



Timely Access Regulations
for Non-Emergency Health Care Services:
Title 28, CCR, Section 1300.67.2.2 - DMHC Information

For All Prospective Facey Medical Group Contracted Providers

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

The following is a **Summary of the Timely Access Regulations for quick reference.** Plans shall:

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

Rescheduling Appointments:

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

Provider Network Capacity Time-elapsed Standards:

Each Plan must ensure its provider network has adequate capacity and availability to **offer appointments** within these timeframes:

- 1) **Urgent Care** appointments for services that do not require prior authorization: within **48 hours** of request
- 2) **Urgent Care** appointments for services that require authorization: **within 96 hours** of the request
- 3) **Non-Urgent** appointments for **Primary Care**: within **10 business days** of the request
- 4) **Non-Urgent** appointment with **Specialist** physicians: within **15 business days** of the request
- 5) **Non-Urgent** appointments with **a non-physician mental health care provider**: within **10 business days** of the request
- 6) **Non-Urgent** appointments for **ancillary services** for the diagnosis or treatment of injury, illness, or other health condition: within **15 business days** of the request.

Exceptions to Time-elapsed Standards:

- 1) **Waiting time** for a particular appointment **may be extended if** the referring or treating provider, or health professional providing triage or screening services, acting within scope of practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee.
- 2) **Preventive care services and periodic follow-up care**, including standing referrals for chronic conditions, periodic office visits for pregnancy, cardiac or mental health conditions, laboratory and radiological monitoring for recurrence of disease **may be scheduled in advance** consistent with professionally recognized standards of practice as determined by the treating health care provider acting within the scope of practice.

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Timely Access Regulations

Page 2

- 3) Plans may demonstrate compliance with the primary care time-elapased standards by providing advanced access to primary care appointments.
 - a. **Advanced Access** means providing appointments with a PCP (includes NPs) **within the same or next business day** from the time the appointment is requested, and
 - b. Advanced scheduling of appointments at a later date if the enrollee prefers not to accept the appointment offered within the same or next business day.
- 4) The Timely Access Regulation does not apply to Medicare Advantage Plans.

Plans must provide or arrange for the provision of Triage or Screening:

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