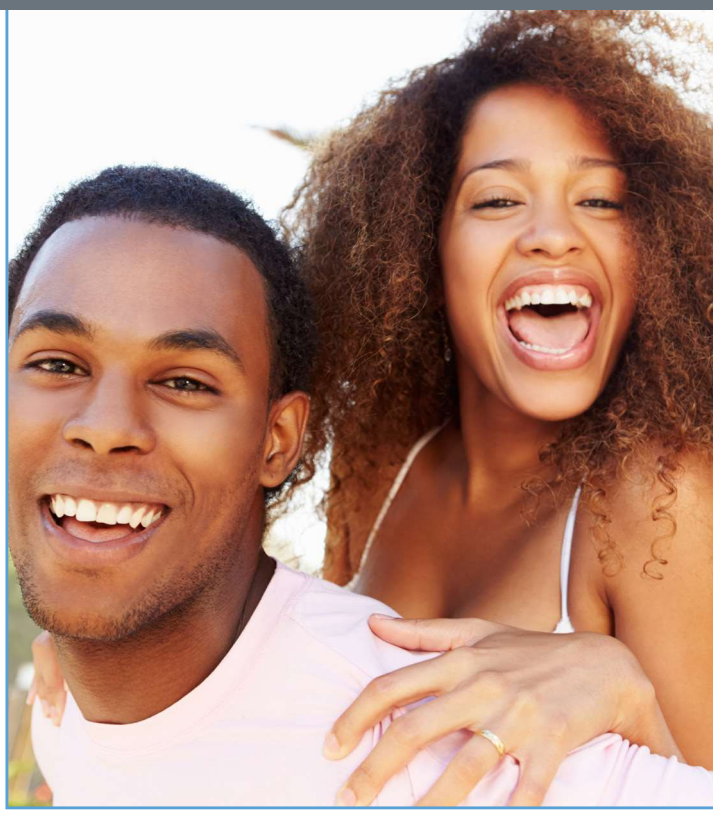
SENDERO HEALTH PLANS

PROVIDER MANUAL



SERVICE AREA: BASTROP, BURNET, CALDWELL, FAYETTE, HAYS, LEE, TRAVIS & WILLIAMSON COUNTIES

Important phone numbers / números telefónicos importantes

SENDERO CUSTOMER SERVICES 1-844-800-4693

NETWORK MANAGEMENT 1-855-895-0475

PROVIDER/CUSTOMER SERVICES 1-844-800-4693

HEALTH SERVICES DEPT. 1-855-297-9191

HEALTH SERVICES DEPT. FAX 512-901-9724

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1.0 – Preauthorization List

EFFECTIVE 5/15/2023

REQUIRED NOTIFICATIONS **SUBMIT NOTIFICATIONS VIA FAX NUMBER 1-512-901-9724**

Sendero Health Plans (Sendero) processes claims for covered health care services subject to plan requirements for notification and preauthorization. The following require prior notice to Sendero for determination of benefit coverage.

Relative to Texas Insurance Code 4201, Subchapter N, **required notifications apply to all providers, regardless of provider preauthorization exemption status.**

Inpatient Admissions

All facilities must notify the health plan within one business day after each admission.

(See also the Elective Inpatient Services preauthorization requirements in the next section)

Inpatient Special Situations:

- Notify Sendero of maternity and newborn stays exceeding two days for vaginal delivery or four days for cesarean section delivery.
- Notify Sendero for inpatient breast cancer treatment exceeding 48 hours after mastectomy or 24 hours after lymph node dissection.

Providers not in the Sendero Network

Submit requests at least (2) weeks before the start of service

All elective out-of-network services are considered Excluded Services and are not covered by Sendero unless approved through preauthorization.

PREAUTHORIZATION LIST GUIDANCE [1, 2, 3, 4]

The following health care services must be submitted to Sendero for medical necessity review and approved before rendering the service(s). Submit requests online at least five business days before the start of service at https://idealcare.mediview.net or via fax number 1-512-901-9724

Include the following with each request: clinical records that support medical necessity, including member history, physical exam findings and outcomes from any previous treatment(s) for the condition, relevant diagnostic test results, and social determinants of health information (if applicable to the request). For out-of-network requests, include the reason that the Sendero Member is being referred out-of-network and any attempts taken to locate services within the Sendero network.

Behavioral health services

- Applied behavioral analysis
- Intensive outpatient program
- Partial hospitalization
- Neuropsychological testing
- Residential treatment

DME/Orthotics/Prosthetics

- DME (rental or purchase) and medical supplies>$500 per line item
- Orthotics or Prosthetics devices over $250 per line item
- Hearing Aids
- Amino acid-based elemental formulas or formulas for the treatment of heritable diseases, or any canned nutrition

Drugs administered in an Office, Home, or Outpatient Setting

- Injectables over $500 per line item

High-Tech Imaging

- CT/CTA Scans
- MRAs, MRI, MRS
- PET and SPECT scans

Providers not in the Sendero Network

All non-emergency out-of-network services are excluded and not covered unless preauthorized by Sendero.

Elective (pre-planned) Inpatient Services, including those received in the following settings:

- Acute care hospitals
- Behavioral health hospitals
- Inpatient hospice facilities
- Long-term acute care hospitals
- Rehabilitation hospitals
- Residential treatment facilities
- Skilled nursing facilities

Continued stays after admission approval (i.e., concurrent reviews)

Each facility is responsible for providing to Sendero admission notifications and records for continued stay concurrent reviews.

PREAUTHORIZATION LIST GUIDANCE [1,2,3,4] (CONTINUED)

Other Health Care Services requiring Preauthorization[2]

- Ambulance, non-emergency, air or ground
- Any treatment for acquired brain injury that exceeds normal benefit limits[4]
- CAR T-Cell therapy and services
- Cochlear implants
- Dental anesthesia and oral surgery procedures related to accidents or trauma
- External or implanted infusion pumps
- Facility or lab-based sleep studies
- Genetic Testing
- Home health services (after initial evaluation)
- Implantable pumps and devices over $500
- Joint replacements
- Neuropsychological testing
- Organ or tissue transplant(s) and associated services, including initial evaluations
- Orthognathic surgery
- Osteochondral allograft of autologous chondrocyte implantation
- Potentially investigational or experimental services, including new and emerging technologies
- Reconstructive or potentially cosmetic services
- Therapies: Outpatient physical, occupational, and speech therapy (after initial evaluation)
- TMJ surgery and treatments
- Treatment for varicose veins

Spine and Pain Management Procedures including but not limited to:

- Anesthesia services for Interventional pain procedures
- Decompressions
- Discectomies
- Epidural steroid injections
- Facet injections
- Intradiscal procedures
- Radiofrequency joint ablation / Denervation
- Regional sympathetic blocks
- Sacroiliac joint procedures
- Spinal cord stimulators
- Trigger point injections

Providers not in the Sendero Network

Submit requests at least (2) weeks before the start of service

All elective out-of-network services are considered Excluded Services and are not covered by Sendero unless approved through preauthorization.

Drugs on the Pharmacy Benefit

Refer to the "Navitus PA Drug List" document on senderohealth.com

[1] This document explains preauthorization and notification requirements. Newly released codes, (including replacement codes for existing codes requiring preauthorization) in the categories of this Quick Reference Guide will require preauthorization upon date of release from CMS and/or the American Medical Association.

[2] Not every health care service code in a specific category may require preauthorization. Use the Sendero Health Care Service Code Lookup tool found on the preauthorization tab of the Sendero website provider page (https://www.senderohealth.com/providers/) to check preauthorization requirements for any specific health care service code that will be submitted on a medical claim. Failure to obtain pre-approval for the services specified in the code lookup tool will lead to claim denial.

[3] Screening criteria: To determine the medical necessity of healthcare services, Sendero uses evidence-based InterQual criteria published by Change Healthcare. Because these criteria are proprietary, they are not available for public view. Sendero will provide a copy of the criteria upon request for any specific authorization.

[4] For Members with acquired brain injury, obtain preauthorization for any service on this list. In addition, over-the-limit requests will be reviewed for medical necessity.

2.0 – Introduction

2.1 Background of Sendero Health Plans

Sendero Health Plans (Sendero) is a local non-profit corporation based in Austin, Texas and licensed as a community-based Health Maintenance Organization (HMO) that serves Central Texas. Sendero is sponsored by the Travis County Healthcare District, doing business as Central Health, which is providing organizational and financial resources to enable Sendero Health Plans to become a major player in improving health care access for people in Central Texas. In January 2014, Sendero became a qualified health insurance option for consumers in the Travis service area as part of the Affordable Care Act (ACA) which provides for the creation of a health benefit exchange in each state. 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. Sendero began providing services to the Marketplace population in Travis and surrounding counties of Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, and Williamson in January 2014.

Mission Statement
Sendero 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
Sendero 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, Sendero 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), Sendero 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 IdealCare.

2.2 Sendero's Philosophy of Business

Sendero 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 Sendero the respect and cooperation of the provider community throughout the Travis Service Delivery Area (SDA). Sendero encourages providers to be very involved, through the Medical Directors and the Health Services 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 Sendero Members and the community at large.

2.3 Sendero's Program Objectives

The program objectives of Sendero focus on:

- Comprehensive well-child care, including childhood immunization
- Case management opportunities to coordinate care
- ADHD, asthma and diabetes disease management programs to collaboratively improve control of these chronic conditions with affected Sendero Members
- Early and continuous prenatal care for pregnant Sendero Members geared to improve birth outcomes
- Effective behavioral health care services, including medication management

2.4 Sendero's Material Subcontractors / Other Key Vendors

Sendero administers its own programs, manages all quality improvement processes and oversees the development of its comprehensive network of providers and facilities. Sendero contracts with an Administrative Services Organization (ASO) to provide operational services and information management processes along with other subcontractor organizations to provide services. Subcontractors include:

- Clear Visions – providing all non-marketing printed material for providers and Members
- Navitus Health Solutions, LLC – to meet pharmacy needs for Sendero Members
- MediView – providing claims processing and adjudication and Customer Services

Key Vendors include:

- HMS - providing Fraud and Abuse, Special Investigative Unit and notification to Sendero of other insurance
- Bratton Law Firm – providing Subrogation Management services for Sendero
- Envolve – providing Sendero's members with services for their Vision benefits
- ExcessRe – providing reinsurance services for Sendero
- CareNet – providing 24-hour nurse line advice

2.5 Role of Primary Care Provider

The primary care provider is the cornerstone for Sendero. The primary care provider serves as the "Medical Home" for the Member. The "Medical Home" concept should help in establishing a relationship between the patient and provider, and ultimately better health outcomes. The primary care provider is responsible for the provision of all primary care services for the Sendero Member. In addition, the primary care provider is responsible for facilitating referrals and authorization for specialty services to Sendero network providers, as needed. For more information on the responsibilities of the primary care provider, see "*3.0 Guidelines for Providers*" in this manual.

2.6 Role of the Specialty Care Provider

The Specialty Care provider collaborates with the primary care provider to deliver specialty care to Sendero 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.

2.7 Role of the Pharmacy

The role of Navitus, the chosen pharmacy benefits manager for Sendero, is to provide an effective network of sites and pharmacy providers to provide access for members and to provide prescription fulfillment while improving health and providing superior customer service in a manner that instills trust and confidence to Sendero Members. Navitus and the PBM industry are fully compliant with NCPDP E.1 electronic eligibility verification.

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

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

Sendero 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 Sendero or terminates their contract with Sendero 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 Sendero Nurse 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 Health Services at 1-855-297-9191.

3.0 – Guidelines for Providers

3.1 The Role and Responsibilities of the Primary Care Provider

Each Sendero 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. Allergy injections
8. Venipuncture and other specimen collection
9. Eye and ear examinations
10. Preventive care and education / access to second opinion for services
11. Nutritional counseling
12. 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
13. Other covered services within the scope of the Physician provider's Medical Practice
14. Based on evaluation and assessment, coordinate referrals to in network specialty care
15. Behavioral health screening and help to access to care if Member requests
16. May provide behavioral health related services within the scope of his/her practice

The physician provider must deliver the services listed above to Sendero 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 Sendero 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 Sendero procedures with regard to non-network provider referrals (see below) and applicable aspects of the Sendero medical management program outlined in "*6.0 Medical Management*" in this manual
- Be available to Sendero 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 Sendero in identifying and referring Members with chronic asthma, diabetes, attention deficit disorders or who are pregnant and would benefit from Sendero's case or disease management programs. Referrals can be called in to Health Services at 1-855-297-9191.
- Cooperate with Sendero 's case management nurses by providing clinical information and collaborating with Sendero 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 Sendero
- 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 Sendero Members. Sendero 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 Sendero.

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 Sendero Member ID card.

Sendero 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.

Sendero 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 Sendero 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 Sendero 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 Sendero members at 1-800-855-2880.

3.2 Who Can Be a Primary Care Provider?

The following Sendero network provider types are eligible to serve as a primary care provider for Sendero 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 Sendero, willing to provide a medical home for specific Members with certain special health care needs or illnesses (see below)

3.3 OB/GYN Physician

Sendero 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.

> *Sendero allows you to pick an OB/GYN without a referral, but this doctor must be from within the Sendero 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 Sendero network*

OB/GYN Responsibilities

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

- completing the Sendero Pregnancy Notification Form (see **Appendix A**)
- completing a similar form containing the required information
- Notifying Health Services Case Management with the required information by calling 1-855-297-9191 or faxing Sendero at 512-901-9724.

Providers are not required to use the Sendero 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.

Sendero 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 Sendero's in-network provider panel.

Sendero'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, or those who have positive drug screening result, as 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.

3.4 Other Specialists as Primary Care Provider

Sendero allows Members with chronic, disabling, or life-threatening illnesses to select a Specialist as their Primary Care Provider following a review and authorization by Sendero'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 (see **Appendix A**)

To be eligible to serve as a PCP, the Specialist must meet Sendero'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 or in **Appendix A**) 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. Sendero will not reduce the amount of compensation owed to the original primary care physician for services provided before the date of the new designation.

3.5 Primary Care Provider Panel of Members

Open Panel of Members
Sendero desires all primary care providers to maintain an open panel and accept new Members that may select the primary care provider for medical care. Sendero understands that, from time to time, a primary care provider's panel will 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 Sendero'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. Sendero requests that primary care providers provide at least 30 days' notice of the closure of their panel. Once the panel is closed, Sendero 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.

3.6 Primary Care Provider Panel Changes

Primary Care Provider Changes
Sendero Members have a right to change primary care providers. Sendero 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. Sendero 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 Sendero Customer Service line at 1-844-800-4693.

Sendero reserves the right to reassign a Member's primary care provider or close a provider's panel if, in Sendero'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. Sendero 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

3.7 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 and Specialty Care	Routine primary care and specialty care follow-up care must be provided within 14 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.

Event	Requirement
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;
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.

3.8 Primary Care Provider Referrals to Other Providers

Primary Care Provider Referrals to Network Providers

The Texas Standard Preauthorization Request Form for Health Care Services (see Appendix A of this manual) 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 Sendero 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 Health Services department for review and preauthorization. Health Services 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 Health Services Department by calling 1-855-297-9191, faxing a request to 512-901-9724, or complete an online Preauthorization request using the Sendero Health Plans provider portal at https://idealcare.mediview.net. Once the request for out-of-network care is received, it will be reviewed by a Sendero Medical Director and sent to Network Management.

3.9 Members Right to Self-Referral

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

3.10 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 Health Services department of Sendero.

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 Sendero 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 Sendero Member, the Specialist provider is obligated to always:

- Confirm that the Member is an eligible Member and has a valid referral form from the primary care provider.
- Adhere to the Sendero accessibility standards for obtaining appointments.
- Collect the applicable co-payment for office visit from the Sendero 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 abuse 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 Sendero's Health Services line at 1-855-297-9191 for authorization requests or Sendero's Customer Service line at 1-844-800-4693 for questions regarding mental health benefits for Sendero Members.

Specialist providers must also comply with the Sendero 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 Sendero within 24 hours of the admission by calling or faxing the Health Services Department at the numbers listed below. The Health Services 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 Sendero. It is the responsibility of the referring physician to provide any required physician orders to the ancillary provider.

3.11 Pharmacy Provider Responsibilities

Pharmacy providers are required to 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

3.12 Credentialing and Responsibilities of Mid-Level Practitioner

Mid-level practitioners include nurse practitioners and physician assistants. Mid-level practitioners who have continuous physician oversight are not credentialed by Sendero. Mid-level practitioners who work independently and may be within a Rural Health Clinic, or Federally Qualified Health Clinic are credentialed by Sendero and must:

- provide a Texas Standard Credentialing Application to the health plan, along with information identifying the Physician who provides oversight, collaboration, or direction
- 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.

3.13 Medical Records

Maintenance of Records

All Sendero 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 Sendero

Sendero 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.

Sendero Requests for Medical Records

Sendero may from time to time request copies of medical records related to the treatment of Sendero 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 Sendero if the request comes from:

- Federal or state entities of competent jurisdiction.
- Sendero as a direct result of a request for records from federal or state entities of competent jurisdiction.
- Sendero pursuant to the health plan's utilization management preauthorizations requested by the provider.
- Sendero in relation to a quality review.
- Sendero 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.

Sendero will maintain complete confidentiality with regard to medical records that may be requested from providers. Sendero'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.

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

All network providers are required to notify Sendero in writing of any changes in office address or in relevant contact information. Changes in office address should be received by Sendero at least thirty (30) days prior to the change. This includes notifying Sendero 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 Sendero upon opening of new offices where Sendero's Members may be treated OR upon engaging new physician or mid-level practitioners who may be involved in the treatment of Sendero'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 Sendero Provider Information Form (PIF) can be located in Appendix A or on the Sendero website and used for notification of changes to practice location or panel.

3.15 Cultural Sensitivity

Sendero 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. Sendero encourages all providers to be sensitive to varying cultures in the community. Following is a list of principles for Sendero's network providers demonstrating the knowledge, skills and attitudes related to cultural sensitivity in the delivery of health care services to Sendero 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.

3.16 Reporting Fraud, Waste, or Abuse by a Provider or Member

For information regarding reporting Fraud, Waste or Abuse, see "*10.0 – Fraud, Waste or Abuse*" in this Manual.

3.17 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 Sendero network for any reason. If a provider desires to terminate his/her service agreement with Sendero, a written notice to Sendero 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 Sendero. Sendero 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.

Sendero Requested Termination

Sendero 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, Sendero will provide a written explanation to the provider indicating the reasons for termination. Sendero 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 Sendero'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 Sendero's Quality Improvement Committee or Provider Advisory Subcommittee. The decision of the advisory review panel must be considered by Sendero but is not binding on Sendero. Sendero must present to the provider, on request, a copy of the recommendation of the advisory review panel and Sendero's determination.

According to the provider's agreement with Sendero, the provider is entitled to sixty (60) days advance written notice of Sendero'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 Sendero 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 Sendero 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. Sendero may terminate this Network Provider contract at any time for violation of this requirement.

Notice of Proposed Action
Sendero 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 Sendero, the provider may request reinstatement by special notice (registered or certified mail) within thirty (30) days of receiving the notice of termination to Sendero's Medical Director. The provider should include any explanation or other information with their request for reinstatement. Sendero'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 Sendero Board of Directors to reaffirm the provider's agreement, reaffirm with sanctions, or to revoke the provider's contract as a Sendero network provider.

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

Sendero will work with Members currently receiving care from the provider to transition to other providers within the Sendero 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.

3.18 Member/Provider Communications

Sendero 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.

4.0 – Emergency Services

4.1 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

4.2 Prudent Layperson Standards at Sendero

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

4.3 Out of Network Emergency Services

Out of network emergency services are covered by Sendero. 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.

4.4 Emergency Transportation

Emergency transportation, such as ambulance service, is covered by Sendero. 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 Sendero for reimbursement.

4.5 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 Sendero of the incident within 48 business hours (or the primary care provider should notify the Sendero 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 Sendero Health Services Department, in conjunction with the primary care provider, will monitor the Member's condition with the out-of-area attending physician. Sendero will help the primary care provider in arranging for follow up care upon the member's return to the service area when medically appropriate.

5.0 – Behavioral Health Services

5.1 Definition of Behavioral Health

Behavioral health covered services are services for the treatment of mental, emotional or chemical dependency disorders or any combination of these diagnoses. Substance abuse includes drug and alcohol abuse, and the detoxification and withdrawal treatment that may be required.

5.2 Primary Care Provider Requirements for Behavioral Health

Primary care providers must screen, evaluate, refer, and/or treat any behavioral health problems and disorders for Sendero Members. The primary care provider may provide behavioral health related services within the scope of their practice. Timely and appropriate patient assessment and referral are essential components for the treatment of behavioral health issues.

5.3 Sendero Behavioral Health Services

Behavioral Health Services are covered services for the treatment of mental or emotional disorders and for chemical dependency disorders for Sendero members.

Primary care providers are responsible for coordinating Members' physical and behavioral health care, including making referrals to in-network Behavioral Health providers when necessary. In addition, primary care providers must adhere to screening and evaluation procedures for the detection and treatment of, or referral for any known or suspected behavioral health problems or disorders. Providers should follow generally accepted clinical practice guidelines for screening and evaluation procedures, as published through appropriate professional societies and governmental agencies, such as the National Institute of Health. Primary care providers may provide behavioral health related services within the scope of their practice.

- All behavioral health services which require preauthorization must be coordinated through Sendero. Preauthorization may be required prior to seeing a Behavioral Health provider. Call Sendero's Health Services line at 1-855-297-9191 for an authorization or for any questions regarding mental health benefits for Sendero Members.
- For mental health services not covered by Sendero, the Member must access local resources. Please refer the member to Sendero's RN Case Managers in Health Services at 1-855-297-9191 to help in locating these resources.
- A list of local resources for behavioral health care alternatives outside of network providers is available through the following public resources:

- The local Department of Health Services offices
- The local Public Library
- The Finding Help in Texas website-- www.211texas.org/211 – or toll free at 2-1-1.

Community Mental Health Centers will accept patients with the primary diagnosis of schizophrenia, bi-polar or severe major depression, along with many other behavioral health diagnoses (ADD, ADHD, post-traumatic stress disorder, etc.). The following CMHCs serve Members in the Travis Service Delivery Area:

Bluebonnet Trails Community MHMR Center
1009 Georgetown St.
Round Rock, TX 78664
Crisis Phone: 800-841-1255
Main Phone: 512-255-1720
Website: http://www.bluebonnetmhmr.org/

Counties Served: Bastrop, Burnet, Caldwell, Fayette, Lee, and Williamson

Hill Country MHDD Centers
819 Water St., Ste. 300
Kerrville, TX 78028
Crisis Phone: 877-466-0660
Main Phone: 830-792-3300
Website: http://www.hillcountry.org/

Counties Served: Hays

Integral Care
1430 Collier Street
Austin, TX 78704
Crisis Phone: 512-472-4357
Main Phone: 844-398-8252
Website: https://integralcare.org/

Counties Served: Travis

5.4 Sendero's 24-hour/7 Days a Week Behavioral Health Hotline

Sendero behavioral health hotline is available 24 hours a day / 7 days a week at:

1-855-765-9696 for Sendero Members

This number is listed on the Member's ID card. Call Sendero's Health Services line at 1-855-297-9191 for an

authorization, or for any questions regarding mental health benefits for Sendero Members.

The following circumstances indicate that a referral to a physician is recommended:

- The Member is receiving psychoactive medication for an emotional or behavioral problem or condition.
- The Member has significant medical problems that impact his/her emotional well-being.
- The Member is having suicidal and/or homicidal ideations.
- The Member has delirium, amnesia, a cognitive disorder, or other condition for which there is a probable medical (organic) etiology.
- The Member has a substance use disorder such as substance-induced psychosis, substance induced mood disorder, substance induced sleep disorder, etc.
- The Member has or is likely to have a psychotic disorder, major depression, bipolar disorder, panic disorder, or eating disorder.
- The Member is experiencing severe symptoms or severe impairment in level of functioning or has a condition where there is a possibility that a pharmacological intervention will significantly improve the Member's condition.
- The Member has another condition where there is a significant possibility that somatic treatment would be of help. Conditions include dysthymia, anxiety, adjustment disorders, post-traumatic stress disorders, and intermittent explosive disorders.
- The Member has a substance abuse problem.

5.5 Covered Behavioral Health Services

The following services are available to Sendero Members:

- Inpatient Substance Abuse Treatment Services
- Outpatient Substance Abuse Treatment Services
- Inpatient Mental Health Services
- Outpatient Mental Health Services

Behavioral Health Inpatient Facilities must ensure that a seven (7) day follow-up appointment is made prior to Member discharge from an inpatient stay.

5.6 Referral Authorizations for Behavioral Health Services

Sendero Members do not require referrals from their primary care provider for initial evaluation for behavioral health treatment from an in-network Behavioral Health provider. All behavioral health services which require preauthorization must be coordinated through Sendero. Call Sendero's Health Services line at 1-855-297-9191 for an authorization, or for any questions regarding mental health benefits for Sendero Members. Primary care

providers may provide Behavioral Health Services for Sendero Members, if it is within the scope of his/her practice.

5.7 Preauthorization

Preauthorization may be required prior to seeing a Behavioral Health provider. Call Sendero's Health Services line at 1-855-297-9191 for an authorization, or for any questions regarding mental health benefits for Sendero Members. The Behavioral Health Hotline 1-855-765-9696 is available for Sendero members 24 hours a day, 7 days a week.

5.8 Responsibilities of Behavioral Health Providers

Behavioral health providers and/or physical health providers, who are treating a behavioral health condition, are responsible for appropriate referrals to the Texas Department of Protective and Regulatory Services (TDPRS) for suspected or confirmed cases of abuse.

They are also responsible to assure that any necessary preauthorization activities take place and for the following:

- Assure the release of information consent form is signed by the Member/Guardian.
- Refer Members with known or suspected physical health problems or disorders to the primary care provider for examination and treatment.
- Only provide physical health if a behavioral health provider is already rendering treatment for behavioral health conditions.
- Ensure that the Members know of, and are able to avail themselves of, their rights to execute Behavioral Health Advance Directives.
- Assure all Sendero Members that receive inpatient psychiatric services are scheduled for outpatient follow up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven (7) days from the date of discharge.
- Have policies and procedures in place on how to follow-up on Member missed appointments.
- Contact Members who have missed appointments within 24 hours to reschedule appointments.
- Make available to primary care providers behavioral health assessment instruments.
- Communicate with the Member's primary care provider, if okay with the Member, treatment plans and progress to achieving treatment plan.
- Refer the Member for needed lab and ancillary services if not available in the provider's office.

5.9 DSM-IV Coding Requirements

Behavioral health documentation and referral requests should include DSM-IV multi-axial classifications. Subsequently, behavioral health claims should be filed using the applicable and appropriate DSM-IV diagnostic code to define the Member's condition being treated. The DSM-IV is the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, published by the American Psychiatric Association.

5.10 Laboratory Services for Behavioral Health Providers

Behavioral Health providers should facilitate provision of in-office laboratory services for behavioral health Members whenever possible, or at a location that is within close proximity to the Behavioral Health provider's office. Providers may refer Members to any network independent laboratory for needed laboratory services with an appropriate laboratory order/prescription. Sendero does not require a referral for Members to have lab work done.

5.11 Court-ordered Services and Commitments

A Member who has been ordered to receive treatment under the provisions of Chapter 573 or 574 of the Texas Health and Safety Code must receive the services ordered by that court of competent jurisdiction. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. The Member cannot appeal the commitment through the complaint or appeals process.

5.12 Confidentiality of Behavioral Health Information

The provider is required to obtain consent for disclosure of information from the Member in order to permit the exchange of clinical information between the behavioral health provider and the Member's primary care provider.

If the Member refuses to sign a release of information, documentation will need to indicate that they refused to sign. In addition, the provider will document the reasons for declination in the medical record.

6.0 – Medical Management

6.1 Utilization Management Program

Utilization Management is a set of activities performed by Sendero to ensure that medically necessary services are coordinated for Members in an efficient and timely manner and that appropriate health care services are available to Members. Utilization Management activities are retrospective, concurrent and prospective. All Utilization Management activities are performed by Registered Nurses and clinicians under the supervision of a Medical Director. Sendero utilization management staff is available during normal business hours, Monday-Friday 8 am – 5 pm, excluding holidays, for inbound collect or toll-free calls regarding questions about the utilization management process or issues at 1-855-297-9191. Language assistance for members with utilization management issues is available through bilingual staff or by calling Sendero Customer Service at 1-844-800-4693.

Goals of Utilization Management

Objectively, consistently, impartially, and fairly promote, monitor, and evaluate the delivery of high quality, cost effective medical and behavioral healthcare services for all members.

- Facilitate access to medically appropriate services
- Fair and consistent Utilization Management decision-making
- Focus resources on timely resolution of identified problems
- Promote the use of evidence-based clinical practice guidelines and preventive care guidelines
- Establish, update and utilize nationally recognized, peer-developed review criteria
- Ensure confidentiality of personal health information
- Provide case management services for members with complex medical conditions and /or chronic conditions
- Identify, educate, and manage members with select chronic conditions, promote increased member participation in the self-management of their disease, and reduce acute exacerbations of their illness.
- Promote patient safety
- Improve member and provider satisfaction
- Monitor Utilization turnaround times for authorization requests for timely response.
- Respond to complaints and appeals in a timely fashion. Monitor these activities to identify possible trends in issues affecting member satisfaction.
- Identify diverse cultural and ethnic populations of the Sendero membership. Develop, utilize and provide materials and outreach activities that are accessible to all.
- Provide access to language translation services and provide information regarding those services to members.
- Measure member and practitioner satisfaction. Identify trends and implement quality activities to improve the member experience.
- Ensure compliance with requirements of regulatory entities.
- Obtain and maintain accreditation from a nationally recognized Quality organization.

- Meet all state and federal regulatory requirements.
- Maintain policies and procedures that support these requirements.

We strive to assure the Member is receiving the appropriate care at the appropriate time and work proactively on the Member's behalf with the Sendero network providers to assist the Member in maintaining his/her optimal level of health and well-being.

General Standards of Utilization Management

- Sendero Health Plans staff and delegates that perform utilization review do not observe, participate or are present during a Member's physical or mental examination, treatment, procedures or therapy unless approved by the provider and member or modified by contract.

- Physicians, doctors, and other health care providers employed by or under contract with Sendero to perform utilization review are appropriately trained, qualified, and currently licensed. Personnel conducting utilization review hold unrestricted licenses, an administrative license, or are otherwise authorized to provide health care services by a licensing agency in the United States.

- Staff or agents are not permitted to receive compensation, nor is it a condition of employment or the evaluation process to base performance ratings on:
  - Volume of adverse determinations.
  - Reductions or limits on length of stay, benefits, services or charges,
  - The number or frequency of telephone contacts with providers or Members.

- Quality of care is not adversely impacted by financial and reimbursement-related processes and decisions.

- Utilization review determinations are made in a manner that takes special circumstances of the case into account that may require deviation from the norm stated in the screening criteria or relevant guidelines. Special circumstances include, but are not limited to, an individual who has a disability, acute condition, or life-threatening illness.

Utilization Review Processes

The screening criteria used for medical necessity determination by Sendero includes Milliman Care Guidelines and/or InterQual Criteria and other guidelines from recognizable resources, as necessary. Other resources may be, but are not limited to, the National Heart, Lung and Blood Institute (NHLBI), the Agency for Health Care Policy and Research (AHCPR), National Institute of Health (NIH), American Academy of Pediatrics (AAP), National Coverage Determinations (NCD), or internally developed guidelines. The screening criteria used are objective, clinically valid, compatible with established principles of health care, and are flexible enough to deviate from the normal, when justified, on a case-by-case basis. Each case will be reviewed individually, for special circumstances that may cause deviation from the standard. Utilization Management Decision Criteria is available upon request by calling Sendero Health Services at 1-855-297-9191.

6.2 Management of Utilization

Concurrent Inpatient Review
Concurrent inpatient reviews are conducted to ensure that services rendered to the Member are medically necessary, meet InterQual Criteria, are provided in the appropriate environment, and that continuity of care is appropriately planned for discharge.

Determinations on appropriateness of care and of hospitalization are made by reviewing information in the medical record and through discussions with the attending physician. The following criteria must be met:

1. Documentation in the medical record must indicate that the medical condition requires continuous daily monitoring by the facility staff and by the provider that cannot be provided at a less restrictive setting.
2. The Member's condition cannot be managed safely at another level of care (such as outpatient, home health care, etc.)
3. Continued stay criteria for both intensity of service and severity of illness must be present and documented in the medical record for each day of confinement.

It is the responsibility of the attending / admitting practitioner to ensure that hospital admissions are certified and that authorized lengths of stay are extended, as indicated.

If InterQual Criteria is not met, or transfer to an alternative level of care is medically appropriate, the Medical Director reviews the information and, if necessary, discusses the case with the attending physician prior to making a determination of whether continued hospitalization is authorized.

If Concurrent Review indicates a discharge and / or transfer of care is appropriate:

- The Health Services Department Concurrent Review Nurse is available to help the attending physician with arranging discharge and transfer of patients from acute care facilities to other facilities, such as rehabilitation, or home health care.
- Faxed or telephone reviews are usually conducted for inpatient cases in acute inpatient care, inpatient rehabilitation, and short-term facilities. The frequency and intensity of the reviews are based on the severity of illness and care required by the patient.
- Discharge plans will be discussed with the attending physician/ case manager/discharge planner as needed.
- If the hospitalization is deemed not medically necessary, the Member, the primary care provider, and the hospital will be notified regarding denial of services beyond a specified date.

Retrospective Review
Retrospective reviews may be conducted on any claim without an authorization, partial hospitalizations, and emergency room treatment, out of area treatment, admissions or Member reimbursement. The reviews are conducted to ensure that services rendered to the patient are medically necessary, provided in the appropriate environment and contractually covered.

The process includes the following steps:

- When the claim in question is received, the provider is notified within fifteen (15) days that the claim has been received and that it is under review.
- Specific parts of the medical record are requested from the provider.
    - If records are not received with thirty (30) days, the claim is considered denied. The provider is notified of the denial, the reason for the denial and the appeal process.
    - When records are received, a decision is made within thirty (30) days using the following criteria:
        - medical appropriateness, timeliness, and necessity
        - established medical criteria
        - plan benefits

Once a decision is made, the provider is notified of the results.

Discharge Planning

Discharge planning refers to all aspects of planning for post-hospital needs and ensuring the continuity of quality medical care in an efficient and cost-effective manner, and should begin prior to admission. Discharge planning activities include provisions for and/or referrals to services required in improving and maintaining the patient's health and welfare following discharge.

Sendero's Health Services Concurrent Review Nurse work with the attending physician and staff, the Member, the Member's family, and other health care professionals to ensure continuity of care after discharge. It is recognized that discharge planning is a process which requires multidisciplinary involvement to achieve the greatest success. Consequently, input is sought from all healthcare professionals such as nurses, physical therapists, as well as any other ancillary staff and services.

Anticipated discharge needs should be discussed with the Health Services Department prior to admission, or as early as possible in the admission. Upon notification, each admission will receive an anticipated length of stay that indicates the estimated discharge date.

To facilitate discharge planning for Members in the hospital, call the Health Services Department. The Health Services Department Concurrent Review Nurse may help in:

- Arranging home health services and durable medical equipment (DME)
- Admissions / transfers to other facilities
- Coordinating medical transportation
- Questions on benefits or coverage
- Authorization and arrangement of transfer of out-of-area patients
- Information and referral to community resources

6.3 Referrals

Free flow of communication between PCPs and specialists enhances the efficiency and quality of care. Sendero does not require preauthorization of a referral from a plan PCP to in-network specialists. Sendero encourages PCPs to submit a referral form to specialists that reflects the need for the referral as well as any supporting documentation, lab results, x-ray reports, etc. In addition, Sendero encourages specialists to report their findings

back to the PCP.

Members with Special Health Care Needs
Members with special health care needs may need several referrals to meet their health care needs. These Members may need direct access to a Specialist provider. Members with special health care needs may have a standing referral to a Specialty Physician as approved by the Medical Director.

Referral Procedure
When a referral to a Sendero Specialist or ancillary facility is necessary, the following steps should be taken:

- The primary care provider selects a Specialist from the Sendero network panel.
  - The primary care provider arranges for services with the Specialist in the usual manner including coordination of pertinent clinical information and then issues a referral. A referral form is sent to the specialist by using the Texas Standard Preauthorization Request Form for Health Care Services in **Appendix A** of this manual or online via the internet.
- The Specialist will examine and treat the Member (as requested by the primary care provider) and document recommendations and treatment. The Specialist should keep the primary care provider continually informed of findings and treatment plans.
- The Specialist will submit a claim form to Sendero. For further details regarding claim filing, please see "*7.0 Billing and Claims*" in this manual.
- If the Member requires additional services not directly associated with the diagnosis in the referral, the Specialist must contact the primary care provider prior to rendering the additional care to coordinate these services.

Primary Care Provider Referrals to Specialists
A Member's referral is usually initiated during an office visit to the primary care provider. Referrals usually include visits to the Specialist through the Member's enrollment period.

Referrals should be issued prior to the visit to the Specialist (with the exception of emergency room and behavioral health initial evaluation).

Specialist to Specialist Referrals / Facility to Specialist or Ancillary Referrals
When a specialist wishes to refer to another specialist they need to refer the patient back to the primary care provider to initiate the physician to physician referral. Specialists can, however refer patients for in network ancillary services that fall under the scope of their practice. (For example, an Orthopedic Specialist can make a referral for Physical Therapy or Occupational Therapy.) Specialists should ensure that the primary care providers are kept informed of the results of any examinations and any additional treatment recommended. When a member discharges from a facility the discharge orders from the facility may serve as an acceptable referral to a Specialist or Ancillary provider.

Self-Referral Services
Members are allowed to self-refer, without a primary care provider referral, for the following services and must receive services from in-network providers according to the terms of their benefit plan:

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

Out-of-Network Referrals
All non-emergent services requested by non-contracted providers, out of area/out of network providers require preauthorization by the Health Services Department. The preauthorization will require that the requesting provider submit the clinical rationale to Sendero for specific needed services to this out-of-network specialist that cannot be provide by any in-network specialist.

Non-participating Specialist care requires preauthorization by the Health Services Department. A request for Out-of Network services can be initiated by calling Sendero's Health Service's Department at 1-855-297-9191 or by faxing a request with the appropriate documentation to justify the request to 512-901-9724.

Physician-requested Second Opinions and Member-requested Second Opinions
Second opinions requested by either the Member or the physician do not require preauthorization. For questions regarding a second opinion request, contact the Health Services Department.

Results of Not Obtaining Preauthorization
Cases that require preauthorization and in which preauthorization was not obtained are subject to denial. Appeal information can be found in "*7.22 Filing a Reconsideration or Appeal for Non-payment of a Claim*" in this manual.

Appealing Non-Payment for Lack of Referral
Information on how to appeal can be found in "*7.22 Filing a Reconsideration or Appeal for Non-payment of a Claim*" in this manual.

Online Referrals and Authorization Processes
Request for authorization of outpatient services can be initiated online at https://idealcare.mediview.net. Once in the Provider Portal, select the link for creating an online referral or for initiating the preauthorization process depending on your need.

Faxing Paper Referrals and Authorization Requests
Providers may fax the Texas Standard Preauthorization Request Form for Health Care Services (see **Appendix A**) to the Health Services Department at 512-901-9724**.**

Obtaining Referral and Authorization Forms
Forms are available online at https://www.senderohealth.com/providers.

6.4 Preauthorization

Overview

Sendero requires that all services described on the preauthorization list be authorized prior to services being rendered. Preauthorization requests should be submitted no less than 5 business days prior to the start of service. A list of these services is located in Section 1.0 of this manual. All services are subject to eligibility at the time of service and benefit limitations or exclusions. The preauthorization process is used to evaluate the medical necessity of a procedure or course of treatment, appropriate level of service and the length of confinement prior to the delivery of services. The clinical information provided aids in the medical review of the request and to ensure that discharge planning can be facilitated timely.

Sendero provides prospective, concurrent, and retrospective utilization review services. All services that require preauthorization must be phoned or faxed to the Health Services Department utilizing the Texas Standard Preauthorization Request Form for Health Care Services included in **Appendix A** of this manual. The request may be submitted via the Provider Portal at https://idealcare.mediview.net/ as well.

Failure to obtain preauthorization may result in non-payment of claims and encounters.

Members may request reconsideration of benefit determinations in accordance with the medical appeals process. Physicians are responsible for making medical treatment decisions in consultation with their patients. Any denial of preauthorization based on lack of medical necessity or documentation of such, will be made by the Medical Director.

Physician and Provider Preauthorization Exemptions

Sendero's processes align with Texas 87th Legislature House Bill 3459 regarding Texas Insurance Code 4201.653, Subchapter N "Exemption from Preauthorization Requirements for Providers Providing Certain Health Care Services". Sendero's policy and Provider Preauthorization Exemption Correspondence
Preference Form are available online at https://www.senderohealth.com/providers and are found under the 'Prior Authorizations' heading and in **Appendix A** of this manual.

Protocols and procedure for obtaining Preauthorization

The physician (primary care provider or Specialist) initiates a preauthorization using the same procedure as requesting a referral, by calling or by faxing the Texas Standard Preauthorization Request Form for Health Care Services (see **Appendix A**) to Sendero's Health Services Department and providing the same demographic and clinical information as required for a referral as stated above. Preauthorizations can also be initiated over the internet and provider offices with internet access have been instructed in this procedure. Provider offices interested in additional information on entering web based requests can call Network Management at the phone number listed on the bottom of this page.

Definition of Admissions:

Elective Admission: Elective, or pre-planned, admissions generally include elective surgeries and admissions for elective treatment that requires an acute care setting for management.

Observation Admission: Observation admissions are intended for use when it is necessary for a Member to be monitored for a longer period of time post-operatively, or if the member has known risk factors or medical conditions requiring frequent monitoring by the nursing staff. Observation is authorized for up to 24 hours per the Sendero Evidence of Coverage. If the decision is to keep the patient beyond 24 hours, the hospital or the

attending physician should contact Sendero within one (1) business day.

Direct Urgent Admissions: Urgent admissions are defined as those admissions that take place upon direct referral from a physician's office or when the Member is directed by a physician to go to the hospital. The facility is required to notify Sendero within 24 hours or next business day of the admission.

Emergency Admissions: An emergency admission usually occurs directly from a hospital emergency facility following evaluation and stabilization of a medical condition of recent onset and severity. These admissions may occur after regular business hours. The facility must contact the Health Services Department within 24 hours or the next business day.

Services Requiring Preauthorization
For Preauthorization, contact the Health Services Department at the number at the bottom of this page, or via the internet.

Please notify the Health Services Department at least three to five (3-5) business days prior to rendering the service to allow time for Sendero to complete the preauthorization review process.

All elective surgeries are performed on the day of admission unless, based on medical necessity, the Health Services Department has approved the admission the day prior to surgery.

6.5 Vision Services

Sendero offers vision services through a contracted vendor. This vendor is Envolve Benefit Options. The vision benefit includes a routine eye exam and eyewear. Vision services that are for medical conditions of the eye require a Primary Care Physician's referral to an Ophthalmologist. Questions regarding the routine vision benefit and services for Sendero Members should be directed to Envolve at **1-855-279-9680.**

6.6 Transplant Services

Providers who are caring for Members under consideration for transplant services must notify Sendero. An RN Case Manager will become involved with this Member and follow them through the pre-transplant and final transplantation process. Sendero requires preauthorization for admission to any transplant facility. Any nationally recognized facility will be evaluated for approval based on the medical necessity of services for the Member. For prior approval and to notify of potential transplantation, contact the Sendero Health Services Department at the phone number at the bottom of this page.

6.7 Complex Case Management Program

Sendero provides case management services for catastrophic medical cases or for specific types of health care services through the Complex Case Management Program which can be contacted at 1-855-297-9191. Complex Case Management activities are performed by Sendero Health Services' 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 Health Services at 1-855-297-9191. Referrals are accepted by any person or provider with a concern, such as:

- A child's family/self-referral
- Customer Services Referral
- Behavioral Health Referral
- Member Satisfaction Surveys
- State developed Assessment tool
- Primary Care Provider/ Provider Referral
- Community/ External Agency Referral
- Analysis of claims utilization reports
- Administrator Contract for any State program

Patients with high risk diagnoses or conditions may trigger a complex case management intervention. Sendero's complex case management program involves the Member, family or significant others, physicians, social services, community resources and facility team members, all of whom contribute to decisions regarding care.

When appropriate, the Social Worker/Case Manager refers the Member and family to public health resources. A partial listing of these resources may include the following:

- Texas Health and Human Services Commission (HHSC)
- Supplemental Nutrition Assistance Program (SNAP)
- Women, Infants, and Children Program (WIC)
- Early Childhood Intervention Program (ECI)
- Texas Department of State Health Services (DSHS)
- Texas Department of Aging and Disability Services (DADS)
- Local School Districts as appropriate
- Texas Information and Referral Network (2-1-1, TIRN)
- Texas Department of Rehabilitative Services (DARS)
- Other child-serving civic & religious organizations and consumer & advocacy groups.
- March of Dimes
- American Heart Association
- American Lung Association

The Social Worker/Case Manager arranges social services, community services and other services as needed, including DME.

For more information regarding Sendero's Complex Case Management Program or for additional information on the community agencies, contact Sendero's Health Services Department at 1-855-297-9191.

6.8 Disease Management Programs

Disease Management Programs are largely retrospective oversight of high risk medical conditions. Disease management is designed to prevent exacerbation of symptoms that might result in hospitalization. Disease management is also designed to help Members with specific illnesses deal more effectively with their disease or condition to as to improve their quality of life.

Currently, Sendero offers Disease Management Programs for Attention Deficit Hyperactivity Disorders (and related conditions), Asthma, Diabetes, and high risk pregnancy. These services are designed to increase patient knowledge regarding their health, their disease process, nutrition, medication and importance of compliance with the introduction of community resources available to them. If you encounter a Member that you feel would benefit from one of these programs, please contact the Health Services Department by phone at 1-855-297-9191. A RN Case Manager will be available to help in facilitating the physician based treatment plan in a collaborative effort with the Member's various healthcare providers to help in improving or maintaining the wellbeing of the Member.

6.9 Practice Guidelines

Sendero Health Plans uses clinical practice guidelines to help practitioners and members make decisions about appropriate health care for specific clinical circumstances and behavioral health services.

Please see Appendix D for a list of clinical practice guidelines for medical conditions and preventive care guidelines that Sendero has adopted.

Board certified practitioners, participating in the Sendero Health Plans Provider Advisory Subcommittee, are involved in the adoption of Clinical Practice and Preventive Care Guidelines. The organization approves, adopts promotes the guidelines to practitioners in an effort to improve health care quality and reduce unnecessary variation in care. The guidelines selected are evidence-based and from recognized sources.

The guidelines are reviewed and adopted by Sendero every two years. Reviews are more frequent if national guidelines change within the two-year period. Practitioners are notified of any changes or updates made to the guidelines.

Practitioners are informed via the Practitioner Welcome Packet and annually in the Sendero Provider Newsletter.

You can access the recommended guidelines through the Sendero Health Plans website at **www.senderohealth.com**. This will give you the most up-to-date clinical resources and references from nationally recognized sources.

If you do not have Internet access, you can request a hard copy of the Clinical Practice Guidelines by contacting your Network Representative or by calling 1-855-895-0475.

Our recommendation of these guidelines is not an authorization, certification, explanation of benefits, or a contract. Benefits and eligibility are determined in accordance with the requirements set forth by the state.

7.0 – Billing and Claims

7.1 What is a Claim?

A claim is a request for payment. Sendero 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.

7.2 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 Sendero Member, with the data necessary for Sendero 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, Sendero 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.

7.3 Electronic Claims Submission: ANSI-837

Claim Dates of Service 1/1/2017 – 12/31/2018:
Please note that EDI Payor ID 11440 was deactivated effective 4/1/2019. Claims for dates of service 1/1/2017 – 12/31/2018 submitted after the deactivation date must be submitted directly to:

Sendero Health Plans
ATTN: CLAIMS
2028 E Ben White Blvd, Ste 400
Austin, TX 78741

Claim Dates of Service 1/1/2019 and after:
Sendero accepts claims via 837 electronic claims submission utilizing Change Healthcare and Cognizant as our clearinghouse. Change Healthcare EDI Payor ID = SCS17. Cognizant EDI Payor ID = MV440. Please verify that Change Healthcare or Cognizant can accept your electronic claims or contact your Provider Relations Representative for assistance.

7.4 Submitting Paper Claims to Sendero

Paper claim forms should be mailed to:

Claim Dates of Service 1/1/2017 – 12/31/2018:

Sendero
ATTN: CLAIMS
2028 E Ben White Blvd, Ste 400
Austin, TX 78741

Please note that PO BOX 301425, Houston TX 77230 closed effective 4/1/2019. Claims for dates of service 1/1/2017 – 12/31/2018 sent to PO BOX 301425 after the closure date will be rejected with a notice to re-submit all claims to the correct address: 2028 E Ben White Blvd, Ste 400, Austin, TX 78741.

Claim Dates of Service 1/1/2019 and after:

Sendero
ATTN: CLAIMS
P.O. Box 759
Austin, TX 78767

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.

7.5 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:

Claim Dates of Service 12/31/2018 and prior:

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	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	95 days from the **DATE OF DISCHARGE**

Claim Dates of Service 1/1/2019 and forward:

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

7.6 Timeliness of Payment

Sendero 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 Sendero fail to pay the provider within the thirty days, Sendero follows the Texas Administrative Code Title 28, Part 1, Chapter 21, Subchapter T, Rule 21.2815 for interest and penalty payments to providers.

Sendero 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".

7.7 Coding Requirements: ICD10 and CPT/HCPCS Codes

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

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

Inpatient Institutional Claims: Sendero 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: Sendero 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: Sendero 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.

7.8 Billing Requirements

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

Other Requirements:

- Sendero 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.
- Sendero requires submission of a valid ICD-10-CM preventive diagnosis code as the first pointer in order to be considered for the preventive benefit.

7.8a Billing for Chiropractic Services

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

7.8b Billing for 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).

7.8c Billing for Applied Behavior Analysis Services

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

7.8d National Drug Code Billing Requirements

Effective for dates of service 07/08/2021 and after, Sendero Health Plans 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 Sendero for reconsideration.

7.9 E&M Consult Billing Requirements

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

7.10 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 Sendero.

7.11 Use of Modifier 25

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

7.12 Billing for Assistant Surgeon Services

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

7.13 Billing for Capitated Services

Capitated providers are required to submit encounter claims for all capitated services. Sendero 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.

7.14 Billing for Immunization and Vaccine Services

Sendero 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 Sendero's website for coverage information.

7.15 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 website at https://idealcare.mediview.net, by faxing a request to the Health Services Department at 512-901-9724 or by contacting the Health Services 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.

7.16 Billing for Hospital Observation Services

Facilities are eligible to receive reimbursement for Observation Admissions congruent with the Sendero Evidence of Coverage (up to 24 hours). Sendero 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 Health Services Department at 1-855-297-9191.

7.17 Coordination of Benefits (COB) Requirements

Sendero utilizes a third party vendor to verify COB status on all Sendero Members. Verified information obtained through this process will take precedent on all claim processing. For more information on other coverage please contact Sendero Customer Service. Timely filing requirements apply to COB claims. Claims must be received by Sendero 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 Sendero.

7.18 Collecting from or Billing Sendero Members for Co-pay Amounts

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

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

7.19 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* (see **Appendix A**) 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 Sendero, 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 Sendero. By signing this form, the Member agrees to have the services rendered, and agrees to personally pay for the services. (See **Appendix A** for a copy of this form.)

- ***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 Sendero. (See **Appendix A** for a copy of this form.)

7.20 Providers Required to Report Credit Balances

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

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

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

Sendero 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. Sendero 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.

Claim Dates of Service 1/1/2017 – 12/31/2018:

Level I Appeal Reconsideration
In the event that a provider disagrees with Sendero's denial of a medical and/or claim determination, the provider has the right to submit a request for administrative reconsideration of Sendero'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 for claims dates of service 1/1/2017 – 12/31/2018 may elect to utilize the "Claim Reconsideration/Appeal Request Form – 2018" found in Appendix A. Level I Appeal Reconsiderations must be mailed to:

ATTN: Sendero Reconsiderations
2028 E Ben White Blvd, Ste 400
Austin, TX 78741

Please note that PO BOX 301425, Houston TX 77230 closed effective 4/1/2019. Claim appeals for dates of service 1/1/2017 – 12/31/2018 sent to PO BOX 301425 after the closure date will be rejected with a notice to re-submit all claim appeals to the correct address: 2028 E Ben White Blvd, Ste 400, Austin, TX 78741.

Level II Appeal

If a provider disagrees with Sendero's reconsideration decision, the provider has the right to appeal Sendero'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 for claims dates of service 1/1/2017 – 12/31/2018 may elect to utilize the "Claim Reconsideration/Appeal Request Form – 2018" found in Appendix A. Level II Appeals must be mailed to:

Sendero Health Plans
ATTN: Sendero Appeals
2028 East Ben White Blvd, Suite 400
Austin, TX 78741

Claim Dates of Service 1/1/2019 and after:

Level I Appeal Reconsideration

In the event that a provider disagrees with Sendero's denial of a medical and/or claim determination, the provider has the right to submit a request for administrative reconsideration of Sendero'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 for claims dates of service 1/1/2019 and after may elect to utilize the "Claim Reconsideration/Appeal Request Form – 2019" found in Appendix A. Level I Appeal Reconsiderations must be mailed to:

Sendero Health Plans
ATTN: Sendero Reconsiderations
PO Box 759
Austin, TX 78767

Level II Appeal

If a provider disagrees with Sendero's reconsideration decision, the provider has the right to appeal Sendero'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 for claims dates of service 1/1/2019 and after may elect to utilize the "Claim Reconsideration/Appeal Request Form – 2019" found in Appendix A. Level II Appeals must be mailed to:

Sendero Health Plans
ATTN: Sendero Appeals
2028 East Ben White Blvd, Suite 400
Austin, TX 78741

7.22 Claims & Appeals Questions

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

7.23 Electronic Funds Transfer (EFT)

For your convenience, Sendero is pleased to offer Electronic Funds Transfer (EFT) as a method of receipt for claims payment. You may authorize Sendero to present credit entries into a bank account with minimal paperwork. A copy of the EFT form can be obtained in this Provider Manual in Appendix A, on the Sendero website at **www.senderohealth.com** or by calling your Network Management Representative at 1-855-895-0475.

8.0 – Sendero Quality Program

8.1 Sendero's Quality Improvement Program (QIP)

Sendero's Quality Improvement Program actively monitors and evaluates services provided to health plan enrollees. The program is designed to assist Members of Sendero in receiving appropriate, timely, and quality services rendered in settings suitable to their individual needs while promoting primary preventive care in an effort to achieve optimal wellness.

Authority for the program is received from the Sendero Board of Directors. The Board of Directors receives annual reports concerning the operation of the program from the Quality Improvement Committee.

Annually, a Quality Improvement (QI) Work Plan is developed to identify areas to monitor for the coming year. The QI Work Plan includes monitoring and evaluating the structure, process, and outcomes of the health plans delivery system. The Sendero Board of Directors approves the QI Work Plan.

8.2 Sendero's Provider Quality Measures

The purpose of the Sendero Quality Improvement Program is to identify, monitor, and evaluate clinical and service improvement opportunities. Areas identified for quality activities include:

- Accessibility and Availability of Providers.
- Complaints from Members and Providers
- Emergency Room utilization
- Clinical Performance Improvement Projects
- Member and Provider Satisfaction surveys
- Review of Denials and Appeals
- Continuity of Care reviews
- Medical and Behavioral Utilization Statistics

Sendero monitors after hours accessibility and appointment availability of providers. Providers are expected to follow the standards as defined "*3.0 – Guidelines for Providers"* in this Provider Manual.

8.3 Sendero's HEDIS® Measurements

Sendero is required by the Centers for Medicare and Medicaid (CMS) Health Insurance Marketplace Quality Initiatives to measure and monitor certain clinical metrics that are defined by Health Employer Data Information Sets (HEDIS®). HEDIS® contains specific criteria defined by the National Committee for Quality Assessment (NCQA), the national accrediting agency for Health Plans. The Health Insurance Marketplace Quality Initiatives defined criteria include, but are not limited to, the following:

- Evaluation of well child examinations
- Annual Monitoring for Patients on ACE inhibitor/ARB's, diuretics and Digoxin
- Appropriate Testing for Children with Pharyngitis
- Appropriate Treatment for Children with Upper Respiratory Infection
- Cervical Cancer Screening
- Chlamydia Screening in Women
- Comprehensive Diabetes Care: Eye Exam
- Comprehensive Diabetes Care: Hemoglobin A1c Testing
- Comprehensive Diabetes Care: Medical Attention for Nephropathy
- Controlling High Blood Pressure
- Use of appropriate medications for Members with asthma
- Mental health follow-up appointments following hospitalization (at 7 days and 30 days)
- Follow-Up Care for Children Prescribed ADHD Medication
- Prenatal and postpartum care
- Use of Imaging Studies for Low Back Pain
- Evaluation of Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
- Adult BMI Assessment
- Annual Dentist Visit
- Colorectal Cancer Screening
- Breast Cancer Screening
- Childhood immunizations (Combination 3)
- Human Papillomavirus Vaccination for Female Adolescents
- Immunizations for Adolescents (Combination 1)

The Health Insurance Marketplace Quality Initiatives includes Member Experience Survey Measures. The following are health plan provider related Member Experience Survey Measures:

- Access to Care
- Access to Information
- Aspirin Use and Discussion
- Care Coordination
- Cultural Competence
- Medical Assistance With Smoking and Tobacco Cessation

- Rating of Personal Doctor
- Rating of Specialist

For more information regarding HEDIS® criteria, and monitoring, contact Network Management at the number below.

8.4 Sendero's Quality Improvement Committee

Sendero has a Quality Improvement (QI) Committee which is responsible for oversight and ensuring that quality processes and quality of care is provided to all Members. The QI Committee reviews and approves the annual QI Program and Work Plan. Each committee meeting consists of review of areas associated with the work plan. In addition, all policies and procedures for Sendero are reviewed and approved by this committee. The QI Committee reports to the Sendero Board of Directors.

8.5 How to Get Involved in Sendero's Quality Program

All providers are encouraged to participate in Sendero's Quality Program. This includes participation in the QI Committee. For more information on how to participate in the Quality Program and/or the QI Committee, contact the QI Director at 512-978-8196.

8.6 Provider Report Cards

Sendero Health Plans prepares individual provider report cards that evaluate each provider's performance as it relates to the care of the Members. Practitioners allow the plan to use practitioner performance data. Facilities allow Sendero to use facility performance data. The information is compiled from claims and utilization data and is compared to like providers so that a peer to peer assessment can be completed. For more information regarding the report card, the provider may contact Network Management at the number at the bottom of this page**.**

8.7 Confidentiality

Each physician contracted with Sendero must 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).

Only healthcare providers treating a Sendero Member and essential Sendero employees involved in the coordination of a Member's care are permitted access to medical records and Member-specific information. Essential personnel are defined as those with "a need to know". All Member-specific information shall be maintained in a secure area both in the provider's office and at the Sendero corporate and operational offices.

Verbal and written exchange of Member-specific information is permitted when used for purposes of treatment, payment or operational procedures. Some examples of these purposes may be:

- During professional conferences, consultations and reports that are required as part of the Sendero Utilization Management or Quality Improvement programs.
- Between essential Sendero staff and the healthcare providers involved in the Member's care.
- Healthcare providers include primary care providers, specialists, behavioral health providers and other persons involved in the direct care for a Member at in- and out-patient facilities.

Only pertinent and essential health information is communicated. The general rule of "the least amount of information required to accomplish the task" is followed in all cases.

All Sendero records are the property of Sendero. They may be removed from the Sendero jurisdiction and safe-keeping only in accordance with recognized statues of law, including but not limited to, court order or subpoena.

Copies of hospital medical records of Sendero Members are released according to the policies and procedures of the Medical Records Department of the particular institution and their contract with Sendero.

Copies of the physician office medical records may be released in compliance with state and federal regulations, and the terms of the individual physician's or group's contract with Sendero.

Unauthorized release of confidential information by an employee or agent of Sendero results in disciplinary action, in compliance with Sendero Confidentiality Policy.

Confidential information relating to a Member, is not to be disclosed or published without the prior written consent of the patient, parent, family, or legal guardian.

Any information that is no longer required confidential information is completely destroyed (i.e. shredded, etc.).

8.8 Focus Studies and Utilization Management reporting requirements

In conjunction with the QI Work Plan, Sendero conducts focus studies to look at the quality of care. Examples of focus studies are Continuity of Care between Specialist and PCP, Continuity of Care between Medical Providers and Behavioral Health providers, diabetes care and treatment, and asthma care and treatment.

Utilization Management reports reviewed at the Provider Advisory Subcommittee (summary of subcommittee functions is listed in Credentialing and Re-credentialing section 9.0) and the QI Committee.
Utilization reports include:

- Review of admissions and admission/1,000 Members (Medical and Behavioral Health)
- Review of bed days and bed days/1,000 Members (Medical and Behavioral Health)
- Average length of stay for inpatient admissions (Medical and Behavioral Health)

- ER utilization and health services utilization/1,000 Members
- Denials and appeals
- Other reports as needed to evaluate utilization of services by Membership

For information on any of the above reports, or to see one of these reports, contact the Sendero Health Services Department at **1-855-297-9191.**

9.0 – Credentialing and Re-credentialing

9.1 Credentialing and Re-credentialing Oversight

The Provider Advisory Subcommittee (PAS) is led by Sendero's Medical Director. One of its functions is to review and approve credentialing files of providers who apply to the Sendero network. The Subcommittee meets as often as necessary to complete provider credentialing and re-credentialing activities. There are contemporaneous dated and signed minutes that reflect all Provider Advisory Subcommittee 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 Sendero network and to protect the Members from professional incompetence. The Quality Improvement Committee and the Sendero Board of Directors review all activities of the Provider Advisory Subcommittee related to the credentialing and the re-credentialing of providers for the Sendero network. If you are interested in the PAS, please contact the Health Services Director at 512-978-8176 for more information

Sendero'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 Sendero 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 Sendero Directory. Sendero 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 Sendero Medical Director is accountable for the credentialing and re-credentialing program and the Sendero Provider Advisory Subcommittee, chaired by the Medical Director, functions as the credentialing committee.

9.2 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 Sendero. 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 Sendero.

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.

9.3 Required Office Policies & Procedures

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

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

- **Oversight of Mid-Level Practitioners**: Sendero 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**: Sendero 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.

9.4 Re-Credentialing Requirements

The re-credentialing cycle is three years. The following updated information is required for re-credentialing. Sendero'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 license;
- Current DPS license;
- 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, Sendero 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

9.5 Practitioner Credentialing Rights

❖ You have the right to review information that Sendero 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 PAS 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
2028 E. Ben White Blvd., Suite 400
Austin, TX 78741
(512) 978-8008
Credentialing@senderohealth.com

10.0 – 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 Sendero card
- Using someone else's Sendero 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 Services. You must include Sendero'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:
  - Sendero
    2028 East Ben White, Suite 400
    Austin, TX 78741

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

- **Texas Standard Preauthorization Request Form for Health Care Services**
- **Provider Preauthorization Exemption Correspondence Preference Form**
- **Policy- Physician and Provider Preauthorization Exemptions**
- **Claim Reconsideration/Appeal Request Form – 2018 and prior**
- **Claim Reconsideration/Appeal Request Form – 2019 and after**
- **Pregnancy Notification Form**
- **Specialist Acting as a PCP Request Form**
- **Complaint Form**
- **Provider Information Form (PIF)**
- **Electronic Fund Transfer (EFT)**
- **Member Acknowledgement Statement Form**
- **Private Pay Form Agreement**
- **Sendero ID Cards**

Texas Standard Preauthorization Request Form for Health Care Services

Texas Standard Prior Authorization Request Form for Health Care Services

NOFR001 | 0415 Texas Department of Insurance

Please read all instructions below before completing this form.
*Please send this request to the issuer from whom you are seeking authorization. **Do not send this form** to the Texas Department of Insurance, the Texas Health and Human Services Commission, or the patient's or subscriber's employer.*

Beginning September 1, 2015, health benefit plan issuers must accept the Texas Standard Prior Authorization Request Form for Health Care Services if the plan requires prior authorization of a health care service.

In addition to commercial issuers, the following public issuers must accept the form: Medicaid, the Medicaid managed care program, the Children's Health Insurance Program (CHIP), and plans covering employees of the state of Texas, most school districts, and The University of Texas and Texas A&M Systems.

Intended Use: Use this form to request authorization **by fax or mail** when an issuer requires prior authorization of a health care service. An issuer may also provide an **electronic version of this form** on its website that you can complete and submit electronically, through the issuer's portal, to request prior authorization of a health care service.

Do not use this form to: 1) request an appeal; 2) confirm eligibility; 3) verify coverage; 4) request a guarantee of payment; 5) ask whether a service requires prior authorization; 6) request prior authorization of a prescription drug; or 7) request a referral to an out of network physician, facility or other health care provider.

Additional Information and Instructions:

Section I – Submission:
An issuer may have already entered this information on the copy of this form posted on its website.

Section II – General Information:
Urgent reviews: Request an urgent review for a patient with a life-threatening condition, or for a patient who is currently hospitalized, or to authorize treatment following stabilization of an emergency condition. You may also request an urgent review to authorize treatment of an acute injury or illness, if the provider determines that the condition is severe or painful enough to warrant an expedited or urgent review to prevent a serious deterioration of the patient's condition or health.

Section IV – Provider Information:
- If the Requesting Provider or Facility will also be the Service Provider or Facility, enter "Same."
- If the requesting provider's signature is required, you may not use a signature stamp.
- If the issuer's plan requires the patient to have a primary care provider (PCP), enter the PCP's name and phone number. If the requesting provider is the patient's PCP, enter "Same."

Section VI – Clinical Documentation:
- Give a brief narrative of medical necessity in this space, or in an attached statement.
- Attach supporting clinical documentation (medical records, progress notes, lab reports, etc.), if needed.

***Note**: Some issuers may require more information or additional forms to process your request. If you think more information or an additional form may be needed, please check the issuer's website before faxing or mailing your request.*
***Note**: If the requesting provider wants to be called directly about missing information needed to process this request, you may include the provider's direct phone number in the space given at the bottom of the request form. Such a phone call cannot be considered a peer-to-peer discussion required by 28 TAC §19.1710. A peer-to-peer discussion must include, at a minimum, the clinical basis for the URA's decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision.*

Texas Department of Insurance | 333 Guadalupe | Austin, Texas 78701 | (800) 578-4677 | www.tdi.texas.gov | @TexasTDI

TEXAS PRIOR AUTHORIZATION REQUEST FORM

Sendero Health Services
Phone: 1-855-297-9191
Fax: 512-901-9724

SENDERO HEALTH PLANS

SECTION I — SUBMISSION

Web Authorizations may be completed at www.senderohealth.com

Issuer Name:	Phone:	Fax:	Date:
Sendero Health Plans	1-855-297-9191	512-901-9724	

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: _____

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Provider Preauthorization Exemption Correspondence Preference Form

Change Form:

Provider Preauthorization Exemption Correspondence Preference Form

Keep Sendero up to date about your preferred method of receiving preauthorization exemption correspondence:

*Name of physician or provider*_____

*NPI of physician or provider*_____

*Name of your preferred contact person*_____

How do you prefer to receive preauthorization exemption correspondence from Sendero Health Plans?

(select just one below. If more than one choice is checked, we will use the first method checked. If no choice is selected, we will default to the fax number on file in Sendero credentialing records)

☐ *Fax number:*_____
OR

☐ *Mailing address:* _____
OR (PRINT)

☐ *Email address:*_____
(PRINT)

Signature of Physician or Provider_____***Date***_____

Fax this notice with any changes to Sendero at (512) 901-9724.

Policy- Physician and Provider Preauthorization Exemptions

SENDERO HEALTH PLANS

Policy/Procedure Title: Physician and Provider Preauthorization Exemptions	
Policy/Procedure Number: 696	**Primary Department:** Health Services
Effective Date: 10/01/2022	**Policy Category:** Utilization Management
Last Review Date: 07/01/2022 **Last Revision Date:** N/A, new policy **Next Review Date:**	**Replaces Policy:** N/A
Internal References: *(Related Policies/Desktops)* N/A	**External References:** *(Regulatory/Accreditation)* Texas Insurance Code 4201, Subchapter N *"Exemption From Preauthorization Requirements For Physicians And Providers Providing Certain Health Care Services"*

Policy: Physician and Provider Preauthorization Exemptions
Policy Purpose: To describe for physicians and providers ("Providers") how Sendero Health Plans' processes are designed to align with Texas 87th Legislature House Bill 3459 regarding Texas Insurance Code 4201.653, Subchapter N "Exemption from Preauthorization Requirements for Providers Providing Certain Health Care Services".
Scope: This policy applies to IdealCare products.

Policy: (*Outline of activities and steps used to implement the policy)*

General Preauthorization Exemption Information

Providers must supply Sendero with their preferred way of receiving exemption correspondence for their NPI. Instructions on how to notify Sendero are included on all Sendero exemption correspondence and are published on the Sendero website provider pages in the authorization section.

Sendero will send each exemption approval, denial or rescission notice once to each physician or provider via their preferred method – Fax, Email, or Mail.

Providers are responsible for circulating any received exemption notice to each of their affiliated offices and groups where Sendero Members are treated.

Initial Exemption Determinations

A. Sendero Health Plans (Sendero) will conduct initial exemption determinations once every six months.

1. Providers will be identified for initial exemption review by examining the volume of medical necessity preauthorization determinations by health care service code listed on the preauthorization code lookup list and individual NPI.

2. Each Provider will be eligible for initial exemption review if there were at least five eligible preauthorization requests submitted by the provider and determined during the evaluation period.

3. Sendero will send an "*Initial Notice of Exemption for Certain Healthcare Services*" notice to Providers who meet the exemption threshold of a 90% preauthorization approval rate.

    a. When a provider has received such notification from Sendero, they are not required to obtain preauthorization for the service(s) listed on the notice from Sendero.
    b. Exemptions will be in place for a minimum of six (6) months and unless or until Sendero issues an exemption rescission notice.
    c. Twice-a-year for the exempt services Sendero will conduct retrospective medical necessity reviews to determine if the exemption is subject to rescission.

4. Sendero will send a *Denial of Exemption* notice to Providers identified for initial exemption review not meeting the exemption threshold of a 90% approval rate.

Ongoing Exemption Review and Determinations

A. No more than twice a year, Sendero will conduct retrospective medical necessity reviews of the exempt services.

B. This procedure involves:

1. Selection of a random sample of not fewer then 5 and not more than 20 claims for a particular exempt service for each Provider.
2. Request medical records associated with each claim from each exempt provider using their preferred contact information for exemption correspondence. Sendero will review the records using the medical necessity criteria that would have been used when conducting preauthorization review for the service during the relevant evaluation period (the "Retrospective Medical Necessity Review").
3. Providers will be given 30 calendar days to fax or deliver the necessary records to Sendero. **Time is of the essence in responding**, so Providers should watch carefully at their preferred email, fax number, or mailing address that they provided to Sendero for exemption correspondence for a Sendero

notice titled "Retrospective Review Records Request". **Failure to provide records within the stated timeframe may lead to rescission of the exemption.**

4. Upon receipt of any medical records, Sendero will promptly perform the Retrospective Medical Necessity Review.

C. Continuation of exemption
   1. Through the Retrospective Medical Necessity Reviews, if Sendero determines that 90% or more of the claims for a particular service met the medical necessity criteria the exemption will remain for the service identified in the initial exemption notice.

D. Rescinding an exemption
   1. Preauthorization exemption(s) will be rescinded in the following circumstances:

      a. The semi-annual Retrospective Medical Necessity Review finds less than 90% of the claims for a particular service met the medical necessity criteria.
      b. The provider fails to supply the requested records for the Retrospective Medical Necessity Review within the requested 30 calendar days.

   2. Sendero will notify providers of rescinded exemptions, using a *Notice of Rescission of Preauthorization Exemption* sent via each Provider's preferred exemption communication method.

   3. The exemption will remain in place until 30 days Sendero notifies the provider about the rescission.

Independent Review of Exemption Determination

A. A provider may appeal the rescission decision by

   1. Completing the *"Request for a Review by an IRO"* form contained within the Rescission Notice and faxing it to Sendero at (512) 901-9724 to ask Sendero for an expedited review of the decision by an IRO.
   2. If the appealed rescission was based on failure to send medical records for the retrospective review, the appealing provider must include the medical records with the appeal.

B. Upon receipt of an IRO appeal request, Sendero will send the records to TDI, except that in the case of rescissions caused by lack of records, Sendero may choose to review records submitted with an appeal internally. For appeals forwarded from Sendero to TDI, TDI will assign the case to an IRO. The IRO must make a determination within 30 days after the physician or provider files the appeal. Sendero

will notify the Provider of the IRO appeal outcome within 5 days of receipt of the determination from TDI.

Preauthorization Requests for Exempt Services

A. Any preauthorization requests from a requesting (ordering) Provider for which the Provider is exempt at the time of request will not be processed by Sendero.

Other Information

A. As required by 28 TAC §19.1731 claims from treating physicians or providers must include the name and NPI of the ordering physician or provider on the claim in fields 17 and 17B of CMS Form 1500, or in fields 76-79, or another appropriate field in Form UB-04 or in the corresponding fields for electronic claims using the ASC X12N 837 format. Without this ordering provider information on the claim, Sendero is unable to waive the preauthorization requirement for the service. This means the claim will deny of there is not a medical necessity approval preauthorization in place. (see also TAC 21.2803 *"Elements of a Clean Claim"*.

B. Preauthorization requests for post-acute care must include the name and NPI of the treating provider from the referring facility who is making the decision that post-acute care is needed and requesting the preauthorization.

Attachments: *(List of any attached forms and information related to this policy)*

TDI Rescission Notice

Definitions: *(List of any important terms and definitions related to this policy)*

"Preauthorization exemption" means that a physician or provider who has been notified by Sendero of a preauthorization exemption for a specific healthcare service (e.g., service code or drug) is not-required to obtain a preauthorization for that health care service for members in the health benefit plan specified on the exemption notice.

Policy History: *(List of dates and major changes to this document)*

2022-10 New policy

Approval Signature(s):

_____ _____

Director, Health Services Date

_____ _____

Medical Director Date

Claim Reconsideration/Appeal Request Form – 2018 and prior

CLAIM RECONSIDERATION REQUEST FORM

This form is to be used when a provider is requesting a reconsideration of a previously adjudicated claim but there is no additional or corrected data to be submitted. No new claims should be submitted with this form. Please submit a separate form for each claim.

☐ **Level I Reconsideration:** Sendero Health Plans ATTN: Claims 2028 East Ben White Blvd., Ste 400 Austin, TX 78741	☐ **Level II Appeals:** Sendero Health Plans ATTN: Claims 2028 East Ben White Blvd., Ste 400 Austin, TX 78741

Date form completed: _____

Member information

Member ID:	Claim#:	Date of Service **(must be 12/31/2018 and prior):**
Member Name: Last	First	

Physician/health care professional information

Contact Person:	Phone Number:	Email address:
Mailing address for response:		
Physician Name (as listed on Provider Remittance Advice or Explanation of Payment):		Amount Owed
Facility/Group Name		Tax Identification Number (TIN):

Reason for reconsideration request

1. Timely Filing – Acceptable proof of timely filing includes 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.
2. Pricing
3. Eligibility
4. Code Review
5. Other (explain below)

Description of Claim Reconsideration request

Comments:

If, after you have received a response upon completion of the Claim Reconsideration process, you still do not agree with the outcome of the claim reconsideration, you may submit a Level II Appeal Request to Sendero: ATTN Claim Appeals, 2028 E Ben White Blvd, Ste 400, Austin TX 78741

Claim Reconsideration/Appeal Request Form – 2019 and after

CLAIM RECONSIDERATION REQUEST FORM

This form is to be used when a provider is requesting a reconsideration of a previously adjudicated claim but there is no additional or corrected data to be submitted. No new claims should be submitted with this form. Please submit a separate form for each claim.

☐ **Level I Reconsideration:** Sendero Health Plans ATTN: Claims PO Box 16493 Austin, TX 78761	☐ **Level II Appeals:** Sendero Health Plans ATTN: Claims 2028 East Ben White Blvd., Ste 400 Austin, TX 78741

Date form completed: _____

Member information

Member ID:	Claim#:	Date of Service **(must be 1/1/2019 and after)**:
Member Name: Last	First	

Physician/health care professional information

Contact Person:	Phone Number:	Email address:
Mailing address for response:		
Physician Name (as listed on Provider Remittance Advice or Explanation of Payment):		Amount Owed
Facility/Group Name		Tax Identification Number (TIN):

Reason for reconsideration request

1. Timely Filing – Acceptable proof of timely filing includes 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.
2. Pricing
3. Eligibility
4. Code Review
5. Other (explain below)

Description of Claim Reconsideration request

Comments:

If, after you have received a response upon completion of the Claim Reconsideration process, you still do not agree with the outcome of the claim reconsideration, you may submit a Level II Appeal Request to Sendero: ATTN Claim Appeals, 2028 E Ben White Blvd, Ste 400, Austin TX 78741

Pregnancy Notification Form

Pregnancy Notification Form

Please submit the following information to Sendero Health Plans after the initial prenatal visit to:

- FAX : 512-901-9724
- Call: 1-855-297-9191
- Mail: Sendero Health Plans
  2028 East Ben White Boulevard, Suite 400
  Austin, TX 78741

MEMBER'S NAME:		DATE OF BIRTH:	
Member's ID#:		Member's Phone #	
Member's Address:			
Member's Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
OB's Name:		OB's Phone #:	
Office Contact Person:		Office Fax #:	
Gravida/Para/AB/Living:		Delivery Hospital	
Due Date by Sonogram:		Due date by Dates:	
Risk Factors / Significant Medical History: ☐ Age _____ ☐ Weight _____ ☐ Anemia ☐ Pre-eclampsia/eclampsia ☐ Multiple birth ☐ HIV / STD / Infection ☐ Diabetes ☐ High Blood Pressure ☐ Kidney Disease ☐ Heart Disease ☐ Seizures ☐ Depression/Anxiety ☐ Drugs / Alcohol ☐ Tobacco abuse ☐ Homelessness ☐ Victim of abuse ☐ Previous preterm labor / delivery ☐ Previous miscarriage/SAB/Stillbirth ☐ Other _____			
Date of first appt with this Physician's office:		# Weeks gestation at first office visit:	
Previous Prenatal Care:		Location of Previous Prenatal Care:	
Date of first Prenatal Visit for this pregnancy:		# Weeks gestation at first prenatal visit:	
Comments / Concerns:		Any special needs?	

Standard Length of Stay is two nights following a vaginal delivery and four nights following a Cesarean section.
Please call 1-855-297-9191 if your patient's medical condition warrants a longer stay.

Specialist Acting as a PCP Request Form

SENDERO HEALTH PLANS

Request by Specialist to act as a PCP

Date of Request:	**Date received:**	**Date Review Completed:**
Member Name:	**Guardian Name:**	**Member ID Number:**
Member/Guardian Address:		**Member/Guardian Phone Number:**
PCP on Record		**PCP's Phone Number:**
Specialist Requesting PCP Status		**Specialist's Phone Number:**
Member's Diagnosis/(es)		
Clinical & Historical Data supporting requested action:		

I hereby request to serve as a Sendero Primary Care Physician for the above named member. I accept all responsibility for coordination of all of this member's health care needs and will follow all requirements of a Sendero Primary Care Physician pursuant to any and all contractual obligations.	
Specialist Signature	
Member's Reason for Request	
Member Signature	
Approved YES NO	**Effective Date:** *Note the effective date will not be retroactive"
Medical Director Signature: **Date:**	
Date Sent to Provider Relations	**Date Sent to Customer Services**
Medical Director Signature	**Health Services Manager Signature (Confirming PCP change)**

NM-SPPCP08

Complaint Form

SENDERO HEALTH PLANS

PROVIDER COMPLAINT FORM

Please fill out the form as completely as possible

MAIL: Sendero Health Plans
Attn: Network Management
2028 East Ben White, Suite 400, Austin TX 78741
FAX: 512-901-9704 / **PHONE**: 1-844-800-4693 / **EMAIL**: providers@senderohealth.com

If you disagree with a Sendero claim determination, you must complete the Claim Reconsideration/Appeal Request Form. Claim reconsideration and appeal requests submitted on the Provider Complaint Form will be rejected.

PROVIDER NAME AS NOTED IN PROVIDER DIRECTORY:	**PROVIDER TAX ID:**
PROVIDER TYPE *Please circle one* Ancillary Hospital PCP Specialty Other: _____	
DESCRIPTION OF COMPLAINT: *Please be specific*	
Attaching additional information? Yes No	
EXPECTED OUTCOME:	

Contact Name (print)	Title Date	( ) Phone Number
Signature	E-Mail Address	( ) Fax Number

NM-CF02 rev. 2019-09-30

Provider Information Form (PIF)

SENDERO HEALTH PLANS

Provider Information Form (PIF)

Providers can complete and submit this form to update their provider data file. Please type or print all of the information on this form. E-mail, fax or mail the completed form and any additional documentation to:
Email: *providers@senderohealth.com*
Fax: (512) 901-9704
Mail: Sendero Health Plans, 2028 East Ben White Blvd., Ste 400, Austin, TX 78741

Provider Name: *As noted in the Provider Directory*	**Date:**

TYPE OF ADDS / CHANGES DOCUMENTED (Check Appropriate Box)
- ☐ **Add New Provider**
- ☐ **Change of address**
- ☐ **Change of Provider Status, to include Effective Date (e.g., termination from plan, moved out of area)**
- ☐ **Call Covering Physician (Please indicate in the comments section**
- ☐ **Other (please indicate in the comments section)**

PCP Panel Status: (30 day notice req)
- ☐ **Do not list in Directory**
- ☐ **Closing Panel**
- ☐ **Opening Panel**
- ☐ **Accepting existing patients only**

Physician National Provider Identifier (NPI):
Group National Provider Identifier (NPI) :

Physical Address:	**The Physical address cannot be a PO Box Number**
Street:	City:
County:	State: Zip Code:
Telephone: ( ) -	Fax Number: ( ) -
Email address:	

Secondary Physical Address:	**The Physical address cannot be a PO Box Number**
Street:	City:
County:	State: Zip Code:
Telephone: ( ) -	Fax Number: ( ) -

Remittance/Mailing Address: All Providers who make changes to the Remittance/Mailing address Must submit a copy of the W-9 form along with this PIF.

Street:	City:
County:	State: Zip Code:

Provider Demographic/Directory Information:

Languages Spoken other than English:	Office Hours by Location
Specialty:	

Tax ID Number:
Effective Date:
Provider Name: *As Reported to the IRS:*

Comments:

Provider Signature:	**Date:**
Provider Representative (update per office contact):	**Date:**

NM-PIF05 rev. 2014-03-01

SENDERO HEALTH PLANS

Instructions for Completing the Provider Information Form (PIF)

Form should be typed and forwarded to the Network Management team (see contact information below). No updates will be completed without initial review by the Network Management Team.

Signatures:

- The Provider signature is required on the Provider Information Form for any update involving change to billing ID, or panel closing.
- A signature by the authorized representative of a practice or facility is acceptable for all other requested changes. Provider Rep may submit changes to demographic data and add of provider to practice.

Tax Identification Number (TIN):

- TIN changes for individual practitioner provider numbers can only be made by the individual to whom the number is assigned.
- Performing providers in a group cannot change the TIN.
- The W-9 form is required for all name and TIN changes.

General:

- *E-mail, Fax or Mail the completed form to:*

providers@senderohealth.com

Fax: (512) 901-9704

Sendero Health Plans
2028 East Ben White Blvd, Ste 400
Austin, TX 78741

Internal Use Only

Current provider id#:
Add / Change requested by: **Department:** **Date:** **Add / Change loaded by: Name:** **Date:** **Add / Change filed by: Name:** **Date:**

NM-PIF05 rev. 2014-03-01

Electronic Fund Transfer (EFT)

SENDERO HEALTH PLANS

ELECTRONIC FUNDS TRANSFER

Electronic Funds Transfer (EFT) is a payment method used to deposit funds directly into a provider's bank account. These funds can be credited to either checking or savings accounts, if the provider's bank accepts Automated Clearinghouse (ACH) transactions. EFT also avoids the risks associated with mailing and handling paper checks by ensuring funds are directly deposited into a specified account.

The following items are specific to EFT:

- Pre-notification to your bank occurs on the weekly cycle following the completion of enrollment in EFT.
- Future deposits are received electronically after pre-notification.
- The Remittance and Status (R&S) report furnishes the details of individual credits made to the provider's account during the weekly cycle.
- Specific deposits and associated R&S reports are cross-referenced by both the provider identifiers (i.e. NPI, TPI, API) and R&S number.
- EFT funds are released by **SHP** to depository financial institutions..
- The availability of R&S reports is unaffected by EFT and they continue to arrive in the same manner and time frame as currently received.

SHP must provide the following notification according to ACH guidelines:

Most receiving depository financial institutions receive credit entries on the day before the effective date, and these funds are routinely made available to their depositors as of the opening of business on the effective date. Contact your financial institution regarding posting time if funds are not available on the release date.

However, due to geographic factors, some receiving depository financial institutions do not receive their credit entries until the morning of the effective day and the internal records of these financial institutions will not be updated. As a result, tellers, bookkeepers, or automated teller machines (ATMs) may not be aware of the deposit and the customer's withdrawal request may be refused. When this occurs, the customer or company should discuss the situation with the ACH coordinator of their institution, who in turn should work out the best way to serve their customer's needs.

In all cases, credits received should be posted to the customer's account on the effective date and thus be made available to cover checks or debits that are presented for payment on the effective date.

To enroll in the EFT program, complete the attached Electronic Funds Transfer Authorization Agreement. **You must return a voided check or signed letter from your bank on bank letterhead with the agreement to the SHP address indicated on the form along with a current W-9.**

SENDERO HEALTH PLANS

NOTE: Complete all sections below and attach a voided check or a signed letter from your bank on bank letterhead along with a current W9.

Type of authorization: ☐ New ☐ Change	Line of Business *(check all that apply)*: ☐ IdealCare

Provider name:	Billing TPI or Tax ID/EIN: *(9-digit)*
National Provider Identifier (NPI)/Atypical Provider Identifier (API):	**Primary taxonomy code:**

Provider accounting address: Number Street Suite City State ZIP
Provider phone number:
Provider Request Electronic Funds Transfer (EFT) Yes No

Bank name:	Bank phone number:
ABA/Transit number:	**Account number:**
Bank address:	**Account type:** *(check one)*
	☐ Checking ☐ Savings

I (we) hereby authorize Sendero Health Plans (SHP) to present credit entries into the bank account referenced above and the depository named above to credit the same to such account. I (we) understand that I (we) am responsible for the validity of the information on this form. If the company erroneously deposits funds into my (our) account, I (we) authorize the company to initiate the necessary debit entries, not to exceed the total of the original amount credited for the current pay period.

I (we) will continue to maintain the confidentiality of records and other information relating to clients in accordance with applicable state and federal laws, rules, and regulations.

Authorized signature:	Date:
Title:	**E-mail address:** *(if applicable)*
Contact name:	**Contact phone number:**

Please return this form to:

IdealCare by Sendero Health Plans
Attn: System Support and Development
PO Box 16493
Austin, TX 78761

Member Acknowledgement Statement Form

SENDERO HEALTH PLANS

MEMBER ACKNOWLEDGEMENT STATEMENT FORM

"I understand that, in the opinion of (Provider's name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under the (Program Name) as being reasonable and medically necessary for my care. I understand that Sendero Health Plans determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care."

Signed: _____

Date: _____

Private Pay Form Agreement

Private Pay Agreement

I understand (Provider's name) is accepting me as a private pay patient for the period of (dates of service), and I will be responsible for paying for any services I receive. The provider will not file a claim to Sendero Health Plans for services provided to me.

Signed: _____

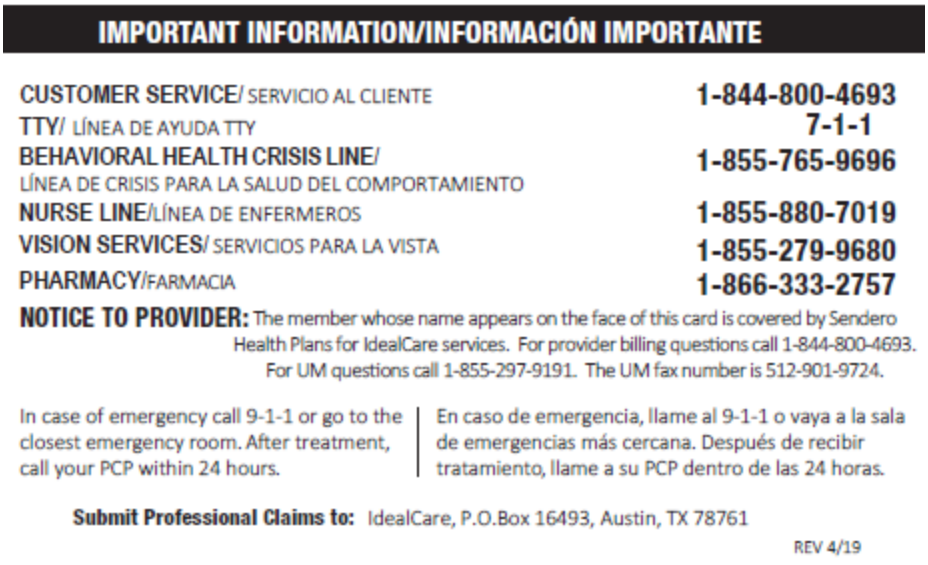
Date: _____

NM-PPAY36

Sendero IdealCare ID card – On Exchange

FRONT

BACK



IMPORTANT INFORMATION/INFORMACIÓN IMPORTANTE

CUSTOMER SERVICE/ SERVICIO AL CLIENTE	**1-844-800-4693**
TTY/ LÍNEA DE AYUDA TTY	**7-1-1**
BEHAVIORAL HEALTH CRISIS LINE/ LÍNEA DE CRISIS PARA LA SALUD DEL COMPORTAMIENTO	**1-855-765-9696**
NURSE LINE/LÍNEA DE ENFERMEROS	**1-855-880-7019**
VISION SERVICES/ SERVICIOS PARA LA VISTA	**1-855-279-9680**
PHARMACY/FARMACIA	**1-866-333-2757**

NOTICE TO PROVIDER: The member whose name appears on the face of this card is covered by Sendero Health Plans for IdealCare services. For provider billing questions call 1-844-800-4693. For UM questions call 1-855-297-9191. The UM fax number is 512-901-9724.

In case of emergency call 9-1-1 or go to the closest emergency room. After treatment, call your PCP within 24 hours.

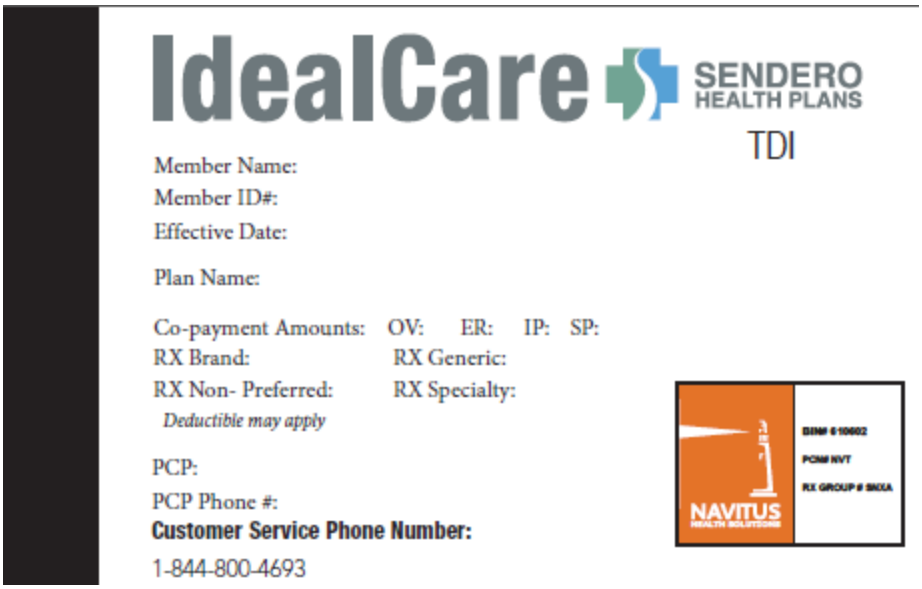
En caso de emergencia, llame al 9-1-1 o vaya a la sala de emergencias más cercana. Después de recibir tratamiento, llame a su PCP dentro de las 24 horas.

Submit Professional Claims to: IdealCare, P.O.Box 16493, Austin, TX 78761

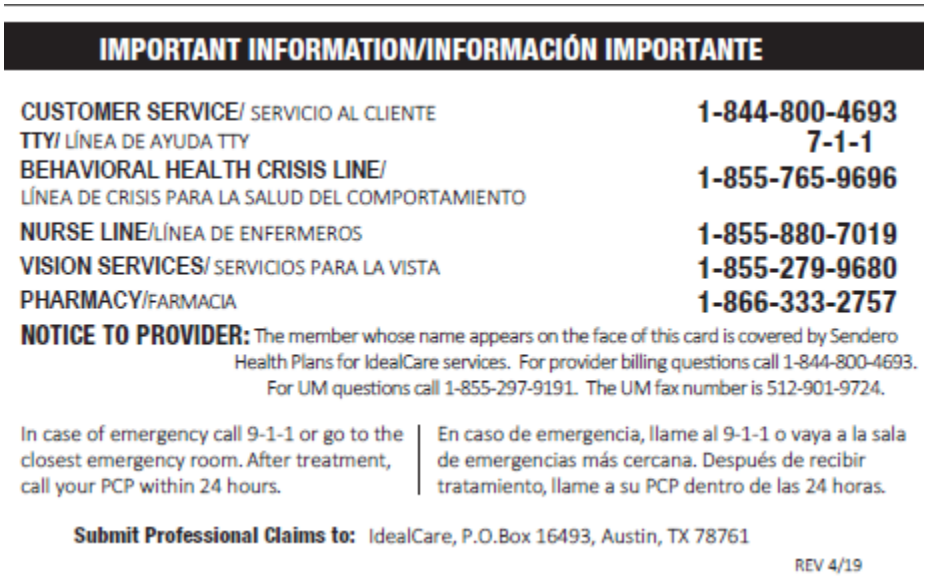
REV 4/19

Sendero IdealCare ID card – Off Exchange

FRONT



BACK



IMPORTANT INFORMATION/INFORMACIÓN IMPORTANTE

CUSTOMER SERVICE/ SERVICIO AL CLIENTE	**1-844-800-4693**
TTY/ LÍNEA DE AYUDA TTY	**7-1-1**
BEHAVIORAL HEALTH CRISIS LINE/ LÍNEA DE CRISIS PARA LA SALUD DEL COMPORTAMIENTO	**1-855-765-9696**
NURSE LINE/LÍNEA DE ENFERMEROS	**1-855-880-7019**
VISION SERVICES/ SERVICIOS PARA LA VISTA	**1-855-279-9680**
PHARMACY/FARMACIA	**1-866-333-2757**

NOTICE TO PROVIDER: The member whose name appears on the face of this card is covered by Sendero Health Plans for IdealCare services. For provider billing questions call 1-844-800-4693. For UM questions call 1-855-297-9191. The UM fax number is 512-901-9724.

In case of emergency call 9-1-1 or go to the closest emergency room. After treatment, call your PCP within 24 hours.

En caso de emergencia, llame al 9-1-1 o vaya a la sala de emergencias más cercana. Después de recibir tratamiento, llame a su PCP dentro de las 24 horas.

Submit Professional Claims to: IdealCare, P.O.Box 16493, Austin, TX 78761

REV 4/19

Appendix B

Provider Complaints and Appeals

A. Sendero 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 Sendero either through telephone contact or through a written complaint.
    a. If the Provider calls into Sendero , 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, Sendero will refer the provider to the Sendero web portal to download the Provider Complaint Form (see Appendix A) 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 Sendero. If after completing Sendero'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, Sendero'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 Sendero.

Appendix C

Benefits, Covered Services, Limitations and Exclusions

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

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 http://senderohealth.com*

Member Rights and Responsibilities

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

MEMBER RIGHTS

Sendero is your partner in managing your health. This partnership is built upon cooperation, with rights and responsibilities for both Sendero 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 Sendero.
- 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 Sendero 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 Sendero in accordance with procedures.

MEMBER RESPONSIBILITIES

As a member, you have the responsibility to:

- Read the Member handbook to learn how Sendero 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 Sendero 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 Sendero 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 Sendero staff and providers.

Member Complaints and Appeals

APPEALS PROCESS

DENIALS OR LIMITATIONS OF DOCTOR'S REQUEST FOR COVERED SERVICES

Sendero may deny health care services that are not considered to be medically necessary. If Sendero 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 Sendero 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 Sendero 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 Sendero 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 Health Services 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 Sendero 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 Sendero may seek review of that determination by requesting an independent federal external review by contacting Sendero or directly to MAXIMUS Federal Services, Inc. by fax or mail.

To request the independent federal external review, please contact Sendero Health Plans at:

Sendero Health Plans
Attn: Appeals Coordinator
2028 E. Ben White Blvd., Ste. #400
Austin, TX 78741
Toll-free phone: 1-855-297-9191
TTY/TDD: 7-1-1
Fax: 512-901-9724
Or

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:

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

HOW TO FILE A COMPLAINT AND APPEAL

If you have concerns about the services you have received from Sendero, a Sendero provider, or any aspect of your health plan benefits, please call us. Call Sendero'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. Sendero 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

Sendero
Preventive and Clinical Practice Guidelines List
2022-2023

Sendero Health Plans evaluates the Sendero membership and maintains Preventive and Clinical Practice Guidelines that are consistent with evidence-based care. Sendero encourages practitioners to make use of the Guidelines when caring for members. Guidelines are updated periodically following review by the Sendero Provider Advisory Subcommittee. The Guidelines can be accessed through the Provider Portal or directly through the Sendero Health Plans website at https://www.senderohealth.com/providers. Please call 1-855-895-0475 to request a copy of a guideline.

IMPORTANT PHONE NUMBERS
NÚMEROS TELEFÓNICOS IMPORTANTES

SENDERO CUSTOMER SERVICES 1-844-800-4693

NETWORK MANAGEMENT 1-855-895-0475

PROVIDER/CUSTOMER SERVICES 1-844-800-4693

HEALTH SERVICES DEPT. 1-855-297-9191

HEALTH SERVICES DEPT. FAX 512-901-9724

www.senderohealth.com