For all Accountable Health Care, IPA Providers

Accountable Health Care, IPA (AHC) complies with the Department of Managed Health Care (DMHC) guidelines. The Access Standards require every physician and Behavioral Health practitioner office’s answering service and/or machine must meet the access to timely care and services standard section as follows:

1300.67.2.2. Timely Access To Non-Emergency Health Care Services
AHC must ensure that all participating providers arrange for the provision, 24 hours per day, 7 days per week, including holidays & weekends of triage or screening services by telephone as defined. That triage or screen services are provided in a timely manner appropriate for the patient’s condition, and that the triage or screening waiting time does not exceed 30 minutes.

Your recorded message machine and/or answering service must follow:

- For non-emergent needs, a phone number or pager number must be given to reach the physician, on-call physician, a health care professional, or an exchange service OR the caller should have the option to page the doctor through the recording and receive a call back within 30 minutes.

- For emergent needs, the patient should be directed to emergency care for any life threatening situation with this message: “If you are experiencing a life-threatening situation, hang-up and dial 911 or go to the nearest emergency room”.

Under the regulations, AHC is obligated to ensure that all of our providers immediately meet these quality access standards to prevent patient dissatisfaction and potential risk issues. Audits will be conducted in order to verify compliance and corrective actions will be implemented as needed.

The new DMHC Timely Access Regulations for Non-Emergency Health Care Services were effective January 1, 2011 for Primary Care, Specialist and Behavioral Medicine Services. It is expected that all contracted providers will follow these DMHC Access Regulations for our HMO and PPO patients.

The following is a Summary of the Timely Access Regulations for quick reference.

Plans shall:

1) Provide or arrange for the provision of covered health care services in a timely manner appropriate for the enrollee’s condition, consistent with good professional practice.
2) Establish and maintain provider networks, P&Ps and QA monitoring systems and processes sufficient to ensure compliance with clinical appropriateness standard.

Rescheduling Appointments:
If it is necessary to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee’s health care needs, and that ensures continuity of care consistent with good professional practice. Interpreter services shall be coordinated with scheduled appointments.

Provider Network Capacity Time-elapsed Standards:
Each Plan must ensure its provider network has adequate capacity and availability to offer appointments within these timeframes:
1) Urgent Care appointments for services that do not require prior authorization: within 48 hours of request
2) Urgent Care appointments for services that require authorization: within 96 hours of the request
3) Non-Urgent appointments for Primary Care: within 10 business days of the request
4) Non-Urgent appointment with Specialist physicians: within 15 business days of the request
5) Non-Urgent appointments with a non-physician mental health care provider: within 10 business days of the request
6) Non-Urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition: within 15 business days of the request.

Exceptions to Time-elapsed Standards:
1) Waiting time for a particular appointment may be extended if the referring or treating provider, or health professional providing triage or screening services, acting within scope of practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee.
2) Preventive care services and periodic follow-up care, including standing referrals for chronic conditions, periodic office visits for pregnancy, cardiac or mental health conditions, laboratory and radiological monitoring for recurrence of disease may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating health care provider acting within the scope of practice.
3) Plans may demonstrate compliance with the primary care time-elapsed standards by providing advanced access to primary care appointments.
   a. Advanced Access means providing appointments with a PCP (includes NPs) within the same or next business day from the time the appointment is requested, and
   b. Advanced scheduling of appointments at a later date if the enrollee prefers not to accept the appointment offered within the same or next business day.
4) The Timely Access Regulation does not apply to Medicare Advantage Plans.

Plans must provide or arrange for the provision of Triage or Screening:
1) 24 hours per day, 7 days a week by telephone by a qualified health professional
2) Ensure triage/screening services are provided in a timely manner appropriate to enrollee’s condition, and
3) That triage or screening waiting time does not exceed 30 minutes.
4) Require a procedure which includes **during and after business hours**, a telephone answering machine and/or answering service and/or office staff that will inform the caller regarding:
   a. Wait time for a return call;
   b. How to obtain urgent or emergency care, including, when applicable, how to contact another provider who has agreed to be on-call.
   c. Unlicensed staff handling calls may ask questions on behalf of a licensed staff person to help ascertain the condition of an enrollee so the enrollee can be referred to licensed staff, but may not use the answers to assess, evaluate, advise or make any decision regarding the condition of an enrollee or determine when an enrollee needs to be seen.