).

Other Requirements:

- ACHP requires the provider taxonomy code on all electronic or paper claims submissions.
- ACHP requires the submission of the entire numeric identification number as it appears on the member's ID card. This includes a nine (9) character base ID number, followed by a two (2) character suffix.
- ACHP requires submission of a valid ICD-10-CM preventive diagnosis code as the first pointer in order to be considered for the preventive benefit.

Chiropractic Services

ACHP provides coverage for Chiropractic services in accordance with the benefits under the Evidence of Coverage found at https://www.accesstocarehealth.com. Covered chiropractic services include spinal manipulations and adjustments only (CPT codes 98940, 98941, and 98942).

Home Health Services Initial Evaluation

Effective for dates of service 03/01/2020 and after, Home Health skilled nursing visits, PT, ST and OT initial evaluation services must be billed with the following HCPCS codes:

HCPCS Code	Description
G0159	Services performed by a qualified physical therapist, in the home health setting, in the establishment or delivery of a safe and effective physical therapy maintenance program, each 15 minutes.
G0160	Services performed by a qualified occupational therapist, in the home health setting, in the establishment or delivery of a safe and effective occupational therapy maintenance program, each 15 minutes.
G0161	Services performed by a qualified speech-language pathologist, in the home health setting, in the establishment or delivery of a safe and effective speech-language pathology maintenance program, each 15 minutes.
G0162	Skilled services by a registered nurse (RN) for management and evaluation of the plan of care; each 15 minutes (the patient's underlying condition or complication requires an RN to ensure that essential non-skilled care achieves its purpose in the home health or hospice setting).

Billing for Applied Behavior Analysis Services

Effective for dates of service 08/26/2020 and after, ACHP requires the name and NPI of the rendering Qualified Healthcare Professional (QHP) on all Applied Behavior Analysis CMS-1500 professional claims.

National Drug Code Billing Requirements

Effective for dates of service 07/08/2021 and after, ACHP requires the appropriate 11-digit National Drug Code (NDC) on drug related services for all professional claims and facility claims for outpatient services. The NDC must be a valid code that corresponds with Food and Drug Administration (FDA) NDC. This requirement includes CMS-1500 and UB-04 paper claims and 837 Electronic Data Interface (EDI) transactions. Drug-related medical claims without a NDC number or with an invalid NDC number will be denied. All claims denied for this reason must be corrected and resubmitted timely to ACHP for reconsideration.

E&M Consult Billing Requirements

ACHP follows standard coding and billing requirements for consults (CPT codes 99241-99275).

5.9 Emergency Services Claims

If emergency care is needed, it should be provided immediately in accordance with the procedures described in "4.0 - Emergency Services" in this manual. Services provided in an emergency situation will be reimbursed in accordance with the Hospital's or provider's agreement with ACHP.

5.10 Use of Modifier 25

ACHP will accept modifier 25 codes when submitted in accordance with the following requirements:

- Modifier 25 is used on a valid CPT or HCPCS procedure code to indicate that the identified service was provided as a distinctly separate service from other similar services furnished on the same date of service.

  EXAMPLE: Providing an age-appropriate health screening on the same day as a sick visit.

Sick Visit	Select the appropriate E&M Office Visit Code
Preventive Screen	Select the age-appropriate preventive E&M Code and affix the 25 modifier.

- Providers may use the modifier 25 when billing an E&M code with another significant procedure on the same day. The modifier 25 should be affixed to the E&M code *only*. The medical record should clearly support the significance and distinctiveness of the associated procedure.

- The modifier 25 may also be used to bill a preventive health screen, performed on the same day as a sick visit. The modifier 25 should be affixed to the preventive screen code.

The ACHP Fraud, Waste and Abuse (FWA) special investigative unit monitors modifier 25 billings. Occasional chart audits are performed to comply with our FWA program requirements.

5.11 Billing for Assistant Surgeon Services

ACHP provides coverage for Assistant Surgeon services authorized in accordance with ACHP policies for certain CPT codes.

5.12 Billing for Capitated Services

Capitated providers are required to submit encounter claims for all capitated services. ACHP accepts encounter data on the CMS-1500 form or the professional ANSI-837 electronic format. The forms should be completed in the same manner as a claim.

For a complete list of capitated services along with applicable carve outs and allowables please refer to your provider contract.

5.13 Billing for Immunization and Vaccine Services

ACHP covers immunization services. Providers may bill for both the vaccine (using the appropriate HCPCS code) and for vaccine administration. Please reference the Member Benefit documents available on ACHP's website for coverage information.

5.14 Billing for Outpatient Surgery Services

A limited number of Outpatient Surgeries require preauthorization which is outlined in Section 1.0. To ensure payment for any of these surgeries, include the authorization number on the submitted claim. An authorization may be obtained by submitting a request via our provider portal at https://www.accesstocarehealth.com, by faxing a request to the Medical Management Department at 512-901-9724 or by contacting the Medical Management Department at 1-855-297-9191.

Physician Claims: Submit the claim on the standard CMS-1500 or using the acceptable ANSI-837 professional electronic format. The applicable CPT-coded surgical procedure code(s) must be identified.

Facility Claims: Claims from hospitals, ambulatory surgery centers or other facilities where outpatient surgery may be performed must be submitted on the CMS-1450 (UB04) form of using the acceptable ANSI-837 institutional electronic format, with the applicable ICD10 surgical procedures code(s), date of the surgery, itemized charges, and associated CPT/HCPCS procedure codes.

5.15 Billing for Hospital Observation Services

Facilities are eligible to receive reimbursement for Observation Admissions congruent with the ACHP Evidence of Coverage (up to 24 hours). ACHP considers an observation claim to be an outpatient claim. In the itemized charges section of the claim form, a line showing the UB Revenue Code should be shown with the number of hours of observation. In cases where an observation stay is converted to inpatient, the facility should notify the Medical Management Department at 1-855-297-9191.

5.16 Coordination of Benefits (COB) Requirements

ACHP utilizes a third party vendor to verify COB status on all ACHP Members. Verified information obtained through this process will take precedent on all claim processing. For more information on other coverage please contact ACHP Customer Service. Timely filing requirements apply to COB claims. Claims must be received by ACHP within 95 days from the date of the other payer's Explanation of Payment.

Other Payer Makes Payment: In cases where the other payer makes payment, the CMS-1500, CMS-1450, or applicable ANSI-837 electronic format claim must reflect the other payer information and the amount of the payment received.

Other Payer Denies Payment: In cases where the other payer denies payment, or applies their payment to the Member's deductible, a copy of the applicable denial letter or Explanation of Payment (EOP) must be attached with the claim that is submitted to ACHP.

5.17 Collecting from or Billing ACHP Members for Co-pay Amounts

ACHP Members have co-pay amounts for certain services. The Members' ACHP identification card will indicate the co-pay amounts for these specific services. Only valid co-pay amounts can be collected from ACHP Members.

Co-pay Amounts for ACHP Members: Providers may collect co-pay amounts from ACHP Members as outlined on their identification card.

5.18 Billing Members for Non-covered Services

Providers may not bill Members for non-covered services **UNLESS** the provider has obtained a signed *Member Acknowledgement Statement* or a *Private Pay Form* from the Member or guarantor prior to furnishing the non-covered service. These forms must be maintained in the provider's records and made available to ACHP, state, or federal agencies upon request.

- ***Member Acknowledgement Statement Form***

The provider obtains and keeps a written Member Acknowledgement Statement, signed by the Member, when a Member agrees to have services provided that are not a covered benefit for ACHP. By signing this form, the Member agrees to have the services rendered, and agrees to personally pay for the services

- ***Private Pay Form Agreement***

The provider obtains and keeps a written Private Pay Form Agreement, signed by the Member, when the Member agrees to have services provided as a private paying patient. By signing this form, the Member agrees to pay for all services, and the provider will not submit a claim to ACHP.

5.19 Providers Required to Report Credit Balances

Providers are required to report credit balances on accounts of ACHP Members within 45 days of the credit balance occurring on the account, if the credit balance was caused by:

(a) Receiving payment from both ACHP and another payer, or
(b) Receiving duplicate payment from ACHP.

5.20 Filing a Reconsideration or Appeal for Non-payment of a Claim

ACHP follows an established process for providers to pursue resolution of medical and/or administrative appeals. This process is available to all providers, in-network and out-of-network. ACHP utilizes a Level I and Level II classification system for processing appeals. All reconsiderations and appeals are reviewed and a response is sent within 30 calendar days of receipt.

Level I Appeal Reconsideration

In the event that a provider disagrees with ACHP's denial of a medical and/or claim determination, the provider has the right to submit a request for administrative reconsideration of ACHP's initial determination. This is considered a Level I Appeal Reconsideration and must be filed in writing within 120 calendar days of the initial decision (Explanation of Payment (EOP) or medical necessity determination).
Level I Appeal Reconsiderations are required to include:

- A completed claim form
- A copy of the EOP with the claim in question
- A written explanation of the reconsideration which should identify as "Administrative Appeal Reconsideration"
- Supporting documentation

Providers submitting a reconsideration may elect to utilize the "Claim Reconsideration/Appeal Request Form" found on our website. Level I Appeal Reconsiderations must be mailed to:

ACHP
Attn: Reconsiderations
1111 E. Cesar Chavez St.
Austin, TX 78702

Level II Appeal

If a provider disagrees with ACHP's reconsideration decision, the provider has the right to appeal ACHP's reconsideration determination. An appeal cannot take place unless a previous reconsideration has been submitted and denied. This is considered a Level II Appeal and must be filed in writing with supporting documentation within 30 calendar days of the reconsideration decision. Level II Appeals are required to include:

- A completed claim form
- A copy of the EOP with the claim in question
- A written explanation of the reconsideration which should identify as "Administrative Appeal Reconsideration"
- Supporting documentation

Providers submitting an appeal may elect to utilize the "Claim Reconsideration/Appeal Request Form"
Level II Appeals can be either emailed or mailed to:

SenderoClaims@SenderoHealth.com

ACHP
Attn: Appeal II
1111 E. Cesar Chavez St.
Austin, TX 78702

5.21 Claims & Appeals Questions

For questions regarding claims, please contact ACHP Customer Service at the phone number at 1-844-800-4693.

5.22 Electronic Funds Transfer (EFT)

For your convenience, ACHP is pleased to offer Electronic Funds Transfer (EFT) as a method of receipt for claims payment. You may authorize ACHP to present credit entries into a bank account with minimal paperwork. A copy of the EFT form can be obtained on the ACHP website at https://www.accesstocarehealth.com or by emailing our Network Management Representative at SenderoProviders@SenderoHealth.com

6.0 – Credentialing and Re-credentialing

6.1 Credentialing and Re-credentialing Oversight

The Credentials Committee is led by ACHP's Medical Director. One of its functions is to review and approve credentialing files of providers who apply to the ACHP network. The Credentials Committee meets as often as necessary to complete provider credentialing and re-credentialing activities. There are contemporaneous dated and signed minutes that reflect all Credentials Committee activity. Reports are then made to the Quality Improvement Committee. The main scope of the committee is to ensure that competent qualified practitioners and providers are included in ACHP network and to protect the Members from professional incompetence. The Quality Improvement Committee and the ACHP Board of Directors review all activities of the Credentials Committee related to the credentialing and the re-credentialing of providers for the ACHP network. If you are interested in the Credentials Committee, please contact the Medical Management Director at 512-978-8176 for more information

ACHP's initial credentialing and re-credentialing decisions are made using standards that are consistent with NCQA standards and regulatory requirements. The standards apply to all licensed independent providers that provide care to ACHP members. All aspects of the credentialing verification process must be completed before the effective and re-credentialing date of the Provider contract and inclusion of the Provider's name in the ACHP Directory. ACHP does not make credentialing and re-credentialing decisions based on an applicant's race, ethnic/national identity, gender, age or sexual orientation, or on types of procedures or patients managed by the Provider. The ACHP Medical Director is accountable for the credentialing and re-credentialing program and the ACHP Credentials Committee, chaired by the Medical Director, functions as the credentialing committee.

6.2 Provider Site Reviews

Site visits may be conducted at the offices of primary care providers, OB/GYN physicians, and high volume individual specialist providers, by your local Network Management Representative prior to initial credentialing at ACHP. In addition, site visits will be conducted at any time for cause, including a complaint made by a Member or another external complaint made to ACHP.

The site visit review will consist of at least the following components:

- Physical Structure and Surroundings
- Provider Accessibility
- Provider Availability
- Confidentiality processes
- Treatment Areas

- Patient Education / Patient Rights
- Medical Record Review

For Rural Health Clinics, if a Nurse Practitioner or Physician Assistant is the main provider, additional criteria are reviewed that includes:

- Evidence of current state licensure for the Nurse Practitioner (Advance Practice Nurse) and Physician Assistant;
- Evidence of protocols or orders in place to provide medical authority and prescriptive authority;
- Verification that these protocols or orders are signed by the Medical Director and reviewed annually;
- Evidence that the Medical Director has visited at least once every ten (10) days; and
- Evidence that the Nurse Practitioner or Physician Assistant has given a daily report to the Medical Director if there are complications.

The physician and office are notified of the results of the review by registered letter, with any deficiencies identified. Physician office site visits that do not achieve a score on the assessment of 85% compliance or higher will be written as failing the visit score. The physician's office will be made aware of the deficiency, and will be given a time frame to make corrections. Another site visit will be conducted within six months from the date of the deficient visit. The provider's office will be given feedback of the site visit findings as they work towards correcting areas of non-compliance.

6.3 Required Office Policies & Procedures

ACHP requires that network providers have Policies & Procedures in place for:

- **Advance Directives**: ACHP requests that information on Advance Directives be provided to any ACHP Member 18 years of age or older.

- **Oversight of Mid-Level Practitioners**: ACHP requires that policies defining the role of the Mid-Level Practitioner in providing health care within their scope of practice be in place at the provider's office.

- **Medical Record Confidentiality**: ACHP requests that the provider's office implement and maintain a policy which acts to ensure the confidentiality of patient information as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

- **Release of Records**: The provider's office must have a policy in place directing its staff to follow a specific process that is HIPAA compliant for release of records.

- **Informed Consent and ID**: A written policy and procedure must be in place for confirming the identification of a member and obtaining consent for treatment prior to rendering services.

- **Maintenance of Medical Records**: The office should have a written policy regarding the safeguard against loss, destruction, or unauthorized use of any medical records.

6.4 Re-Credentialing Requirements

The re-credentialing cycle is three years. The following updated information is required for re-credentialing. ACHP's Network Management representative will request the following information for the re-credentialing process.

- Texas Standard Credentialing Application
  -Attestation via the Texas Standard Credentialing Application as to:
  -Reasons for inability to perform the functions of the position, with or without accommodation:
  -History of present illegal drug use;
  -History of felony convictions;
  -History of loss or limitations of privileges or disciplinary actions; and the completeness of the application
- Current Texas medical license;
- Current DEA certificate;
- Clinical privileges at the primary network admitting facility
- Malpractice/Liability insurance declaration page with minimum coverage of $200,000/$600,000 or as required by the primary admitting facility and expiration date*;
- National Practitioner Data Bank inquiry;
- Board certification if newly certified or recertified since last credentialing
- State and Federal, restrictions on licensure or limitations on scope of practice
- Sanction inquiry (Medicare and Medicaid);
- Any additional medical diplomas and/or certificates; and
- Malpractice history
- Work history

* Failure to provide Malpractice/Liability Insurance will result in immediate termination of the Provider Service Agreement.

Disputes from participating providers denied participation in the Health Plan will be addressed through the Health Plans' formal credentialing appeals process, in a timely manner.

In addition, ACHP must be notified by the provider whenever any of the following occurs:

- Malpractice settlements
- Any disciplinary actions taken (i.e. from hospital where physician has privileges, from state medical board, etc.)
- Change in malpractice coverage

- Loss, restriction or suspension of medical license

6.5 Practitioner Credentialing Rights

❖ You have the right to review information that ACHP obtains to evaluate your credentialing application. This includes information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards), with the exception of references, recommendations or other peer-review protected information.

❖ You have the right to correct erroneous information submitted by another source.
- ➢ You will be notified in the event that the credentialing information that we obtain varies substantially from the information that you have provided to us.
- ➢ You will be requested to provide, in writing or by email, the clarifying documentation within 15 business days of the notification.

❖ You have the right to be informed of the status of your application. You can be informed of the following information, upon request:
- ➢ Date the application and addenda were received
- ➢ Date request for additional information was sent to the applicant with an offer to resend the request
- ➢ Scheduled date of the next Medical Director review or if appropriate the next Credentials Committee meeting and following credentialing or re-credentialing decision, a response will be mailed or e-mailed to the applicant
- ➢ Communication of credentialing decision

For any questions regarding the Credentialing process, or to execute any of the above rights, please contact:

Credentialing Department
1111 E. Cesar Chavez St.
Austin, TX 78702
(844) 800-4693
Credentialing@SenderoHealth.com

7.0 – Fraud, Waste or Abuse

REPORTING FRAUD, WASTE OR ABUSE BY A PROVIDER OR CLIENT

Do you want to report Fraud, Waste or Abuse?

Let us know if you think a doctor, dentist, pharmacist at a drug store, other health care provider, or a person getting benefits is doing something wrong. Doing something wrong could be fraud, waste or abuse, which is against the law. For example, tell us if you think someone is:

- Getting paid for services that were not given or necessary
- Not telling the truth about a medical condition to get medical treatment
- Letting someone else use their ACHP card
- Using someone else's ACHP card
- Not telling the truth about the amount of money or resources he or she has to get benefits.

To report suspected Fraud, Waste or Abuse, chose one of the following:

- Confidential contact through Lighthouse/Syntrio Services (Confidential Third-Pary Reporting Service). You must include ACHP's name with the report.
  - Confidential hotline at 833-290-0001
  - Confidential fax at 215-689-3885
  - Confidential email at reports@lighthouse-services.com
  - Confidential website at **www.lighthouse-services.com**/senderohealth
- Call Customer Service at 1-844-800-4693; or
- You can report direct to:

  Compliance Department
  ACHP
  1111 E. Cesar Chavez St.
  Austin, TX 78702

To report fraud, waste or abuse, gather as much information as possible.

- When reporting a provider (a doctor, dentist, counselor, etc.) include:
  - Name, address, and phone number of provider
  - Name and address of the facility (hospital, nursing home, home health agency, etc.)
  - Type of provider (doctor, dentist, therapist, pharmacist, etc.)
  - Names and phone numbers of other witnesses who can help in the investigation
  - Dates of events
  - Summary of what happened

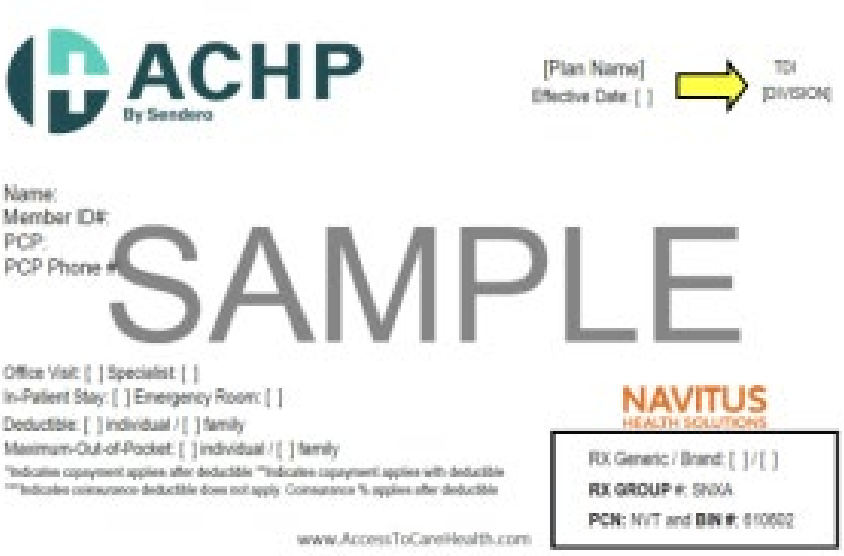
- When reporting someone who receives benefits such as a Member, include:
    - The person's name
    - The person's date of birth, Social Security number, or case number if you have it
    - The city where the person lives
    - Specific details about the fraud, waste or abuse

Appendix A

- **ACHP ID Card**

ACHP ID card – Off Exchange

FRONT



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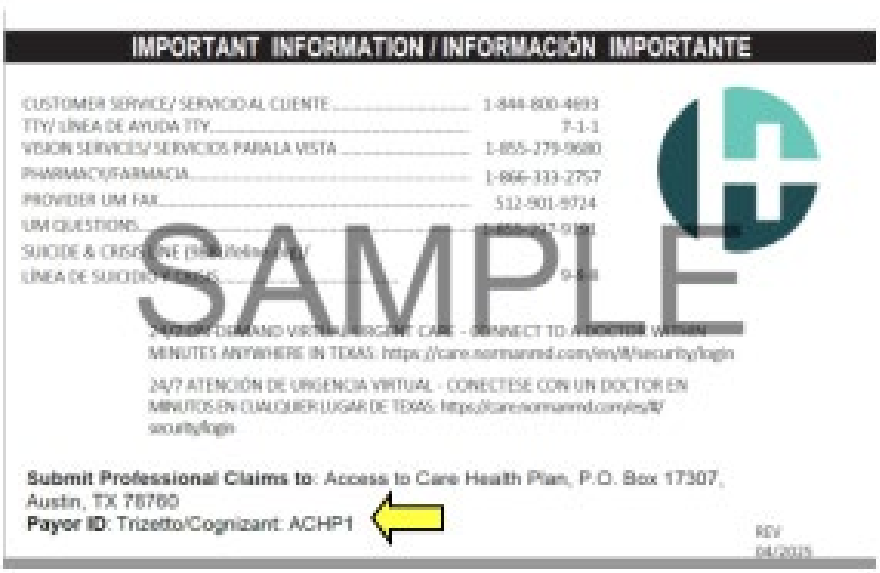

Appendix B

Provider Complaints and Appeals

A. ACHP has established the following process for receiving, resolving, tracking and reporting all provider indications of dissatisfaction.

1. A complaint(s) from a provider is received at ACHP either through telephone contact or through a written complaint.
    a. If the Provider calls into ACHP , he/she will be warm transferred to the Network Management Manager
    b. If a complaint is received in writing, the complaint will be forwarded to the Network Management Manager
2. All complaints must be submitted in writing. If received telephonically, ACHP will refer the provider to the ACHP website to download the Provider Complaint Form or will fax or mail the form to the provider to complete. The complaint will then be logged onto the Provider Complaint Tracking tool with the following data elements:
    a. The date the Complaint was received;
    b. Provider name and NPI number
    c. Where the complaint was received
    d. Provider phone number
    e. Provider name
    f. Provider contact person/caller
    g. A detailed description of the complaint

B. The Network Management Manager will review each complaint from a provider and investigate the concerns expressed by the provider. The Network Management Manager will collaborate with department leadership of units involved in the complaint to establish a resolution for the provider that is consistent with all applicable regulatory, accrediting and contract statutes.

The Network Management Manager will send a written notice to the provider outlining the findings of their review. The notice to the provider will include the opportunity for and an explanation of how the provider can pursue a Formal Desk Review through TDI if he/she is not satisfied with the review outcome within ACHP. If after completing ACHP's internal review process, the provider believes they did not receive full due process, they may file a complaint or inquiry by writing or calling:

Texas Department of Insurance
PO Box 12030
Austin, Texas 78711-2030
1-800-252-3439

C. After the Formal Desk Review, ACHP's Network Management Manager will send a FDR final determination notice to the provider with the outcome of the review noting that the provider has exhausted all review procedures available through ACHP.

Appendix C

Benefits, Covered Services, Limitations and Exclusions

Each ACHP member receives a copy of the Evidence of Coverage. ACHP is providing a link here for your reference also: https://www.accesstocarehealth.com

COVERED BENEFITS

Primary Care Visit to Treat an Injury or Illness	Home Health Care Services*	Other Providers Visit (Nurse, Physician Assistant)	Outpatient Services (including facility provider and surgical fees)
Hospice Services	Infertility Treatment* (diagnosis of the cause of infertility only)	Routine Eye Exam*	Specialist Visit
Urgent Care Center /	Delivery and all inpatient maternity care services	Behavioral Health* (inpatient and outpatient services)	Substance Abuse Disorder* (inpatient and outpatient services)
Prenatal and Postnatal Care	Delivery and all inpatient maternity care services	Behavioral Health* (inpatient and outpatient services)	Substance Abuse Disorder* (inpatient and outpatient services)
Prescription Drugs (see IdealCare formulary)	Outpatient Rehabilitation Services* (including physical, occupational, speech therapy, and Chiropractic care)	Durable Medical Equipment / Prosthetic Devices	*Hearing Aids/ Cochlear Implant*
Imaging (including CT, PET scans, MRIs, laboratory services, x- rays, and diagnostic)	Transplants*	Dialysis	Diabetes Education/ Management
Reconstructive Surgery*	Infusion Therapy	Treatment for Temporomandibular Joint Disorders*	Nutritional Counseling

**Review your EOC and the SBC for coverage specifications, limitations and exclusions at* https://www.accesstocarehealth.com

Member Rights and Responsibilities

Each ACHP member receives a copy of the member rights and responsibilities. ACHP is providing a copy here for your reference also. Each ACHP member has certain rights and responsibilities when receiving health care services and should expect the best possible care available.

MEMBER RIGHTS

ACHP is your partner in managing your health. This partnership is built upon cooperation, with rights and responsibilities for both ACHP staff and our members. As a member you have the right to:

- Be treated courteously and in a manner that respects your right to privacy and dignity in a nondiscriminatory manner.
- Have these rights and responsibilities explained to you by ACHP.
- Request a copy of the Member handbook and any member materials in a language other than English or Spanish, audio form, larger print, or Braille.
- Understand how to access ACHP health care benefits as well as select and be assigned to an Plan PCP within 30 calendar days of enrollment.
- Receive prompt, courteous and appropriate medical treatment, without physical or communication barriers.
- Participate in and understand your health conditions, recommended treatment, alternate treatment available, the risks involved to maintain optimum health, and to request a second opinion.
- Consent to treatment unless a life-or limb-threatening emergency exists and establish advanced directives as permitted under federal and state laws and have someone not directly involved in your care be present during your examination or treatment.
- Review your records and have your records treated with privacy and confidentiality.
- Take part in available wellness programs.
- Suggest how we can improve our services to you and other members.
- File a complaint or appeal a decision made by ACHP in accordance with procedures.

MEMBER RESPONSIBILITIES

As a member, you have the responsibility to:

- Read the Member handbook to learn how ACHP works and your Evidence of Coverage to understand your health plan benefits, limitations, and exclusions.
- Carry your member ID card with you at all times while enrolled.
- Not share your ID card with anyone.
- Contact ACHP and the Exchange as soon as possible when you have changes in family status, address, and phone number, employment status and other insurance coverage.
- Appropriately use your health plan.
- Use only in-network PCPs.
- Use in-network specialists when referred by your PCP.

- Use an in-network OB/GYN provider.
- Use in-network Behavioral Health providers/facilities.
- Advise ACHP as soon as possible whenever you receive care from an out-of-network provider, whether in or out the service area.
- Establish a positive and collaborative relationship with your provider, schedule appointments for routine care, keep scheduled appointments and arrive on time, and promptly contact your provider when you are unable to keep an appointment.
- Give your provider complete and accurate information and help them obtain your medical records.
- Cooperate with the treatment instructions you and your health care provider agree upon.

Additionally, communicate to your provider any concerns that you or your family members have about your health or health care. Adopt personal habits which promote good health.

- Contact your PCP for your non-emergency medical need sand understand when you should or should not go to the emergency room.
- Pay all applicable deductibles, copayments, and coinsurance at the time services are rendered and pay for services or supplies not covered by your Plan.
- Pay all applicable Plan premiums in a timely manner; your coverage may be terminated due to unpaid premiums.
- Respect the dignity of other members and ACHP staff and providers.

Member Complaints and Appeals

APPEALS PROCESS

DENIALS OR LIMITATIONS OF DOCTOR'S REQUEST FOR COVERED SERVICES

ACHP may deny health care services that are not considered to be medically necessary. If ACHP denies healthcare services, a letter will be mailed to you with the reason for the denial and an appeal form. If you are not happy with the decision, you may file an appeal by phone or by mail.

You may also request an appeal if ACHP denied payment of services in whole or in part. Send in the appeal form or call us at toll-free at 1-844-800-4693. If you appeal by phone, you or your representative will need to send us a written signed appeal. You do not need to do this if an Expedited Appeal is requested.

A letter will be mailed to you within 5 working days to tell you we received your appeal and we will mail you our decision within 30 calendar days. If ACHP needs more information to process your appeal, we will notify you of what is needed within the appeal acknowledgement letter. For life threatening care concerns or hospital admissions, you may request an Expedited Appeal.

EXPEDITED APPEALS

An Expedited Appeal is when ACHP is required to make a decision quickly based on your health status, and taking the time for a standard appeal could jeopardize your life or health, such as when you are in the hospital or continued treatment has been denied. To request an Expedited Appeal, call our Medical Management department toll-free at 1-855-297-9191. You may also request an Expedited Appeal in writing. We will make a determination as soon as possible and communicate the decision to you and your provider as soon as possible based on the immediacy of your needs but not to exceed one business day from the date of your request.

Through the expedited appeals process, you have the right to continue any service you are presently receiving until the final decision of your appeal is issued. If ACHP denies your request for an expedited appeal, we will notify you. Your request will be moved to the regular appeals process. We will mail you our decision within 30 days.

INDEPENDENT FEDERAL EXTERNAL REVIEW

Effective July 1, 2018, any member whose Appeal of an Adverse Determination is denied by ACHP may seek review of that determination by requesting an independent federal external review by contacting MAXIMUS Federal Services, Inc. by fax or mail.

To request the independent federal external review, please contact ACHP at:

MAXIMUS Federal Services, Inc.
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534
Toll-free phone: 888-866-6205
Fax: 888-866-6190

You may also visit http://www.externalappeal.com/Forms.aspx to download and complete a HHS Federal External Review Request Form and return it to:

HOW TO FILE A COMPLAINT AND APPEAL

If you have concerns about the services you have received from ACHP, a ACHP provider, or any aspect of your health plan benefits, please call us. Call ACHP's Customer Service toll-free at 1-844-800-4693.

A full investigation of your complaint will be completed and our decisions will be forwarded to you in writing within 30 calendar days from receipt of your written complaint or complaint form. ACHP will not discriminate or take punitive action against a member or a member's representative for making a complaint, an Appeal, or an Expedited Appeal. The HMO will not engage in retaliatory action, including refusal to renew or cancellation of coverage, against a member because the member or a person acting on behalf of the member has filed a complaint against the HMO or appealed a decision of the HMO. The HMO will not engage in retaliatory action, including refusal to renew or termination of a contract, against a provider because the provider has, on behalf of a member, reasonably filed a complaint against the HMO or appealed a decision of the HMO. At any time you may file a complaint with the Texas Department of Insurance (TDI) by writing or calling:

Texas Department of Insurance (TDI)
P.O. Box 12030
Austin, Texas 78711-2030
1-800-252-3439

Appendix D

ACHP
Preventive and Clinical Practice Guidelines List
2024-2025

ACHP evaluates the ACHP membership and maintains Preventive and Clinical Practice Guidelines that are consistent with evidence-based care. ACHP encourages practitioners to make use of the Guidelines when caring for members. Guidelines are updated periodically following review by the ACHP Credentials Committee. The Guidelines can be accessed through the Provider Portal or directly through the ACHP website at https://www.accesstocarehealth.com. Please call 1-844-800-4693 to request a copy of a guideline.

Appendix E

NONDISCRIMINATION

Access to Care Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Access to Care Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

If you believe that Access to Care Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a complaint in person, fax or by mail at Access to Care Health Plan, Attn: Civil Rights Officer Sharon Alvis, 1111 E. Cesar Chavez St., Austin, TX 78702, Telephone: 1-844-800-4693, TTY: 711, Fax: 512-901-9724, Complaints@SenderoHealth.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue,
SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Contact Us

Network
senderoproviders@senderohealth.com

Contracting
senderoprovidercontracts@senderohealth.com

Provider Customer Service
1-844-800-4693

Medical Management Dept.
1-855-297-9191

Medical Management Dept. Fax
512-901-9724