

CASE NO. 85525; *Combined with* CASE NO. 85656

IN THE SUPREME COURT OF NEVADA

UNITED HEALTHCARE INSURANCE COMPANY; UNITED HEALTHCARE SERVICES, INC. D/B/A UNITEDHEALTHCARE; UMR, INC. D/B/A UNITED MEDICAL RESOURCES; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.; AND HEALTH PLAN OF NEVADA, INC.,

Appellants/Petitioners,

vs.

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C.; AND CRUM STEFANKO AND JONES, LTD., D/B/A RUBY CREST EMERGENCY MEDICINE.

Respondents/Real Parties in Interest.

Appeal from the Eighth Judicial District Court, Clark County
District Court Case No. A-19-792978
Hon. Nancy L. Allf, District Judge

APPENDIX OF EXHIBITS TO RESPONDENTS' ANSWERING BRIEF

VOLUME 7 OF 13

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APPENDIX OF EXHIBITS TO RESPONDENTS' ANSWERING BRIEF

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CERTIFICATE OF SERVICE

I certify that I am an employee of BAILEY ❖ KENNEDY and that on the 28th day of August, 2023, service of the foregoing **Appendix of Exhibits to Respondents' Answering Brief – Volume 7 of 13** was made by electronic service through Nevada Supreme Court's electronic filing system and/or by depositing a true and correct copy in the U.S. Mail, first class postage prepaid, and addressed to the following at their last known address:

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EXHIBIT 37

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PROVIDER SUMMARY GUIDE

Redacted

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Redacted

PROVIDER SUMMARY GUIDE

SECTION 1

INTRODUCTION

1 – Introduction

Redacted

Dear Provider:

Redacted thanks you for participating in our preferred provider network. Redacted is an affiliate of United Healthcare (UHC), a diversified healthcare company headquartered in Las Vegas, Nevada.

To make your participation with Redacted as easy as possible, our Redacted Provider Summary Guide can be used as a quick reference tool for you and your office staff. Our goal is to make SHL's eligibility, billing, and managed care program procedures easy for you and your office staff to follow. By following the guidelines outlined in the Redacted Provider Summary Guide, we can work together to ensure that quality health care is provided to our members and your patients.

Changes to information contained in the SHL Provider Summary Guide may occur due to changes in policies and procedures. To remain current on SHL policies and procedures, we encourage you to visit our website at www.mySHLprovider.com and also watch for periodic mailings and facsimiles.

If you have any questions or need assistance, please contact the Provider Services Department at **(702) 242-7088 or (800) 745-7065**.

Thank you for being a valued member of the SHL family of providers.

Sincerely,

Provider Services

**SHL
PROVIDER SUMMARY
GUIDE**

SECTION 2

OVERVIEW

Section 2 – Overview



SIERRA HEALTH AND LIFE A UnitedHealthcare Company

Sierra Health and Life Insurance Company, Inc. (SHL) is a UnitedHealthcare Company which provides affordable, accessible and quality health care coverage. We offer a variety of commercial medical and dental, group and individual, as well as Medicare benefit plan options designed to provide services and solutions to meet our member's needs.

Our **Provider Relations and Network Management** department is available to provide ongoing assistance and support to providers and their office staff.

To assist in this process, a **Provider Advocate** is assigned to every contracted provider. Provider Advocates serve as a liaison and are available for staff orientations, ongoing assistance, education and support. Our Advocates conduct on-site visits to provide current, updated information, educational materials, and assist with problem resolution, including claims payment and status.

SHL's **Network Management** team is responsible for the initial contracting of providers, as well as for re-contracting, contract amendments and updates. The Network Management team processes all provider changes, including distributing new and updated information throughout Sierra Health and Life's internal departments, and producing the provider network directories for SHL.

To contact a member of the Provider Relations Department, please call:

Medical:

Las Vegas area
Toll free

(702) 242-7088
(800) 745-7065

Dental:

Las Vegas area
Toll free

(702) 242-7086
(866) 253-8378

Hours of Operation: Monday - Friday 8:00 a.m. - 5:00 p.m. Pacific Standard Time

**SHL
PROVIDER SUMMARY
GUIDE**

**SECTION 3
FREQUENTLY CALLED NUMBERS**

3 - Frequently Called Numbers

Below is a listing of frequently called numbers. The departments listed below are described in greater detail throughout the provider summary guide.

3.1 ACCESS CENTER

Telephone	(702) 242-7716
Toll free	(800) 288-2264
Telephone Advice Nurse (TAN)	(702) 242-7330
Fax	(702) 242-7025

Business Hours: 7 days/week, 24 hours/day Pacific Standard Time

3.2 BEHAVIORAL HEALTHCARE OPTIONS

Las Vegas Prior Authorization	(702) 364-1484
Toll free and Mohave County	(800) 873-2246
Fax	(702) 341-7681

Business Hours: Mon- Fri, 8 a.m. – 5 p.m. Pacific Standard Time

3.3 CASE MANAGEMENT

Telephone	(702) 242-7423
Toll free	(877) 692-2058
Fax	(702) 667-4684
Transplants	(702) 240-8917

Business Hours: Mon. – Fri., 8 a.m. – 5 p.m. Pacific Standard Time

3.4 HOSPITAL CASE MANAGEMENT

For Members in area:

Admit Notification	(702) 242-7770
Concurrent Review	(702) 797-2100
Toll free	(877) 487-6659

For Members out-of-area:

Notification of Admission	(800) 365-9687
Utilization Review	(800) 216-7525
Fax Toll free	(800) 278-8701

Business Hours: Mon. – Fri., 8 a.m. – 5 p.m. Pacific Standard Time

3.5 MEMBER SERVICES DEPARTMENT

Sierra Health and Life	(800) 888-2264
Fax	(702) 240-6281

Interactive Voice Response System (24 hours 7 days a week)

SHL	(702) 242-7393
Toll Free	(800) 768-2808

Business Hours: Mon. – Fri., 8 a.m. – 5 p.m. Pacific Standard Time

3.6 **PROVIDER SERVICES**

Medical:

Telephone	(702) 242-7088
Toll free	(800) 745-7065
Fax	(702) 242-9124

Dental:

Las Vegas area	(702) 242-7086
Toll free	(866) 253-8378
Fax	(702) 242-9124

Business Hours: Mon. – Fri., 8 a.m. – 5 p.m. Pacific Standard Time

3.7 **PHARMACY SERVICES**

Telephone	(702) 242-7050
Toll free	(800) 443-8197
Fax	(702) 242-6751
	(702) 341-7566
Fax Toll free	(800) 997-9672
	(877) 219-1612

Business Hours: Mon. – Fri., 8 a.m. – 5 p.m. Pacific Standard Time

3.8 **PRIOR AUTHORIZATION**

Phone	(702) 242-7330
	(702) 243-8499
Phone Toll free	(800) 288-2264
	(888) 224-4036
Fax	(702) 838-8297
	(702) 304-7411
Fax Toll free	(800) 282-8845

Business Hours: Mon. – Fri., 8 a.m. – 5 p.m. Pacific Standard Time

**SHL
PROVIDER SUMMARY
GUIDE**

SECTION 4

**PROVIDER ADMINISTRATIVE
REQUIREMENTS AND
RESOURCES**

4 - Provider Administrative Requirements and Resources

4.1 Provider Educational Materials

SHL works hard to ensure our network of contracted providers are equipped with the information and tools necessary to deliver quality healthcare to our members. The SHL Provider Summary Guide is one of the many educational tools available to assist providers and their office staff. The Provider Summary Guide is supplied at the time of initial contracting and annually thereafter by the Provider Services Department. The SHL Provider Summary Guide is also available in electronic format by visiting www.mySHLprovider.com. Additionally, important information is communicated between the annual guides by periodic updates on the SHL website, correspondence and faxes to all affected providers.

For copies of the Provider Updates and/or SHL Provider Summary Guide, please contact your Provider Advocate at **(702) 242-7088** or **(800) 745-7065** or visit our website www.mySHLprovider.com.

SHL Website

Another valuable tool available to providers and their office staff is the SHL website located at www.mySHLprovider.com. The SHL website has a section devoted entirely to providers and their office staff. By visiting the SHL website and selecting the "I'm a Doctor/provider", you'll gain access to:

- Online Provider Summary Guide
- Online provider directories
- SHL Preferred Drug Lists, mail-order pharmacy information and plan pharmacies
- SHL clinical guidelines
- UM Protocols
- Information regarding [@YourService](#)
- Credentialing information
- Quality Improvement Information
- Frequently Used Forms
- HEDIS measures
- Star Rating
- Claim reconsiderations/appeals
- Provider News (i.e., health plan updates, provider notifications and ongoing information related to services, care, process changes and legislative and regulatory updates impacting providers).

Online Provider Center- @YourService

Keep track of health plan information the easy way – whenever, wherever.

Convenient and available 24/7, SHL's [online provider center](#) brings health insurance information together in one place. Use this convenient service to:

- View member eligibility and benefits
- Check the status of a claim, referral or prior authorization
- Submit a referral or prior authorization request
- View and print explanation of payments

Each practice should designate an account administrator. Account administrators are responsible for making sure every employee (individual account holder) has a separate username and password, and signs the [Terms of Usage Acknowledgement form](#). The administrator also keeps the forms on file and sends them to Sierra Health and Life upon request. Please review the [Penalties for Violations of Terms of Use](#).

If your office does not currently have an account administrator, you may request an account online through [@YourService](#) (www.myaysonline.com) or refer to **Section 25.2** for the @YourService Administrator Account Request Form. The online provider center tutorial is located on the SHL website and Provider Services is available to answer any specific questions you may have regarding the application.

Please note: Dental pre-determinations must still be submitted through the Claims department.

4.2 Provider Additions, Changes and Terminations

Provide timely notice of demographic changes

SHL is committed to providing our members with the most accurate and up-to-date information about our network.

Proactive notification of changes

As a contracted provider, you are expected to review, update provider records and attest to the information available to our members, including the information listed below, on not less than a quarterly basis. If upon review, you cannot attest to the information because it is inaccurate, you must promptly supply updated information to SHL online, or by mail or fax to Provider Services. In addition, you must proactively notify SHL of changes to all provider information, including the information listed below, as well as the addition of new information and the removal of outdated information, not less than 30 days in advance of the effective date of the change. Providers are responsible for notifying SHL of these changes for all of the participating providers credentialed within their group. If you fail to update provider records, or give 30 days prior notice of changes, or fail to attest to the information available to our members, you or the participating providers within your group may be subject to penalties, including but not limited, to the delay of processing claims, or the denial of claims payment until the provider records are reviewed and attested to, or corrections submitted.

You are required to update all provider information, including but not limited to the following:

- The status as to whether the participating provider is accepting new patients or not,
- The address(es) of the office locations where the participating provider currently practices,
- The phone number(s) of the office locations where the participating provider currently practices,
- The email address of the Office Administrator,
- If the participating provider is still affiliated with listed provider groups,
- The hospital affiliation(s) of the participating provider,
- The specialty of the participating provider,
- The board certification(s) of the participating provider,
- The license(s) of the participating provider,
- The tax identification number used by the participating provider,
- The NPI(s) of the participating provider,

- The languages spoken/written by the participating provider or the staff,
- Whether the participating provider is an Indian Health Service Provider,
- The ages/genders served by the participating provider,
- Office hours,
- And in the event of a departure of health care providers from your practice, we ask that you notify us immediately to allow sufficient time for Member notification.

To Change Status of Panel (Open/Closed)

If you wish to change your panel status with regard to being open to new patients, open to existing patients only, or closed, the request must be made in writing 30 days in advance.

Administrative Terminations for Inactivity

Up to date directories are a critical element of providing our members with the information they need to manage their health. In an effort to accurately reflect providers who are actively treating SHL members in our directories, SHL will take the following actions:

1. SHL may administratively terminate provider agreements for providers who have not submitted claims for a period of one (1) year on the basis that they are not actively treating SHL members, and have voluntarily ceased participation in our provider network.
2. SHL may inactivate any tax identification numbers (TINs) under which there have been no claims submitted for a period of one (1) year on the basis that they are not in active use. Because other TINs associated with a particular agreement have been active, this is not a termination of the agreement with the provider. Providers may contact SHL to reactivate an inactivated TIN.

When providers tell us of practitioners leaving a practice, we make multiple attempts to get documentation of that change.

Effective January 1, 2018, we administratively terminate a care provider if:

- We get oral notice that a practitioner is no longer with the practice, and
- We make three (3) attempts to obtain documentation confirming the practitioner's departure, but do not receive the requested documentation, and
- The practitioner has not submitted claims under that practice's TIN(s) for six (6) months prior to our receipt of oral notice the practitioner left the practice, or the effective date of departure provided to us, whichever is sooner.

Provide official notice

You must send notice to us at the address noted in your agreement with us and delivered via the method required, within 10 calendar days of your knowledge of the occurrence of any of the following:

- Material changes to, cancellation or termination of, liability insurance;
- Bankruptcy or insolvency;
- Any indictment, arrest or conviction for a felony or any criminal charge related to your practice or profession;
- Any suspension, exclusion, debarment or other sanction from a state or federally funded health care program;
- Loss, suspension, restriction, condition, limitation, or qualification of your license to practice;

- For physicians, any loss, suspension, restriction, condition, limitation or qualification of staff privileges at any licensed hospital, nursing home, or other facility; or
- Relocation or closing of your practice, and, if applicable, transfer of member records to another physician/facility

To add a physician or health care provider, please complete a Provider Add Request form in Section 23.3 and fax it back to SHL at (702) 266-8809.

For all other additions, changes, or provider terminations, please fax notification on your company letterhead to SHL at (702) 266-8782.

4.3 After-Hours Access

SHL establishes standards for after-hours care to ensure timely access for our members. Performance against these established standards is measured continually by the Provider Services Department.

After-hours care:

We ask that you and your practice have a mechanism in place for after-hours access to make sure every member calling your office after-hours is provided emergency instructions, whether a line is answered live or by a recording. Callers with an emergency are expected to be told to:

- Hang up and dial 911
- Go to the nearest emergency room
- In non-emergent circumstances, we would prefer that you advise callers who are unable to wait until the next business day to:
 - Go to an in-network urgent care center,
 - Stay on the line to be connected to the physician on call,
 - Leave a name and number with your answering service (if applicable) for a physician or qualified health care professional to call back, or
 - Call an alternative phone number to contact you or the physician on call.

4.4 Dental Access Standards

DENTIST agrees to the following standards:

Sierra Health and Life Insurance Company, Inc. (SHL) Access Standards

- Twenty-four hour dental emergency care
- Routine exams, recall and preventive therapy must be scheduled within three (3) weeks
- Routine hygiene procedures must be scheduled within thirty (30) days

4.5 Access to Records

We may request copies of medical records from you in connection with our utilization management/care management, quality assurance and improvement processes, claims payment and other administrative obligations, including reviewing your compliance with the terms and provisions of your agreement with us, and with appropriate billing practice. If we request medical records, you will provide copies of those records free of charge unless your participation agreement provides otherwise. In addition, you must provide access to any

medical, financial or administrative records related to the services you provide to our members within 14 calendar days of our request or sooner for cases involving alleged fraud and abuse, a member grievance/appeal, or a regulatory or accreditation agency requirement, unless your participation agreement states otherwise. These records must be maintained and protected for confidentiality as applicable with state statutes or federal regulations. For example, for Medicare Advantage plans, you must maintain and protect the confidentiality of the records for at least 10 years or longer if there is a government inquiry/investigation. You must provide access to medical records, even after termination of an agreement, for the period in which the agreement was in place.

4.6 Non-discrimination

You must not discriminate against any patient, with regard to quality of service or accessibility of services, on the basis that the patient is a member of Sierra Health and Life or its affiliates, or on the basis of race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability, disability, genetic information, or source of payment. You must maintain policies and procedures to demonstrate you do not discriminate in delivery of service and accept for treatment any members in need of the services you provide.

4.7 Divorce of Patient Care

SHL recognizes that there may be extenuating circumstances when it becomes necessary for a physician to divorce patient care and terminate the physician-patient relationship. Divorce of patient care is something that SHL takes very seriously and should be a last resort. It is important to note that capitated providers may be responsible for further charges.

If, after reasonable effort, the physician is unable to establish and maintain a satisfactory relationship with a member, the physician may request that the member be discharged from care and transferred to an alternate physician. Reasons for discharge include:

- Disruptive behavior
- Physical threats/abuse
- Verbal abuse
- Gross non-compliance with the treatment plan

Note: You must provide adequate documentation in the member's medical record of the verbal and written warnings. The physician is obligated to provide care to the member until it is determined that the member is under the care of another physician.

To divorce patient care, please follow the steps outlined below:

- Provide the patient with written notification via certified mail of your intent to divorce care
- Copy the health plan on all divorce of care correspondence
- Allow the patient thirty (30) days to find alternative care

Copy of the Divorce of Patient Care letter should be mailed or faxed to the Provider Services Department at:

SHL Provider Services
Attention: Provider Services Advocate

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P.O. Box 15645
Las Vegas, NV 89114-5645
Fax (702) 242-9124

If you have questions regarding divorce of patient care please contact the Provider Services Department at **(702) 242-7088 or (800) 745-7065**.

**SHL
PROVIDER SUMMARY
GUIDE**

**SECTION 5
CREDENTIALING**

5 - Credentialing

Credentialing is the process of assessing and validating the qualifications of a licensed independent practitioner to provide services for Sierra Health and Life (SHL) members.

Credentialing is a requirement for participation in the HPN provider network(s) and all providers must be credentialed prior to contracting. Re-credentialing is conducted every three (3) years, unless the Credentialing Committee specifies a shorter period between reviews, issues are identified, or special credentialing is required to align the provider's credentialing with SHL's credentialing schedule. SHL's credentialing process complies with the National Committee for Quality Assurance (NCQA) credentialing standards, the credentialing requirement of the Centers for Medicare & Medicaid Services (CMS, formerly known as HCFA), and the State of Nevada Medicaid Contract.

It is the Credentialing Committee's policy that if all information required to complete the credentialing process is not received, in its entirety, within 180 days the application will be withdrawn from the process.

For questions regarding credentialing, please contact the Credentialing Department at (702) 242-7559.

5.1 Credentialing Committee

The Credentialing Committee is a peer review body, which includes representation by providers practicing in SHL's network. The committee is also a multidisciplinary committee with representation from various types of practitioners. Other members of the committee include medical management and administrative staff. Practitioners are the only voting members of the committee. The Credentialing Committee meets a minimum of eight (8) times per year.

5.2 Providers Eligible for Credentialing

SHL has established credentialing standards for the following practitioners:

Physicians:

MD, DO, DMD, DDS, DC, DPM, OMD

Extenders:

APN (including NP, CNM), CNS, CRNA, PA-C

Allied practitioners:

OD, PT, OT, SLP, Audiologists, BCAB (Board Certified Behavior Analyst) and Autism Behavioral Interventionist

Non-physician behavioral health practitioners, who may or may not be master's prepared:

Practitioners, who are "Registered" or "Intern" licensed by the state in which they are practicing. Examples include, but are not limited to: marriage and family therapists; professional counselors; mental health counselors, alcoholism and drug abuse practitioners and clinical social workers.

Effective October 1, 2017, a NV State approved credentialing application will no longer be required for **HOSPITAL BASED** providers to participate in the various Health Plan of Nevada (HPN) and Sierra Health and Life (SHL) provider networks. The provider types included in this update are Anesthesiologists, Hospitalists, Neonatologists, Pathologists and Radiologists. A Provider Add Request Form and a Hospital Based Provider Enrollment Form must still be submitted for consideration in order to participate as a participating provider under the specific provider group contract. For APRN's (as applicable), PAC's or other physician extenders, an APRN/PA Competency Statement Form must be submitted along with the aforementioned forms.

5.3 SHL Credentialing Process

The SHL credentialing process includes:

1. Completion, by the provider, of the credentialing application and submission of evidence of professional licensure, malpractice insurance, DEA and state pharmacy certificates. The application must include attestations regarding:
 - Reasons for any inability to perform the essential functions of the position, with or without accommodation,
 - Lack of current illegal drug use and/or sobriety (completion of Health Status Form)
If applicable: SHL requires you to provide the address and a full description of any rehabilitation program in which you are now participating or have participated in and to complete a Health Status Form which provides the name and title of the individual/organization (counselor / diversion program / treating provider) who can advocate on behalf of your sobriety status and/or program completion.
 - History of loss of license or disciplinary activity,
 - Felony convictions,
 - History of loss or limitation of privileges or disciplinary activity,
 - History of any malpractice claim or report to the National Provider Database (NPDB) or Healthcare Integrity and Protection Data Bank (HIPDB),
 - Current malpractice insurance coverage,
 - Correctness and completeness of the application.
2. Primary verification by SHL of the provider's credentials and query of appropriate monitoring agencies.

Verification of information from primary sources:

- License: confirmation from appropriate state agency of license validity, expiration and information as to past, present or pending investigations or sanctions
- DEA certificate and/or state Pharmacy license
- Education and training: graduation from medical school, completion of a residency, board certification (if applicable), graduation from an ACGME professional school (if applicable), etc.
- History of professional liability claims which resulted in settlements or judgments paid by or on behalf of the provider

Queries performed:

- National Practitioner Data Bank
- Medicare and Medicaid Sanction Report
- NPI
- SAM

3. Review and approval or disapproval by the Credentialing Committee
4. Notification to the provider of the Credentialing Committee's decision. Initial Credentialing notification will come from Network Development and Contracts within sixty (60) days of the decision. There will be no notification of positive recredentialing decisions. Decisions to deny initial or renewal of credentialing will be communicated in writing by the Credentialing Department.

At the time of recredentialing, SHL also considers quality indicators. These indicators may include data from member complaints, results of quality reviews, utilization management and patient satisfaction surveys.

Between credentialing cycles, SHL conducts ongoing monitoring of practitioner sanctions and complaints and takes appropriate action against practitioners when occurrences of poor quality are identified. Monitoring of sanctions includes a review of information for Medicare and Medicaid sanctions and limitations or sanctions on licensure. SHL also monitors complaints against practitioners for both quality of care and quality of service issues.

An office site visit and a review of medical record keeping practices are conducted for all PCPs and OB/GYN's at the time of initial credentialing. (HPN monitors for deficiencies subsequent to the initial site visit through member complaints, feedback from health plan staff and other data. If deficiencies are identified, HPN re-evaluates the site and works with the practitioner's office to institute actions for improvement, review and approval or disapproval by the Credentialing Committee).

Practitioners are required to notify SHL within 15 days of any loss of licensure, loss of privileges or Medicare/Medicaid sanctions and exclusions.

5.4 Expired Credentialing

Providers are required to be recredentialed every three (3) years. All SHL providers must be willing to cooperate in the recredentialing process and provide a completed re-credentialing application and any other requested documentation in a timely manner.

Six months prior to the end of the three-year credentialing cycle SHL sends a letter and an abbreviated re-credentialing application (preprinted demographic profile, screening questions and Consent and Release, including an attestation/signature page). Providers must return their application within 60 days. If a provider does not return a completed application in the appropriate time frame, Network Development and Contracting will send a certified letter to the provider advising his/her contract is in jeopardy of termination. Any provider whose contract is terminated will no longer be paid as a contracted provider. A provider whose credentialing has expired may apply for initial credentialing, however, any historical credentialing-related information SHL has regarding the provider (e.g., previous claims history, sanctions or restrictions history, or performance information) is used in consideration of that application and the provider's rights and privileges from previous credentialing are lost.

5.5 Provider Rights

Practitioners are provided the opportunity to review information submitted in support of their credentialing applications. This evaluation includes information obtained from outside primary sources (e.g., malpractice insurance carriers or state licensing boards). In the event that credentialing information obtained from other sources varies substantially from that provided by

the practitioner, SHL notifies the provider. This review does not include references or recommendations or other information that is peer review protected.

Practitioners also have the right to correct erroneous information submitted by another party for use in the credentialing process. The corrected information must be submitted in writing.

Practitioners have the right to be informed of the status of their application upon request. Practitioners may call the Credentialing Department at **(702) 242-7559**.

Network Development and Contracting notifies the practitioner of the final positive initial credentialing decision within sixty (60) days. The Credentialing Department notifies the practitioner of any negative decision within sixty (60) days.

5.6 Provider Credentialing Disapproval Reasons

A practitioner may be disapproved by the Credentialing Committee for any of the following:

At the time of initial credentialing:

- The practitioner has been disciplined by the licensing board of any state in which he/she is or has been licensed, registered, certified, or otherwise authorized to practice;
- The practitioner has been convicted, whether as a result of a guilty plea, a plea of nolo contendere or a verdict of guilty, of a felony, any offense involving moral turpitude, or any offense related to the practice of, or the ability to practice, medicine or the related healing arts;
- The practitioner has been expelled or suspended from the Medicare or Medicaid programs;
- Gross or repeated malpractice which may be evidenced by claims of malpractice settled against the practitioner or by judgments of malpractice against the practitioner;
- Aggregate malpractice settlements in excess of established thresholds;
- The practitioner has made a misrepresentation or a false, misleading, inaccurate or incomplete statement in his/her application;
- The practitioner has been voluntarily or involuntarily suspended or expelled from any hospital medical staff, has had his/her hospital privileges suspended, revoked or limited, or has had action by a managed care organization that affected his/her participation, or
- Other reasons deemed by the committee to be appropriate.

At the time of re-credentialing:

- Any of the issues specified above under "Initial Credentialing";
- Unsatisfactory performance, including:
 - Quality of care issues;
 - Risk management issues;
 - Non-care complaints;
 - Satisfaction survey results;
 - Site visit or medical record review results;
 - Number of member complaints; or
 - Other issues as identified by the Credentialing Committee.

A practitioner seeking participation in the SHL Network who has been reviewed by the Credentialing Committee and has been disapproved for initial credentialing will not be allowed to reapply for one (1) year from the date of the denial. If a practitioner is disapproved by the CC two or more times, he/she will not be allowed to reapply for the number of years equal to the number of denials he/she has received from the date of the last denial.

A practitioner, to whom the Committee determines it intend to deny recredentialing in the HPN Network, is offered the opportunity to respond to the identified issues within 10 business days of notification of the pre-denial. Notification is sent to provider's address of record by Certified Mail. The practitioner may rebut, send new or additional evidence or explain issues in further detail. The Credentialing Committee will review the information submitted by the practitioner prior to making a final decision. **If no response is received from the affected practitioner within 10 business days, the Credentialing Committee will proceed with the denial following and the processes/procedures detailed in the "Practitioner Fair Hearing Procedure".**

5.7 Operational Policy Decisions

Practitioners requesting participation in the SHL network as a specialist or generalist must furnish evidence of training related to the contracted area of practice. In support of this requirement the Credentialing Committee has defined the following criteria for credentialing of generalists and certain specialties:

1. Regarding the requirements to be credentialed as a general specialist (as of September 2006):

POLICY: Any practitioner contracting with SHL to serve as a general specialist must meet requirements determined by the Credentialing Committee. Practitioners seeking contracts to provide general medical care in a non-PCP setting are evaluated on a case-by case basis. This evaluation is based on evidence the practitioner has provided to demonstrate appropriate education and training preparation to act as a general specialist.

During its evaluation the Credentialing Committee will consider the practitioner's: 1) prior and continuing education; 2) training; 3) experience; 4) utilization practice patterns; and 5) current ability to perform this work in a hospital setting.

2. Regarding the requirements to be credentialed as a Pain Management Specialist (as of April 2005):

DEFINITION:

Intractable pain affects millions of people worldwide and can decimate the pain sufferer's quality of life, destroying his ability to work and to interact with friends and family. Although a multidisciplinary approach and conservative treatment with a variety of medications often brings pain relief, a subset of patients require more aggressive management using interventional approaches.

INDICATIONS:

The specialty of Pain Management is reserved for physicians who have been credentialed as pain management providers by the Credentialing Department of Sierra Health and Life.

Provider Services can request an exception be approved by the CMAC on a case-by-case basis for the rural areas and underserved areas where there is not a qualified provider. A comprehensive review by our internal pain specialist will be performed as needed.

Other providers can contribute to the management of pain as far as it is within their scope of practice. Only providers recognized by the Health Plan to be Pain Management specialists may perform invasive pain management procedures.

3. Regarding the requirements to be credentialed as a Hospitalist (as of July 2002):

POLICY: The Credentialing Committee requires that any practitioner contracting with SHL to serve as a Hospitalist must provide evidence of completion of an approved AOA or ABMS residency as a Family Practitioner, Internal Medicine Practitioner, or a Pediatric Practitioner or hold board certification in one of these specialties.

5.8 Provider Fair Hearing Procedure

Element	Procedure
Law	Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11101-11102 Sec. 11111. – Professional review (a) In general (1) Limitation on damages for professional review actions If a professional review action (as defined in section 11151(9) of this title) of a professional review body meets all the standards specified in section 11112 (a) of this title, except as provided in subsection (b) of this section – (A) the professional review body, (B) any person acting as a member or staff to the body, (C) any person under a contract or other formal agreement with the body, and (D) any person who participates with or assists the body with respect to the action, shall not be liable in damages under any law of the United States or of any State (or political subdivision thereof) with respect to the action. The preceding sentence shall not apply to damages under any law of the United States or any State relating to the civil rights of any person or persons, including the Civil Rights Act of 1964, 42 U.S.C. 2000e, et seq. and the Civil Rights Acts, 42 U.S.C. 1981, et seq. Nothing in this paragraph shall prevent the United States or any Attorney General of a State from bringing an action, including an action under section 15c of title 15, where such an action is otherwise authorized. (2) Protection for those providing information to professional review bodies Notwithstanding any other provision of law, no person (whether as a witness or otherwise) providing information to a professional review body regarding the competence or professional conduct of a physician shall be held, by reason of having provided such information, to be liable in damages under any law of the United States or of any State (or political subdivision thereof) unless such information is false and the person providing it knew that such information was false. Sec. 11112. – Standards for professional review actions (a) In general For purposes of the protection set forth in section 11111 (a) of this title, a professional review action must be taken – (1) in the reasonable belief that the action was in the furtherance of quality health care, (2) after a reasonable effort to obtain the facts of the matter, (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3). A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in section 11111 (a) of this title unless the

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Element	Procedure
	presumption is rebutted by a preponderance of the evidence. (b) Adequate notice and hearing A health care entity is deemed to have met the adequate notice and hearing requirement of subsection (a)(3) of this section with respect to a physician if the following conditions are met (or are waived voluntarily by the physician): (1) Notice of proposed action The physician has been given notice stating - (A) (i) that a professional review action has been proposed to be taken against the physician, (ii) reasons for the proposed action, (B) (i) that the physician has the right to request a hearing on the proposed action, (ii) any time limit (of not less than 30 days) within which to request such a hearing, and (C) a summary of the rights in the hearing under paragraph (3). (2) Notice of hearing If a hearing is requested on a timely basis under paragraph (1)(B), the physician involved must be given notice stating - (A) the place, time, and date, of the hearing, which date shall not be less than 30 days after the date of the notice, and (B) a list of the witnesses (if any) expected to testify at the hearing on behalf of the professional review body. (3) Conduct of hearing and notice If a hearing is requested on a timely basis under paragraph (1)(B) - (A) subject to subparagraph (B), the hearing shall be held (as determined by the health care entity) - (i) before an arbitrator mutually acceptable to the physician and the health care entity, (ii) before a hearing officer who is appointed by the entity and who is not in direct economic competition with the physician involved, or (iii) before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved; (B) the right to the hearing may be forfeited if the physician fails, without good cause, to appear; (C) in the hearing the physician involved has the right - (i) to representation by an attorney or other person of the physician's choice, (ii) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof, (iii) to call, examine, and cross-examine witnesses, (iv) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and (v) to submit a written statement at the close of the hearing; and (D) upon completion of the hearing, the physician involved has the right - (i) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and (ii) to receive a written decision of the health care entity, including a statement of the basis for the decision. A professional review body's failure to meet the conditions described in this subsection shall not, in itself, constitute failure to meet the standards of subsection (a)(3) of this section.

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Element	Procedure
	(c) Adequate procedures in investigations or health emergencies For purposes of section 11111 (a) of this title, nothing in this section shall be construed as: (1) requiring the procedures referred to in subsection (a)(3) of this section - (A) where there is no adverse professional review action taken, or (B) in the case of a suspension or restriction of clinical privileges, for a period of not longer than 14 days, during which an investigation is being conducted to determine the need for a professional review action; or (2) precluding an immediate suspension or restriction of clinical privileges, subject to subsequent notice and hearing or other adequate procedures, where the failure to take such an action may result in an imminent danger to the health of any
Hearing Panel	A Hearing Panel shall be appointed as required in policy. The Medical Director shall request the appointment of a Hearing Panel composed of an odd number (at least three (3) of the Practitioner's peers).
Hearing Procedure	Personal Presence. The personal presence of the Practitioner at the hearing is required. A Practitioner who fails without good cause to appear and proceed at the hearing waives his rights to a hearing. Presiding Officer. Sierra's Medical Director, or his or her designee, shall designate an attorney at law to serve as the Presiding Officer at the hearing. The Presiding Officer may be legal counsel to Sierra, but shall not act as the prosecuting officer or as an advocate for either side at the hearing. The Presiding Officer may participate in the private deliberations of the Hearing Panel and may be a legal advisor to the Panel, but may not vote on the Panel's recommendations. The Presiding Officer shall be responsible for assuring that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence, and that decorum is maintained throughout the hearing. The Presiding Officer shall oversee and supervise the entire hearing process, and shall have the sole authority and discretion to rule on all questions such as those pertaining to discovery, procedure, and the admissibility of evidence. Representation. The Practitioner has the right to representation by an attorney or other person of his choice. The body whose actions constituted the adverse recommendation shall appoint an individual to represent it as spokesman, and also may be entitled to be represented by an attorney. Rights of Parties. At the hearing, each party may: 1. Be represented by an attorney or other person of the party's choice; 2. Have a record made of the proceedings and to obtain a copy of that record upon payment of any reasonable charges associated with the preparation thereof; 3. Call, examine, and cross-examine witnesses; 4. Present evidence determined to be relevant by the Presiding Officer, regardless of its admissibility in a court of law; and, 5. Submit a written statement at the close of the hearing. Procedure and Evidence. This is not a de novo hearing. The hearing need not be conducted strictly according to the rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs may be considered, regardless of the admissibility of such evidence in a court of law. Each party is entitled, prior to or during the hearing, to submit memoranda concerning any issue of law or fact, and those memoranda become part of the hearing record.

Element	Procedure
Burden of Proof	The Practitioner has the burden of proving by a preponderance of the evidence, that the adverse action or recommendation is arbitrary and capricious. The body whose adverse action or recommendation occasioned the hearing has the initial obligation to present evidence in support thereof, but the Practitioner thereafter is responsible for supporting, by a preponderance of the evidence, his challenge that the adverse action or recommendation was arbitrary and capricious.
Consideration of New or Additional Matter.	Consideration of New or Additional Matter. New or additional matters or evidence not raised or presented during the original consideration by the Credentialing Committee may be introduced at the hearing only at the discretion of the Hearing Officer, only if the party requesting consideration of the matter or evidence shows that it could not have been discovered in time for the Committee's review. The requesting party shall provide, a written substantive description of the matter or evidence to the Hearing Officer and the other party at least three (3) days prior to the scheduled date of the review.
Post Hearing	Post Hearing: Within fifteen (15) days after final adjournment of the hearing, the Hearing Panel shall make a written report of its findings and recommendations; and a copy of its findings and recommendations shall be sent to the Plan and the affected Practitioner. If the Hearing Panel's result is favorable to the Practitioner, it is effective immediately. If the Hearing Panel's result is not favorable to the Practitioner the decision will be forwarded to the Credentialing Committee for review and action.

5.9 Confidentiality of Credentialing Information

Through its credentialing policies and procedures, SHL ensures the confidentiality of information obtained in the credentialing process, except as otherwise provided by law. SHL is required to provide information about a provider's educational preparation, board certification and re-certification status, and names of hospitals where a provider has admitting privileges, as well as the number of years of practice as a physician and as a specialist.

5.10 Office Site Visits

SHL conducts site visits that result in a structured review of the office site, including physical accessibility, physical appearance, adequacy of waiting and examining room space, availability of appointments, and medical/treatment record-keeping practices.

Site visits are conducted by an SHL representative who is trained to perform a structured review of the site and to assess the adequacy of treatment recordkeeping. This reviewer works closely with the Vice President of Healthcare Quality and Education to make recommendations to the Credentialing Committee Chair and/or Credentialing Committee and, when necessary, to oversee corrective action plans with individual practitioner offices.

Site visits are considered site or location based. The site visit is effective for all practitioners who are at or who join a site or location. Results of the site visit are considered at the time of the Credentialing Committee's review and then communicated to the practitioner's office in a follow-up letter.

SHL conducts an initial site visit for all locations at which PCPs, OB/GYNs, and high-volume behavioral healthcare practitioners provide services. SHL also conducts an initial site visit when a practitioner relocates or opens a new site and the site has never been evaluated. SHL does not conduct a site visit for new practitioners who join existing groups or for practitioners who relocate, if the office was previously reviewed and meets SHL standards. SHL also does not conduct site visits for a behavioral health practitioner who becomes high-volume subsequent to the practitioner's initial credentialing or for a behavioral health practitioner who was previously categorized as high-volume and is re-categorized as low-volume.

SHL conducts ongoing monitoring to detect deficiencies after the initial site visit. In order to respond as quickly as necessary to subsequent deficiencies, monitoring is conducted in a concurrent manner as information is received from the various sources for monitoring. Sources for monitoring include: member complaints or SHL staff concerns; patient satisfaction surveys for those practitioner offices identified as outliers on measures related to the condition of the facility; and feedback received from another health plan department that a problem may exist.

Issues are triaged by the site reviewer who determines whether a site visit needs to be conducted immediately, if he/she believes a significant health or safety problem may be present, or whether the issue is to be tracked and trended to determine if a pattern exists. The Credentialing Committee may, at its discretion, request that a site visit be conducted at any time.

A site/location may be placed on corrective action if the overall site visit score is less than 80% or if the site is non-compliant for any one of the following issues: safety, patient care, confidentiality practices, or medical recordkeeping practices. The site/location is advised of the areas of noncompliance and required to implement a corrective action plan and achieve an overall compliance score of at least 80%, or come into compliance for any of the issues identified above, within 90 to 180 days. SHL monitors the corrective action plan for compliance and revisits the site for physical deficiencies and/or collects evidence of compliance with written deficiencies at least every 180 days until the performance standards have been met.

Results of corrective action monitoring are presented to the Credentialing Committee Chair and/or Credentialing Committee for approval or additional corrective action if performance standards are not met. The Chair or the Committee may, at its discretion, request additional follow-up site visits be conducted after a specified time to determine continued compliance. If the site fails to meet the established goals of the corrective action plan, further action may be taken by the Committee, including loss of participatory status for practitioners associated with the site.

Standards of Provider Office Facilities

TOPIC REQUIREMENT	
I.	FACILITY ACCESS/APPEARANCE (EXTERIOR)
A.	<i>Building & Ground Maintenance</i>
1.	✓ Address visible
2.	✓ Outside clean, well maintained
3.	✓ Exterior doors accessible and not blocked / handrails stable/secure, if present
4.	✓ Walkways free of hazards/obstructions (i.e. potholes/tree roots)
B.	<i>Parking</i>
1.	✓ Adequate parking in close proximity to office
2.	✓ Handicap parking easily identified by visible signs or stencils
C.	<i>Handicap Access (Exterior)</i>
1.	✓ Curb ramp present

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2.	✓ Doors open easily (automatic or semi-automatic or provisions have been made to provide assistance)
3.	✓ Door width is adequate for wheelchair
4.	✓ If elevators (exterior or interior): ❖ Elevator buttons accessible (low enough) ❖ ADA provisions: Braille/auditory references in elevator ❖ Doors wide enough for wheelchair access ❖ Emergency phone available in elevator

II. FACILITY ACCESS / APPEARANCE (INTERIOR)	
A. Handicap Access (Interior)	
1.	✓ Ramps if different levels
2.	✓ Reception counter wheelchair accessible or a process to accommodate patients in wheelchair
3.	✓ Doors / halls wide enough for wheelchair access
B. Bathrooms	
1.	✓ Clean
2.	✓ Appropriately stocked (soap, paper towels, toilet seat covers)
3.	✓ At least 1 bathroom in building is wheelchair accessible with grab bars
C. Office Appearance / Signage	
1.	✓ Practitioner name on office suite door and/or practitioner listed in building directory
	✓ Practice specific information available (days/hours of operation). Must be posted or in patient brochure/business card
2.	✓ Non-discriminatory practices based on race, age, sex or ethnicity must be posted or in patient brochure/business card
3.	✓ Health education information is available appropriate to practice
4.	✓ Routine housekeeping and maintenance are evident (office clean, uncluttered, comfortable)
5.	✓ Adequate seating in waiting room (no one standing)
6.	✓ Adequate lighting provided for reading
7.	✓ Exit signs clearly visible
D. Entry/Hallways	
1.	✓ Obstruction free
2.	✓ Fire extinguishers available/serviced within last year
3.	✓ Smoke detectors or sprinklers present
E. Emergency Evacuation	
1.	✓ Evacuation map posted or process in place for emergency evacuation
III. PATIENT RIGHTS/PRIVACY/CONFIDENTIALITY	
1.	✓ Staff sign confidentiality agreements
	✓ Policy/process for the "release of medical record information" (PHI)
	❖ Written authorization form is required for the release of medical records
2.	❖ Identification required to ensure release to patient or authorized representative
3.	✓ Process is in place to verify identity of an individual on the phone prior to releasing PHI
	✓ An area is provided where financial and insurance discussions will not be overheard by other patients
4.	
IV. SYSTEMS/ADEQUACY OF EQUIPMENT	
A. Exam Room/Close Proximity	
	✓ Exam tables are positioned away from exam door or privacy curtain/screen provides privacy when exam door is opened
1.	✓ Exam rooms (at least one per scheduled MD): The following equipment is available in or within close proximity of each exam room:
	❖ B/P Cuff Y/N/NA
	❖ Opthamaloscope/Otoscope Y/N/NA
	❖ Exam Tables Y/N
	❖ Handwashing Facilities or Hand Sanitizers Are Available (Alcohol Based) Y/N
	❖ Disposable Gloves Y/N
	❖ Scale Y/N
	❖ Disposable Table Covers Y/N
	❖ Disposable Covers/Gowns or Linen Service Y/N
	❖ Sharps Disposal Receptacles Y/N
2.	(If Shots Given In The Exam Room)

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B.	Laboratory (if office conducts laboratory testing: i.e. FOB, Pregnancy Tests, Urine Dip, etc.)
1.	✓ CLIA Certification or Certificate of Waiver posted
2.	✓ State of Nevada license to conduct CLIA waived tests
C.	X-Ray (if applicable)
1.	✓ Current State Certification posted
D.	Infection Control
1.	✓ Autoclave instruments wrapped/dated or solution is dated and used in accordance with manufacturer's instructions (meets OSHA guidelines)
2.	✓ Spore testing maintained per manufacturer's directions
3.	✓ Needle disposal receptacles are available where shots are given
4.	✓ Hazardous waste disposal/labeled and/or red bags are separate from regular trash. Hazardous waste is located in a designated area and is disposed of separately from regular trash utilizing red bags/labels
5.	✓ Process for cleaning equipment, including exam tables, daily
E.	Other Equipment
1.	✓ Evidence of annual maintenance available (calibration of EKG machines, suction equipment, BP equipment, scales, etc) (i.e. logs or stickers on equipment)
V.	PHARMACY
A.	Medication Storage
1.	✓ All medication stored in a secure manner with access limited only to authorized persons (e.g. locked storage cabinet, not visible to patients)
2.	✓ Medication expiration dates are monitored and expired medication is discarded (includes samples) or process in place to check medication expiration date before dispensing
3.	✓ Refrigerated medication stored separately; not co-mingled with food
4.	✓ Temperature log maintained (35-45 degrees F) - Evidence of daily log
5.	✓ Recall system is in place for pharmaceuticals (including samples)
B.	Prescription Pads/Needles/Syringes
1.	✓ All inaccessible to patients; stored in drawer or closet
2.	✓ Prescription pads stored in locked drawer or closet
C.	Narcotics (if applicable)
1.	✓ Logs kept and narcotics accounted for
2.	✓ Limited access/locked cabinet
3.	✓ Written procedures for narcotics (only authorized personnel to dispense)
4.	✓ Disposal of unused and/or expired narcotics
VI.	EMERGENCY SERVICES
A.	Emergency Supplies
1.	✓ Protective mask and/or Ambu bag available as appropriate to practice (i.e. pediatric bag for pediatric offices)
2.	✓ Oxygen tanks, if present, are secured to prevent injury and cannula or mask is readily available
3.	✓ Emergency process (description ok)
B.	CPR
1.	✓ A CPR certified staff member (verify current certification) is available when patients are present
C.	Crash Cart (if present)
1.	✓ ACLS certified personnel when patients present
2.	✓ Crash cart checked regularly with log
3.	✓ Easily accessible, breakaway locks (if applicable)
4.	✓ Evidence of crash cart/defibrillator being maintained
5.	✓ Evidence of checking expiration dates of medications on crash cart

VII.	MEDICAL RECORD KEEPING
A.	General <i>Hard Copy Medical Record or Electronic Medical Record</i>
1.	✓ Identify person(s) responsible for maintaining safekeeping of medical records and/or appropriate system back-up for electronic medical records
2.	✓ Practitioner has standard format (recommend chart dividers for sections, i.e. Lab/X-ray/Progress Notes, etc)
3.	✓ Each patient has their own medical record
4.	✓ Contents fastened securely or electronic medical record
5.	✓ Stored in area inaccessible to patients or , if electronic, password-protected security and appropriate system back-up
6.	✓ Each page has patient identifying information
7.	✓ Process to document/update current medications
8.	✓ Practitioner reviews all lab/x-ray, consults & other Dx tests (verify process)
9.	✓ P&P or process for reporting abnormal results to patients
10.	✓ Documentation of telephone calls and follow-ups including pharmacy refills are incorporated in the medical record
11.	✓ If taken off site for any reason, tracking systems in place and P&P in place for "Transporting Records"
B.	Records include (at a minimum) the following:
1.	✓ Demographic information (insurance, address, telephone, emergency contact, etc.)
2.	✓ Problem list (medical history, surgical history, chronic health problems, health maintenance – will include adult immunizations)
3.	✓ Allergies noted in one central location, including affirmation of "No Known Allergies"
4.	✓ Prenatal Flow Sheet (OB/GYNs only)
5.	✓ Immunization record and Growth Chart (Peds only)
C.	Advance Directives (PCP only) for members 18+ years OR with chronic health problems
1.	✓ Advance Directives are addressed / documented in the medical record
VIII.	ACCESS & AVAILABILITY
A.	No Show/Call Back
1.	✓ Process to evaluate and document No Shows and follow-up
B.	Appointment System – Next available appointment per Health Plan standards
1.	✓ Regular and routine care (Next Available Appointment _____)
2.	✓ Urgent Care (Walk in/Same day appointment)
C.	After Hour Coverage
1.	✓ Arrangement for after hour care – call group/answering service or available to take own calls and has process in place when practitioner on vacation
2.	✓ Patients advised of after hour care arrangements and how to contact
D.	Waiting Time In Office
1.	✓ Average wait time not to exceed 30 minutes
2.	✓ A process in place to acknowledge delays and offer patients an alternative (i.e. reschedule)
E.	Telephone
1.	✓ Telephone calls for appointments are triaged / screened by appropriate medical personnel
2.	✓ P&P or process in place to determine Urgent or Routine
2.	✓ Policy or standards related to returning phone calls
F.	Non-English Speaking Patients
1.	✓ Interpreter service available or process in place
G.	Hearing Impaired Patients
1.	✓ TTY/TDD phone or service for the hearing impaired available or process in place

5.11 MEDICAL RECORD STANDARDS

SHL requires that practitioners maintain medical records in a manner that is current, detailed and organized. Practitioners must have a medical recordkeeping system, either hard copy or

electronic, that allows for the collection, processing, maintenance, storage, retrieval and distribution of patient records. The medical records should facilitate communication, coordination, and continuity of care, and promote efficiency and effectiveness of treatment. SHL conducts clinical medical record reviews to assess the conformity with good professional medical practice and appropriate health management.

Clinical medical record reviews are conducted by a clinical professional. This UM Compliance Nurse Consultant reviewer works closely with the Vice President of Healthcare Quality and Education to make recommendations to the Credentialing Committee Chair and/or Credentialing Committee and to oversee corrective action plans with individual practitioners. If the reviewer identifies specific concerns relating to quality of care criteria, including records that are illegible by the reviewer, a copy of the record is forwarded to the Medical Director for peer review.

Medical record reviews are considered practitioner based. The medical record review is effective for the practitioner regardless of his/her site or location; if the practitioner practices at multiple sites, a review of medical records at only one site is required. SHL conducts a medical record review: annually on one or more of the following:

- Those practitioners whose files were identified as potentially problematic during the annual HEDIS medical record abstractions;
- A sample of high volume practitioners, based on impanelment;
- A sample of those practitioners who are identified as outliers on profiling reports;
- A sample of practitioners who were recently (within the past two years) added to the SHL Network; or
- Any practitioners deemed appropriate based on SHL's experience with their medical record documentation

SHL also conducts medical record reviews if feedback is received from another health plan department or staff that a problem may exist or if the site reviewer chooses to include a medical record review as part of a site visit that is being conducted mid cycle. The Credentialing Committee may, at its discretion, request that a medical record review be conducted at any time.

Results of the medical record review are considered at the time of the Chair's review or the Credentialing Committee's review and then communicated to the practitioner's office in a follow-up letter. A practitioner is placed on corrective action if the overall medical record score is less than 80%. The practitioner is advised of the areas of noncompliance and required to implement a corrective action plan and achieve a compliance score of at least 80% within 90 to 180 days. SHL monitors the corrective action plan and conducts a follow-up audit to assess compliance within the allotted timeframe. Results of corrective action monitoring are presented to the Credentialing Committee for approval or additional corrective action if performance standards are not met. The Credentialing Committee may, at its discretion, request additional medical record reviews be conducted after a specified time to assess continued compliance. If the practitioner fails to meet the established goals of the corrective action plan, further action may be taken by the Credentialing Committee, including loss of participatory status.

Confidentiality standards

- Medical records are treated as strictly confidential and protected from loss, tampering, alteration, destruction and unauthorized or inadvertent disclosure, except when otherwise required by law.
- Confidentiality is maintained at all times and records are secured in an area unavailable to persons not authorized to access medical records.
- Patients are assured confidential treatment of medical records and afforded the opportunity to approve or refuse the release of such information, except when release is required by law.
- Any individuals, other than those authorized, receive access to the medical record only upon written authorization by the patient, or when release is required by law.

Documentation standards

	ELEMENT	STANDARD
A.	PATIENT DEMOGRAPHICS	
1.	Each page of the medical record contains the patient's name or ID Number.	Patient name or ID number is required on each page of all documents reviewed during Plan-specific review period (i.e. either / or).
2.	Personal biographical data includes date of birth, address, home telephone numbers, marital status and emergency contact information. Guardian information to also be documented, if applicable. (Note: If Medicaid: age, race and sex also required.).	Non-Medicaid: Recommend all biographical data requested is documented, however, consistent documentation of 3 of 4 elements constitutes compliance. If not all requested biographical data is documented, recommendation to be included. Medicaid: In addition, requires documentation of age, sex and race (i.e. all or nothing for all three elements).
3.	Employer's name and work telephone number are included in patient's biographical data as applicable.	Documentation to Employer's name and work phone number is required in patient's biographical data.
B.	CHART ORGANIZATION AND COMPLETENESS	
1.	All entries in the medical record contain the author's identification, which may be a handwritten signature, unique electronic identifier or initials.	Each entry must be signed, including legible handwritten signature, unique electronic identifier or initials (i.e. must be one of the three). Note: Illegible signature or inability to identify author constitutes non-compliance.
2.	All entries are dated.	Each entry is to be dated (i.e. all or nothing).
3.	All documents are securely attached in the medical record with no loose papers.	All documents must be secured in the medical record. Unsecured paper in the file is not acceptable.
4.	Content and format of medical records are uniform including sequence of information.	Medical record documentation demonstrates consistent format used per office protocol by practitioner / staff.
5.	The record is legible to someone other than the writer. If the medical record is illegible, a copy of the record will be reviewed by the Plan Medical Director for determination.	All chart entries must be legible. Samples of illegible medical record documentation require review by the Plan Medical Director.

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B.	CHART ORGANIZATION AND COMPLETENESS – cont'd	
6.	Significant illnesses and medical conditions are indicated on the problem list, including current updates.	Documentation of presence or absence of significant illnesses and/or medical conditions is present or medical record documentation format used must clearly demonstrate a current problem list (i.e. Pediatric Well-Child, if applicable).
7.	Medication allergies and adverse reactions or the absence there of are consistently noted in the medical record.	Documentation of presence or absence of medication allergies, including adverse reactions, must be consistently, clearly documented in all medical records.
8.	Medication information is present, including prescribed medications, dosages, dates of initial prescription and refill prescriptions.	Either separate medication list is present or medical record documentation format used must clearly demonstrate a current medication list including dosages, dates of initial prescriptions and refill prescriptions.
9.	Encounter forms or notes have a notation regarding follow-up care, calls or visits. The specific time of return is noted in weeks, months or as needed.	Documentation for each visit must include applicable follow-up plan.
10.	For competent patients 18 and older, there is documentation of advance directives or evidence the member has elected not to execute. If not executed, there is evidence that information was offered.	Medical record documentation must clearly demonstrate either the patient has or does not have advanced directives. If yes: Copy of advanced directive should be requested from the patient for placement in the medical record. If no: Requires documentation advanced directive information was offered.
C.	PATIENT HISTORY/PHYSICAL STUDIES	
1.	For patient's seen three or more times, past medical history is easily identified and includes serious accidents, operations and illnesses. For children and adolescents (18 and younger), past medical history relates to prenatal care, birth, operations and childhood illnesses.	Either separate history/physical is present or medical record documentation format used must clearly demonstrate a current history/physical
2.	For patients 12 and older, there is appropriate notation assessing the use of cigarettes, alcohol and/or other substances. If yes, there is also evidence of education.	<u>Query (2 Pts):</u> Requires documentation of use/no use indication. <u>Education (2 Pts):</u> If yes to query, requires documentation of education / counseling provided.
3.	The history and physical examination identifies appropriate subjective and objective information pertinent to a patient's presenting complaints.	Medical record documentation format used must clearly demonstrate appropriate subjective and objective information pertinent to patient's presenting complaint.
4.	Laboratory and other studies are ordered, as appropriate.	Laboratory and other studies are documented and appropriate to diagnosis and/or presenting complaint.
5.	Working diagnoses are consistent with findings.	Working diagnoses are documented and consistent with clinical findings.
6.	There is evidence of appropriate referral to consultants, as indicated.	There is evidence of appropriate referral to consultants, as indicated.

C. PATIENT HISTORY/PHYSICAL STUDIES – cont'd		
7.	Consultation, laboratory and imaging reports filed in the chart are initialed by the practitioner to signify review. If the reports are presented electronically or by some other method, there is representation of review by the ordering practitioner.	Medical record documentation demonstrates applicable reports are initialed by group or practitioner.
8.	Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow-up plans.	Medical record documentation format demonstrates follow-up plan of abnormal reports or is addressed in SOAP notes.
D. TREATMENT PLAN		
1.	Treatment plans are consistent with diagnoses.	Treatment plans are documented and consistent with diagnoses.
2.	Unresolved problems from previous office visits are addressed in subsequent visits.	Unresolved problems from previous office visits, as defined by Plan-specific review period, are addressed in subsequent visits.
3.	Documentation evidencing continuity and coordination of care is present for all aspects of care including ancillary services, consultations, diagnostic tests, therapeutic services and/or institutional services (i.e. emergency care documentation, hospital discharge summary, ambulatory surgery centers, home health, etc.) including practitioner follow-up plan, as appropriate.	Medical record demonstrates evidence of appropriate continuity and coordination of care present for all aspects of care, including appropriate follow-up plan, as applicable (i.e. ER report, operative report, phone consultation, hospital discharge summaries from all hospitalizations while a member of the health plan and prior admissions as necessary.
4.	There is no evidence the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure (i.e. unnecessary procedures, inappropriate procedures, etc.).	There is no evidence the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure (i.e. unnecessary procedures, inappropriate procedures, etc.).
5.	Documentation of patient education regarding diagnosis, treatment and medications, including risk factors.	Medical record documentation includes patient education provided.
E. PREVENTIVE MEASURES		
1a.	Childhood/Adolescent Immunizations: An immunization record is up to date, including specific vaccines administered, and an appropriate history is presented in the medical record. OR	Medical record documentation includes a current immunization record or documentation of specific immunizations given, including dates per CDC recommendations (i.e. "immunizations up to date" reference is not adequate).
1b.	Adult Immunizations: An appropriate immunization history is documented in the medical record and age-specific immunizations are current.	Medical record documentation includes an appropriate immunization history as indicated by CDC immunization schedule (i.e. influenza, tetanus, high-risk members, etc.).
2.	There is evidence that preventive screenings and services are offered in accordance with the Plan's preventative health guidelines.	Medical record documentation demonstrates evidence of preventative screenings and services provided, as defined by Plan-specific preventative health guidelines.

Systems of organization standards

- There is a unique identification of each patient's medical record.
- Confidentiality, security and physical safety of medical records are maintained.
- There is timely retrieval of individual records upon request.
- There is supervision of the collection, processing, maintenance, storage, retrieval and distribution of medical records.
- Reports, histories and physicals, progress notes and other patient information (such as laboratory reports, x-ray readings, operative reports, anesthesia records, and consultations) are reviewed and incorporated into the record in a timely manner.
- When necessary to promote the continuity of care, summaries or records of a patient who was treated elsewhere (such as by another practitioner, hospital or ambulatory surgical service) are obtained.
- When necessary to promote continuity of care, summaries of the patient's records are transferred to the health care provider to whom the patient was transferred and, if appropriate, to the organization where future care will be rendered.
- Medical records are not removed from the location where care is provided, except by written policy.
- If medical records are carried from one location to another, a tracking mechanism is developed so chart location is known at all times.
- A systematic method for medical record filing and easy access is maintained.
- There is a policy in place that describes where records will be stored if the office practice is closed.

Availability standards

- Medical records are available (or information pertinent to the provision of care provided to the member is available) to authorized medical health care providers at the time of member visits.
- Medical records are available to SHL in accordance with provider contracting to allow for auditing related to quality assurance, quality improvement, utilization management and credentialing.
- Medical records shall be available for review by duly authorized representatives of regulatory agencies in accordance with HIPAA regulations.



SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

5.12

HEALTH STATUS FORM

I, _____, the undersigned, do hereby attest that I have been clean and sober since _____. I further attest I am currently

☐ in compliance with, OR

☐ have completed

all requirements pertaining to any fines, sanctions, monitoring, continuing education or other agreements placed upon my professional license as a result of my addiction/actions.

Organization: _____

Contact: _____

Phone: _____

Address: _____

(A current, signed "Authorization and Release of Information Form" is required from the provider allowing SHS to contact the organization listed above.)

Provider Signature

Date

5.13 Appointment of Credentialing Agent

I hereby consent and agree to the disclosure, copying, and transmission of information and documents related to my credentials, qualifications, conduct and performance by and between my credentialing agent (named below) and Sierra Health Services Credentialing Department. This exchange of information will be for the purpose of any credentialing/re-credentialing applications or mid-cycle credentialing evaluation regarding my professional training, experience, character, conduct, judgment, ethics, ability to work with others, health issues, sanctions or loss of licensure, or other items needed to complete my credentialing application process.

I am informed and acknowledge that federal and state laws provide certain immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of health care providers. I hereby release all persons and entities from any liability they might incur for their acts and/or communications in connection with the evaluation of my qualifications for employment or credentialing to the extent that those acts and/or communications are protected by law.

A photocopy of this document will serve as the original.

I hereby authorize

Agent: _____

Company Name: _____

Contact number: _____

Fax number: _____

E Mail Address: _____

To act as my agent in all matters related to credentialing until I revoke this authorization in writing.

Print Name _____

Practitioner Signature _____

Date: _____

For answers to credentialing questions please call (702) 242-7559

**SHL
PROVIDER SUMMARY
GUIDE**

**SECTION 6
BENEFITS AND ELIGIBILITY**

6 - Benefits and Eligibility

6.1 Enrollee Benefits

Sierra Health and Life (SHL) offers a variety of medical and dental benefit plans that are made available to eligible employees and their eligible family members for many employer groups.

If you have questions regarding the benefits for a specific medical or dental benefit plan, including their exclusions and limitations, please contact SHL Member Services at the following numbers:

SHL	(800) 888-2264
IVR	(702) 242-7393
Toll Free	(800) 768-2808

Business Hours: Mon. – Fri., 8:00 a.m. – 5:00 p.m. Pacific Standard Time

6.2 Eligibility and Plan Coverage Verification

The Member Services Department has a staff of representatives and specialists who can assist you with the following:

- Eligibility
- Plan coverage
- ID card questions
- Member concerns

The following steps will help you identify SHL members and determine their eligibility and plan coverage.

A member's eligibility needs to be determined before services are rendered. Every member and dependent is issued an identification card. All information on the card serves as identification; however, it does not guarantee eligibility.

For verification of eligibility and benefit please contact Member Services IVR (Interactive Voice Response) system at **(702) 242-7393** or **(800) 768-2808** or utilize SHL's online portal – [@YourService](#). See Section 6.4 for details regarding [@YourService](#).

Please Remember any payment for covered services is subject to the member's eligibility at the time of service, compliance with the managed care program, contractual limitations/exclusions and coordination of benefits as set forth in the Evidence of Coverage/Certificate of Coverage/Agreement of Coverage.

6.3 Interactive Voice Response System (IVR)

Eligibility and Benefit Information: 7 days/week, 24 hours/day

The Interactive Voice Response system will enable you to obtain eligibility and benefits for members as well as claim payment information at the touch of a button.

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Providers can receive a fax with information obtained from the IVR system.
Direct numbers to IVR system:

SHL (702) 242-7393
SHL Toll free (800) 768-2808

This service is available 24-hours-a-day, 7-days-a-week. This feature is part of our continuing effort to improve service to our providers.

A flow chart that outlines the process follows in this section.



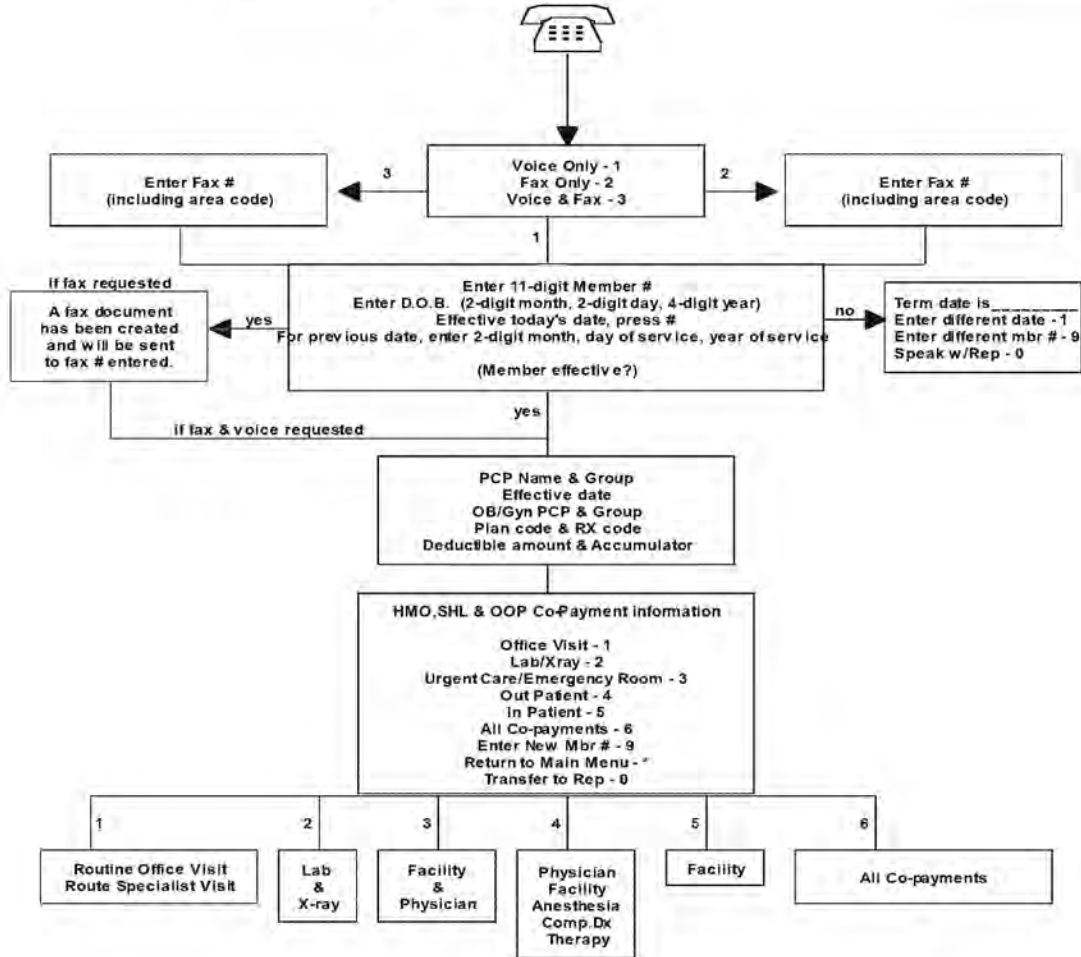
MEMBER SERVICES:

Interactive Voice Response System (IVR)	(702) 242-7393
Toll free	(800) 768-2808
SHL Telephone	(800) 888-2264

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MEDICAL ELIGIBILITY & BENEFITS IVR APPLICATION (PROVIDERS)

Direct to IVR 242-7724 (HPN).....242-7393

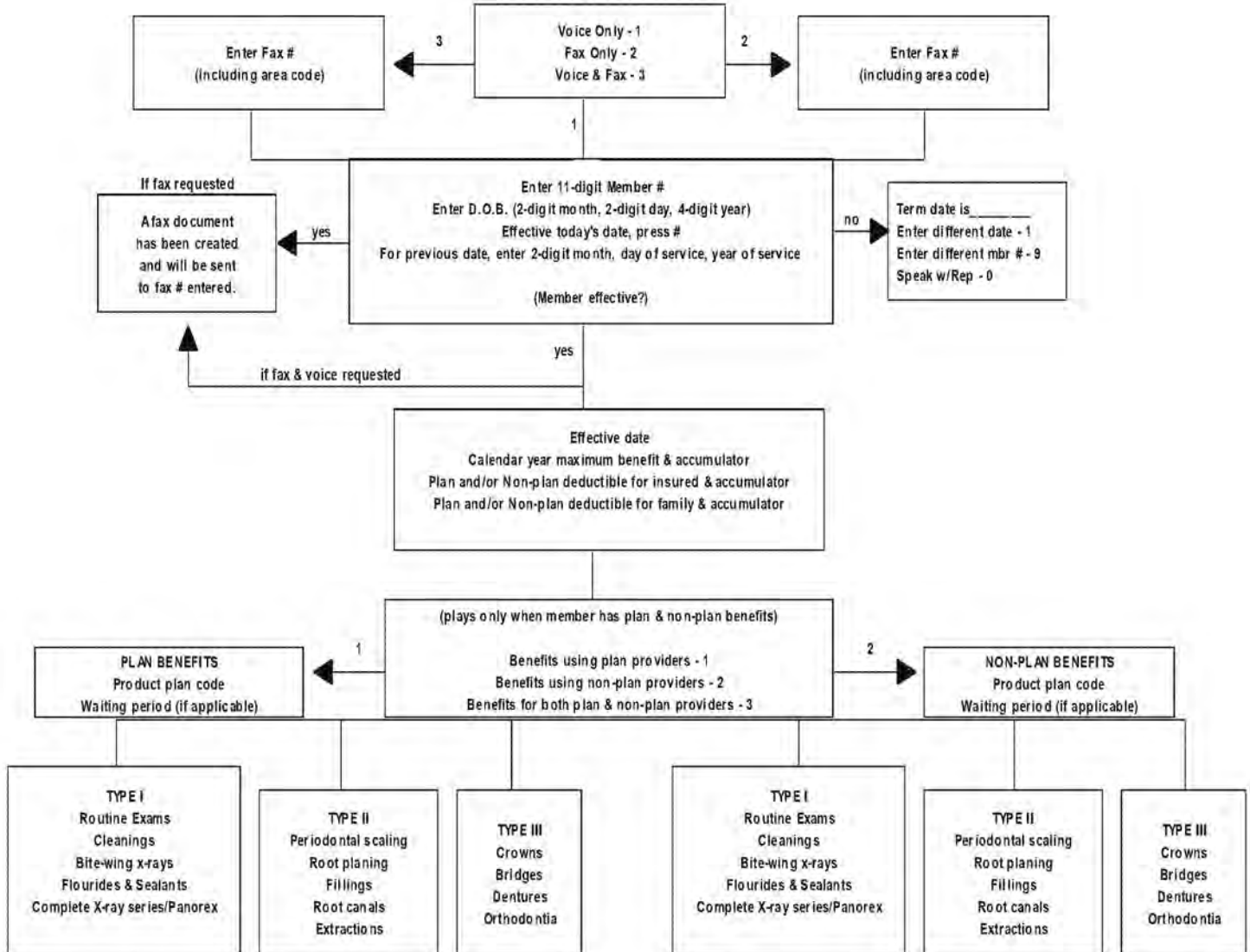


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DENTAL ELIGIBILITY & BENEFITS IVR APPLICATION (PROVIDERS)

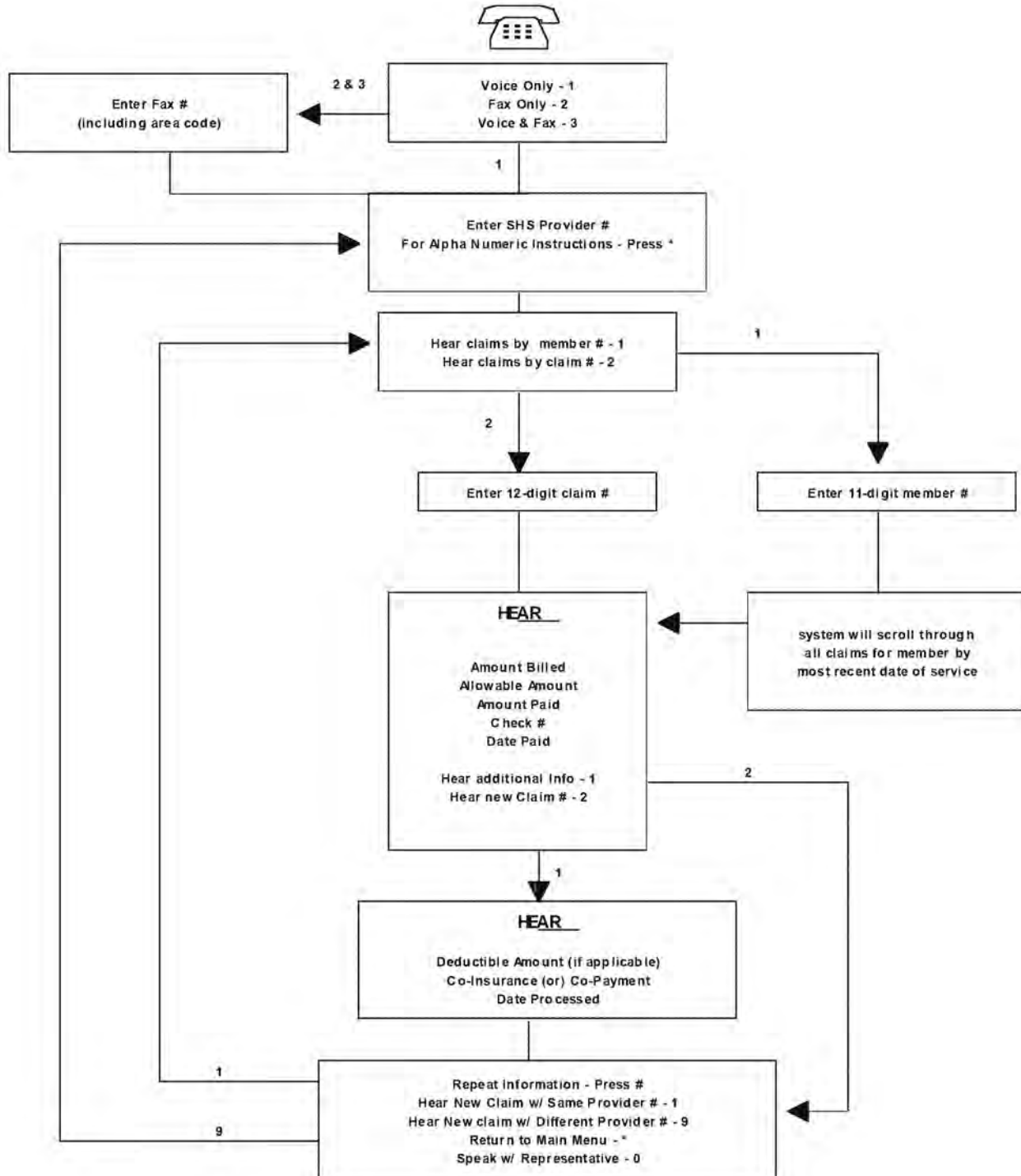
Direct to IVR 242-7724 (HPN).....242-7393 (SHL)



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CLAIMS STATUS IVR APPLICATION (PROVIDERS)

Direct to IVR 242-7724 (HPN).....242-7



6.4 SHL @YourService

Convenient and available 24/7, Sierra Health and Life's online portal- [@YourService](#) is geared toward providing greater convenience and efficiencies for our contracted providers. Contracted providers and their administrative staff have access to important information when they need it.

@YourService is a "real time" application that provides information such as member eligibility and benefits, prescription drug coverage information, prior authorization and claim status. Additional features include viewing and printing EOP's, as well as submitting prior authorization requests. @YourService can reduce or avoid time spent on the telephone with SHL's Member Services Department.

For contracted provider that are not yet connected to @YourService, please submit a request online via the [@YourService](#) website by clicking "Create an Account" and following the on screen instructions. Or refer to **Section 23.2** of this guide for the @YourService Administrator Account request form. The @YourService Provider Tutorial is accessible on the SHL website and Provider Services is available to answer any specific questions you may have regarding the application.

6.5 Sierra Health and Life Web Site

The SHL web site www.mySHLprovider.com is a valuable tool for you and your office staff. The SHL website has a section devoted entirely to providers and their needs. By visiting the SHL website you'll gain access to:

- Online provider directories
- SHL Preferred Drug List
- Mail-order pharmacy information
- Plan pharmacies
- SHL clinical guidelines
- UM Protocols
- Information regarding [@YourService](#) (SHL's online portal)
- Credentialing information
- Online Provider Summary Guide
- Information regarding New Medical Technology

The SHL website will be periodically updated to communicate health plan updates and ongoing information related to services, care, process changes and legislative and regulatory updates impacting providers.

6.6 ID Cards

Copies of identification cards are provided to better identify our members. The front of the card contains information pertaining to the member and their benefits. Included in this information are the following:

Employer Name:	The employer name may be included on the card
Member Name:	Name of member, can be dependent, spouse or insured
Member Number:	Unique 11 digit number identifying each member
Group Number:	Employer Group Number
Benefits:	Medical Pharmacy Vision Dental

Code:	For each benefit a patient is eligible for, a corresponding code will be listed
Effective Date:	Effective dates will be displayed for each benefit code the member is eligible for
Copays:	Copays will be listed for Office Visits and other benefits if applicable
Plan Name:	Sierra Health and Life

Based upon the benefits the member has, the information on the back of the card may contain some of the following information:

Health plan members may now access their ID cards via @YourService (online or on their smartphones).

SHL Solutions Group PPO Plan:

In a life-threatening emergency, call 911 or go to an emergency room. Printed: 12/28/16

Card does not guarantee coverage. Obtain prior authorization or verify benefits at www.mySHLonline.com or call Member Services.

Member Services:	1-800-888-2264
24 Hour Advice Nurse:	1-800-288-2264
Mental Health/Substance Abuse:	1-800-873-2264

For Providers:	www.mySHLonline.com	1-800-888-2264
Medical Claims:	SHL Claims, PO Box 15645, Las Vegas, NV 89114-5645	

UnitedHealthcare Choice Plus Network Outside Nevada	SHL Plan Provider Network Within Nevada & Surrounding Areas
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Pharmacy Claims: OptumRx, PO Box 29044, Hot Springs, AR 71903
For Pharmacists: 1-800-443-8197

In a life-threatening emergency, call 911 or go to an emergency room. **Printed Page 11**

Card does not guarantee coverage. Obtain prior authorization or verify benefits at mySHLonline.com or call Member Services.

Member Services:	1-800-888-2264
24 Hour Advice Nurse:	1-800-288-2264
Mental Health/Substance Abuse:	1-800-873-2248

For Providers:	mySHLonline.com	1-800-888-2264
Medical Claims:	SHL Claims, PO Box 15645, Las Vegas, NV 89114-5645	

UnitedHealthcare Choice Plus Network Circle Network	SHL Plan Provider Network Within Nevada & Surrounding Areas
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Pharmacy Claims: OptumRx, PO Box 29044, Hot Springs, AR 71903
For Pharmacists: 1-800-443-8197

2018 SHL Provider Summary Guide

SHL Solutions Group HSA EPO Plan:

SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

SHL SOLUTIONS GROUP HSA EPO PLAN

Health Plan (80840) 911-76342-01
Member ID: 999000462-00 Group Number: 000000000000

Member:
SAMPLE ID CARD_JM

Benefit Code:
Medical 00000000
Rx 00000000

Payer ID 76342

Effective Date 01/01/2018

OPTUMRx

Rx BIN: 610279
Rx GRP: UNEVADA
Rx PCN: 9999

DOI-0501 Underwritten by Sierra Health and Life Insurance Co., Inc.

In a life-threatening emergency, call 911 or go to an emergency room. Printed: 09/21/17

Card does not guarantee coverage. Obtain prior authorization or verify benefits at mySHLonline.com or call Member Services.

Member Services: 1-877-203-3036
24 Hour Advice Nurse: 1-800-288-2264
Mental Health/Substance Abuse: 1-877-477-6579

For Providers: mySHLonline.com 1-877-203-3036
Medical Claims: SHL Claims, PO Box 15645, Las Vegas, NV 89114-5645

UnitedHealthcare Choice Plus Network Outside Nevada

SHL Plan Provider Network Within Nevada & Surrounding Areas

Pharmacy Claims: OptumRx, PO Box 29044, Hot Springs, AR 71903
For Pharmacists: 1-800-443-8197

Individual PPO Plan:

SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

MySHL SOLUTIONS INDIVIDUAL PPO PLAN

Health Plan (80840) 911-76342-01
Member ID: 999000467-00 Group Number: 000000000000

Member:
SAMPLE ID CARD_JS

Benefit Code:
Medical 00000000
Rx 00000000

Payer ID 76342

Effective Date 01/01/2018

OPTUMRx

Rx BIN: 610279
Rx GRP: UNEVADA
Rx PCN: 9999

Copy: Office /Spec
In Plan \$0 /\$0

DOI-0501 Underwritten by Sierra Health and Life Insurance Co., Inc.

In a life-threatening emergency, call 911 or go to an emergency room. Printed: 09/21/17

Card does not guarantee coverage. Obtain prior authorization or verify benefits at mySHLonline.com or call Member Services.

Member Services: 1-800-888-2264
24 Hour Advice Nurse: 1-800-288-2264
Mental Health/Substance Abuse: 1-800-873-2246

For Providers: mySHLonline.com 1-800-888-2264
Medical Claims: SHL Claims, PO Box 15645, Las Vegas, NV 89114-5645

SHL Plan Provider Network Within Clark County Nevada

Pharmacy Claims: OptumRx, PO Box 29044, Hot Springs, AR 71903
For Pharmacists: 1-800-443-8197

Individual PPO Plan with Calendar Year Deductible:

SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

MySHL SOLUTIONS INDIVIDUAL PPO PLAN

Health Plan (80840) 911-76342-01
Member ID: 990000467-00 Group Number: 100035021001

Member:
SAMPLE ID CARD_JS

Benefit Code:
Medical 00000000
Rx 00000000

Payer ID 76342

Effective Date 01/01/2018

OPTUMRx

Rx BIN: 610279
Rx GRP: UNEVADA
Rx PCN: 9999

Rx Cost share tiers: I / II / III / IV
Rx Cost share: \$0/\$0/\$0/\$0
Rx Deductible may apply.

Copy: Office /Spec
In Plan \$0 /\$0
After CYD

DOI-0501 Underwritten by Sierra Health and Life Insurance Co., Inc.

In a life-threatening emergency, call 911 or go to an emergency room. Printed: 01/15/18

Card does not guarantee coverage. Obtain prior authorization or verify benefits at mySHLonline.com or call Member Services.

Member Services: 1-800-888-2264
24 Hour Advice Nurse: 1-800-288-2264
Mental Health/Substance Abuse: 1-800-873-2246

For Providers: mySHLonline.com 1-800-888-2264
Medical Claims: SHL Claims, PO Box 15645, Las Vegas, NV 89114-5645

SHL Plan Provider Network Within Clark County Nevada

Pharmacy Claims: OptumRx, PO Box 29044, Hot Springs, AR 71903
For Pharmacists: 1-800-443-8197

Individual EPO Plan:

SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

MySHL SOLUTIONS INDIVIDUAL EPO PLAN

Health Plan (80840) 911-76342-01
Member ID: 999000460-00 Group Number: 000000000000

Member:
SAMPLE ID CARD_JK

Benefit Code:
Medical 00000000
Rx 00000000

Payer ID 76342

Effective Date 01/01/2018

OPTUMRx

Rx BIN: 610279
Rx GRP: UNEVADA
Rx PCN: 9999

Rx Cost share tiers: I / II / III / IV
Rx Cost share: \$0/\$0/\$0/\$0
Rx Deductible may apply.

Copy: Office /Spec
In Plan \$0 /\$0

DOI-0501 Underwritten by Sierra Health and Life Insurance Co., Inc.

In a life-threatening emergency, call 911 or go to an emergency room. Printed: 09/21/17

Card does not guarantee coverage. Obtain prior authorization or verify benefits at mySHLonline.com or call Member Services.

Member Services: 1-800-888-2264
24 Hour Advice Nurse: 1-800-288-2264
Mental Health/Substance Abuse: 1-800-873-2246

For Providers: mySHLonline.com 1-800-888-2264
Medical Claims: SHL Claims, PO Box 15645, Las Vegas, NV 89114-5645

SHL Plan Provider Network Within Clark County Nevada

Pharmacy Claims: OptumRx, PO Box 29044, Hot Springs, AR 71903
For Pharmacists: 1-800-443-8197

2018 SHL Provider Summary Guide

Individual HSA EPO Plan:

SERRA HEALTH AND LIFE
A UnitedHealthcare Company

MySHL SOLUTIONS
INDIVIDUAL HSA EPO PLAN

Health Plan (80840) 911-76342-01
Member ID: 999000459-00 Group Number: 000000000000

Member:
SAMPLE ID CARD_JJ

Benefit Code:
Medical 00000000
Rx 00000000

Payer ID
76342

OPTUMRx
Rx BIN: 610279
Rx GRP: UNEVADA
Rx PCN: 9999

Effective Date
01/01/2018

DOI-0501 Underwritten by Sierra Health and Life Insurance Co., Inc.

In a life-threatening emergency, call 911 or go to an emergency room. Printed: 09/21/17

Card does not guarantee coverage. Obtain prior authorization or verify benefits at mySHLonline.com or call Member Services.

Member Services: 1-877-203-3036
24 Hour Advice Nurse: 1-800-288-2264
Mental Health: 1-877-477-6579

For Providers: mySHLonline.com 1-877-203-3036
Medical Claims: SHL Claims, PO Box 15645, Las Vegas, NV 89114-5645

SHL Plan Provider Network
Within Clark County Nevada

Pharmacy Claims: OptumRx, PO Box 29044, Hot Springs, AR 71903
For Pharmacists: 1-800-443-8197

Dental:

SERRA HEALTH AND LIFE
A UnitedHealthcare Company

Health Plan (80840) 911-76342-01
Member ID: 999900280-00 Group Number: 000000000000

Member:
SAMPLE ID CARD_DD

Benefit Code:
Dental 00000000

Payer ID
76342

Effective Date
01/01/2017

DOI-0501 SHL Dental
Underwritten by Sierra Health and Life Insurance Co., Inc.

In a life-threatening emergency, call 911 or go to an emergency room. Printed: 12/28/16

Card does not guarantee coverage. Obtain prior authorization or verify benefits at www.mySHLonline.com or call Member Services.

Member Services: 1-800-888-2264

For Providers: www.mySHLonline.com 1-800-888-2264
Medical Claims: SHL Claims, PO Box 18408, Las Vegas, NV 89114-5645

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GUIDE**

**SECTION 7
UTILIZATION MANAGEMENT**

7 - Utilization Management

Sierra Health & Life (SHL) defines Utilization Management as the process of evaluation and determination for appropriateness of health care services. Listed below are just a few of the functions performed by our Utilization Management System:

- Prior Authorization (Pre-service Determinations)
- Admission and Health Care Services/Telephone Advice Nurse (Patient and Provider Access Center)
- Concurrent Review
- Denials, and Appeals Process
- Retrospective Review (Post-service Determinations)

7.1 Prior Authorization (Pre-service Determinations)

Definition: Pre-service determinations involve cases or services that must be approved, in whole or part, in advance to member's obtaining medical care or services. Prior authorization and precertification are pre-service claim determinations.

Prior authorization is the assessment and screening of requests for health care services from providers. The screening determines if the treatment is compatible with the diagnosis, if the member has benefits for services requested, and if the requested services are to be provided by a participating provider in an appropriate setting. This allows members' access to cost-effective, specialized care, necessary for their medical conditions, through their primary care physician.

The Health Plan's Prior Authorization Department is responsible for the processes of notification and prior authorization with Clinical Review for medical necessity and final determination of selected medical procedures, treatments, services or equipment.

7.2 Notification

Specialty-specific procedures, treatments and services must be processed through the Prior Authorization Department however; they do not require review by licensed personnel. The notification process includes checking eligibility, benefit coverage, and determination of appropriate site and provider. These requests are built into the computer system for provider payment purposes only. Services are to be done by designated providers and facilities. If not, prior authorization with clinical review by licensed personnel will be required.

7.3 Medical Necessity Determination

The Prior Authorization process includes checking member eligibility and benefit coverage, clinical review to determine medical necessity and determination of appropriate site and provider. Clinical review involves gathering all relevant clinical information that supports determinations of medical necessity of requests for medical treatment or services.

Nationally accepted guideline criteria, including, but not limited to; MCG, locally and nationally developed health plan criteria, and CMS and NCQA guidelines and regulations are applied based on the needs of individual members and the local delivery systems. The UM criteria

utilized in rendering a decision is available to providers on our web site at www.mySHLprovider.com or upon request by contacting the Prior Authorization Department at (702) 243-8499 or (800) 288-2264.

SHL also utilizes consultants from appropriate specialty areas. Consultants representing the specialties of cardiology, gastroenterology, hematology, infectious disease, nephrology, neurology, orthopedics, pediatrics, urology, etc. are used for review of individual cases when appropriate. All consultants are either board certified by one of the American Boards of Medical Specialties or other specialty certification appropriate to the practitioner's discipline.

Prior authorization staff has the authority to approve all situations that meet criteria and to refer potential denials or questionable cases to the Medical Director for review. Only the Medical Director may issue a prior authorization denial based on medical necessity review. Notifications of denial with appeal rights are given to members in writing and to providers verbally as well as in writing.

The purpose of the prior authorization function is to ensure that every SHL member receives quality care delivered to promote wellness, through utilization of appropriate resources, in the most appropriate setting and in the most cost-effective manner. This is achieved through the evaluation and determination of the appropriateness of the member's and practitioner's use of medical resources prior to services being rendered and the provision of any needed assistance to health care providers and/or the member to ensure appropriate use of resources.

7.4 Services That Require Prior Authorization

Services that require prior authorization with clinical review include, but are **not** limited to:

- All non-plan provider services (except for physician consultations)
- Elective admissions to an Inpatient facility and extensions of stay in a Hospital or Skilled Nursing Facility
- Outpatient surgical procedures performed in a hospital or an ambulatory surgery facility
- Diagnostic and Therapeutic Services, including but not limited to: complex radiology such as CT, CTA, MRI, MRA, PET and SPECT scans; Intensity Modulated Radiation Therapy and Genetic testing
- Anesthesia Services: Anesthesia for dental procedures; pain management procedures
- Home Health Care Services including IV therapy
- Mental Health and Substance Abuse Services
- Prosthetic and Orthotic devices over \$750
- Durable Medical Equipment purchases or rentals over \$750
- Courses of treatment; which may include, but are not limited to: allergy testing or treatment, home health care, physiotherapy or manual manipulation, rehabilitation services (physical, speech or occupational therapies), cardiac rehabilitation and pulmonary rehabilitation

For a complete list of services that require prior authorization from SHL, please go to www.mySHLprovider.com and select "I Need Help With", "Prior Authorization". This list may be updated periodically, so please check the SHL website for the most current version.

Note: Prior authorization of urgently/emergently needed care is NOT required. However, notification of such services is expected.

The medical review process requires the member, providers and the SHL Plan to work together. All Network Providers have agreed to participate in the medical review process. SHL Plan has no agreement with Out-of-Network Providers.

A prior authorization request may be initiated by a licensed facility, physician, or other ordering provider, patient or responsible patient representative including a family member. Patient prior authorization requests should be submitted by the provider using the appropriate prior authorization request form.

7.5 Prior Authorization Timeframes

Routine Requests:

Routine requests are reviewed with a determination rendered within the timeframes required by the Department of Labor, Centers for Medicare and Medicaid Services (CMS) and Nevada Division of Healthcare Financing and Policy- Managed Care Division. If additional clinical information is needed to render a decision, the provider will be contacted by phone and/or fax to supply the necessary information.

The UM criteria that is utilized to render a decision is available to providers on our web site www.mySHLprovider.com or providers may request a copy by contacting the prior authorization department at (702) 243-8499 or (800) 288-2264.

Urgent (Expedited) Requests:

Urgent (expedited) requests are for those services, which are related to urgent medical care conditions that have the potential to become an emergency in the absence of treatment.

Urgent (expedited) requests are reviewed with a determination rendered and provider notified within the requirements of the, the Centers for Medicare and Medicaid Services (CMS) and State Division of Healthcare Financing and Policy – Managed Care Division, which is 72 hours, although we do strive to provide the determination within one calendar day.

7.6 How to Obtain Prior Authorization for Services

We are committed to providing exceptional service to our members and providers. [@YourService](#) is our online provider portal offering benefit and claim information, referral and prior auth submissions, and more!

All Health Plan of Nevada Inc, and Sierra Health and Life Insurance Company providers are required to submit all Routine prior authorization requests online using the [@YourService](#) provider portal. **STAT/Urgent (Expedited) Requests** can be submitted through [@YourService](#) **Monday – Friday, 7am – 4pm PST ONLY**. Please continue to fax STAT requests on the weekends to the UM department at the numbers below.

Routine authorization requests submitted through [@YourService](#) will be processed prior to routine fax and telephone requests and will receive a prompt turnaround.

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- Website: online via [@YourService](#)
- Fax:
 - Las Vegas area (702) 304-7411
 - (702) 838-8297
 - Toll free (800) 282-8845
- Phone:
 - Las Vegas area (702) 243-8499
 - Toll free (800) 288-2264
 - (888) 224-4036

Note: UM Representatives are available Monday – Friday from 8:00 a.m. – 5:00 p.m. (Pacific Standard Time) to assist you.

Note: If your group is not currently set up with a @YourService Administrator account you may submit a request online via the [@YourService](#) website by clicking on “Create an Account” and following the on screen instructions or refer to **Section 23.2** of this guide for a request form. @YourService tutorials are located on the SHL website and Provider Services is available to answer any specific questions you may have regarding the application.

It is the responsibility of the requesting provider to provide pertinent case specific clinical information to support the request for medical services or treatment.

Hospital Admit Notifications and Utilization Review

Telephone Numbers (for Members in area):

Admit Notification	(702) 242-7770
Concurrent Review	(702) 797-2100
Toll Free	(877) 487-6659

Fax Numbers	(702) 667-4623
	(800) 645-6941

Telephone Numbers (for Members out-of-area):

Admit Notification	(800) 365-9687
Utilization Review	(800) 216-7525

Fax Toll free	(800) 278-8701
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Business Hours: Monday – Friday, 8:00 a.m. – 5:00 p.m. Pacific Standard Time

For Hospital Admission Notification and Utilization review **after hours and weekends** contact the Access Center at:

Telephone Numbers:

Las Vegas area	(702) 242-7716
Outside Las Vegas area	(800) 288-2264
Fax	(702) 242-7025

7.7 Patient and Provider Access Center (After Hours Admission and Healthcare Services/Telephone Advice Nurse)

Understanding the importance of quick and accurate information, the SHL Admission and Healthcare Services and Telephone Advice Nurse line have joined together to develop a department specifically designed to assist members, physicians and all other providers with health care information and services.

This 24-hour information and care management system provides access to a "one-stop-shop" staffed with specially trained professionals who work to meet the service and care needs of members and providers. As liaisons, staff members are actively involved in coordinating care by assisting with admissions and healthcare services and health care triage advice to SHL members.

Staff will assist with urgent/emergent hospital admissions and after-hours prior authorization for urgent outpatient services, patient transfers and referrals for other health care services such as Home Health, Hospice, Case Management, Durable Medical Equipment and Infusion Therapy.

The Telephone Advice Nurse program provides quick, comprehensive solutions to member's health concerns no matter what the time of day or night. Specially trained nurses are available 24 hours a day to offer simple, accurate advice regarding specific symptoms, illness or injury or simply answer member's questions about a particular health concern. If a member does need to see a physician or visit an urgent care clinic, the nurse will direct the member to an urgent care clinic or assist scheduling an appointment.

For information and assistance from the Access Center:

Telephone Numbers:

Las Vegas area	(702) 242-7716
Toll free	(800) 288-2264
Telephone Advice Nurse (TAN)	(702) 242-7330

Fax Numbers:

Las Vegas area	(702) 242 7025
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Note: Prior authorization is NOT required for emergency procedures or services for screening and stabilization in cases where a prudent layperson, acting reasonably, based on presenting systems, would have believed that an emergency existed.

7.8 Inpatient Concurrent Review

At SHL, the Continuity of Care department provides initial and ongoing assessments of members receiving care in the inpatient setting in order to ensure that the member is receiving the appropriate level of care based on medical necessity. The Continuity of Care department accomplishes the assessment process with on-site and telephonic case managers who perform case reviews on all members hospitalized in an acute care facility, a rehabilitation facility or a sub acute or skilled facility. The functions of Case Management include review of medical status for appropriate length of stay and level of care, discharge planning, case management, and referrals for ongoing post hospital care. Nationally accepted guidelines and criteria are used to make medical necessity determinations.

Only the Medical Director issues denials for continued stay. Notifications of denial with appeal rights are given to members in writing and to providers verbally as well as in writing.

SHL's Continuity of Care Department is available 7 days a week from 8:00 a.m. – 5:00 p.m. (Pacific Standard Time) and can be reached at **(702) 797-2100**.

7.9 Denial and Appeal Process

Denial

A denial, or adverse determination, is the determination by a Plan Medical Director that the services requested are not medically necessary after review of the clinical information submitted with the request for services. Only a licensed physician can make utilization management denial decisions based on medical necessity. Prior authorization staff or Hospital Case Management staff communicates the denial verbally and through written correspondence to the requesting provider. The provider is informed at that time of their right to physician-to-physician communication regarding the impending denial, as well as the appeal process. During the physician to physician communication the requesting physician provides NEW or ADDITIONAL clinical information that was not originally submitted with the initial request.

No financial incentives or other types of compensation are given to UM decision-makers for the reduction or denial of services or care. Decision-making is based on appropriateness of care (medical necessity of the service, appropriateness of providers of care), eligibility of the member, benefit coverage for the service, the individual needs of the member and the availability of services within the local healthcare delivery network.

Appeal

A formal appeals process is set into action when requested by a member, his or her designee or his/her provider(s). These requests are evaluated by a Medical Director or a Physician Peer Reviewer. This physician will be in the same or similar specialty that usually provides the service being requested and will not have been involved in the initial decision to deny the requested service. On behalf of a member, a provider can appeal a denial for a specific procedure, treatment or service by contacting the Prior Authorization Department either by phone, mail or fax. Member requests to appeal a denial for a specific procedure, treatment or service are received in the Member Services Department.

For appeals, please call: **(702) 243-8499 or (800) 288-2264**. Additional directions will be outlined in the denial letter.

An expedited (immediate) appeal review by the health plan, for continued stay denials and denials for services that would threaten life or limb of the member if not received immediately can be requested by the member. Sierra Spectrum members also have the right for an immediate Quality Improvement Organization (QIO) review of a denial for continued hospital, skilled nursing facility or home nursing care stays.

7.10 Retrospective (Post-Service) Review

Retrospective (post-service) review is the process of assessing the appropriateness of the medical care, services, treatments and procedures, and the providers of that care, after the care has been rendered. It is normally conducted by review of the members' medical record(s), including admitting diagnosis and presenting symptoms, as applicable.

Retrospective (post-service) review is required for:

- Emergency admissions to out-of-area or out-of-plan facilities,
- Outpatient and emergency room care received in non contracted facilities,
- Other care and services received by members when the provider of care will not cooperate with Health Plan review procedures and
- Other unauthorized care.

Medical Adjudication Department Nurses, who are a part of the Claims department, conduct all reviews using the MCG, Medicare or health plan protocols to review cases. This process can take up to 30 days. Only the Medical Director can issue denial decisions based on medical necessity of services.

7.11 Protocol for Notice of Medicare Non-Coverage (NOMNC)

You must deliver required notice to members at least 2 calendar days prior to termination of skilled nursing care, home health care or comprehensive rehabilitation facility services. If the member's services are expected to be fewer than 2 calendar days in duration, the notice should be delivered at the time of admission, or commencement of services in a non-institutional setting. In a non-institutional setting, if the span of time between services exceeds 2 calendar days, the notice should be given no later than the next to last time services are furnished.

Delivery of notice is valid only upon signature and date of member or member's authorized representative, if the member is incompetent. The notice must include an indication of the member's mentation at the time the notice is rendered; signed and dated by the issuer. The notice uses the standard CMS approved version entitled, "Notice of Medicare Noncoverage" (NOMNC).

Please visit www.mySHLprovider.com and click on Frequently Used Forms to view the NOMNC form as well as the CMS instructions.

The NOMNC is a standardized notice. Therefore, you may not change the language of the notice except where indicated, however the notice may be modified for mass printing to indicate the type of service being terminated if only one type of service is provided by the facility.

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**SECTION 8
CLINICAL GUIDELINES**

8 - Clinical Guidelines Summary

Sierra Health and Life (SHL) has developed a series of clinical practice guidelines for use by physicians and other health care professionals in managing various medical conditions. Some clinical guidelines have been developed with the input and direction of practicing SHL providers, and others have been adopted from the larger UnitedHealthcare group. In most cases, national expert consensus recommendations provide the basis for the final SHL guidelines. National expert recommendations may have been modified to make them applicable to the local environment in Nevada. These guidelines are reviewed at a minimum of every 2 years or as needed based on the release of new clinical evidence.

It is the intent of SHL that such guidelines constitute a framework that can be used by physicians and other health care professionals in managing medical and behavioral health conditions. In all cases, the provider's clinical judgment can override the actual written guideline if the provider feels that strict adherence to the guideline is not in the patient's best interest. If the provider decides to deviate from the guideline, an entry should be made into the medical record indicating the rationale for this variation.

This following is a list of the current SHL Clinical Guidelines. To avoid outdated versions, you can find the completed guidelines on the Sierra Health and Life web site at: www.myshlprovider.com, "I Need Help With", "Clinical Guidelines", and then select the guideline you wish to review.

- Acute Myocardial Infarction with ST Elevation
- Acute Myocardial Infarction without ST Elevation
- Acute Cough Illness (Acute Bronchitis)
- Asthma –Adult and Child
- Attention Deficit Hyperactivity Disorder (ADHD)
- Bipolar Disorder (Adults)
- Bipolar Disorder (Children and Adolescents)
- Cardiovascular Disease – Secondary Prevention and Risk Reduction Therapy for Patients with Coronary and Other Atherosclerotic Vascular Disease
- Cardiovascular Disease Prevention in Women
- Cholesterol Management – Treatment of High Cholesterol in Adults
- Chronic Obstructive Lung Disease
- Depression/Major Depressive Disorder
- Diabetes Mellitus
- Heart Failure
- Human Immunodeficiency Virus (HIV)
- Hypertension
- Lifestyle Management to Reduce Cardiovascular Risk
- Mechanical Circulatory Support Device (MCS)
- Neonatal Abstinence Syndrome
- Neonatal Abstinence Syndrome
- Neonatal Apnea and Bradycardia
- Neonatal Discharge Planning
- Obesity
- Physical Activity
- Preventive Services
- Schizophrenia

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- Sickle Cell Disease
- Spinal Stenosis
- Stable Ischemic Heart Disease
- Substance Use Disorders
- Tobacco Use

If you do not have access to the internet and would like to request a hard copy of the Clinical Guidelines, or if you would like information relating to guideline development, please call the Quality Improvement Department at (702) 242-7735.

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**SECTION 9
MEDICAL DIRECTOR**

9 - Medical Director

As an integral part of its' medical management services, SHL offers a knowledgeable Medical Director who is available 24-hours-a-day, 365-days-a-year for physician to physician communication. The SHL Medical Director may be reached through Southwest Medical Associates' PBX operator at **(702) 877-8600**. The operator will respond to contracted provider's requests to speak with the SHL Medical Director.

9.1 On-Call Medical Director

The Medical Director on-call can assist you with medical and administrative information and decisions related to emergency situations, hospital and sub-acute care admissions, emergency patient transfers and information on specialty consultations in unusual situations.

The Medical Director on-call is not meant to substitute for SHL's operations personnel who are available to address most routine activities, but is available for decisions requiring a physician's knowledge or oversight as needed.

All Medical Directors are licensed in the appropriate state, experienced and trained in utilization management and consult with Physician/Peer Reviewers as needed. Only a licensed physician can make UM denial decisions based on medical necessity. Additionally, a Medical Director oversees the appeals and grievance processes. If the Medical Director is unable to make a determination he/she will utilize a physician Specialist to review the request for prior authorization or appeal. A Medical Director chairs the Care Management Quality Improvement Subcommittee. This committee has oversight responsibility for all Health Plan utilization/case management activities.

Sierra Health and Life

<u>Physician</u>	<u>Specialty</u>
Rutu Ezhuthachan, M.D.	Pediatrics
Huy Ly, M.D.	Internal Medicine
Raul Mendez, M.D.	Internal Medicine
Laurine Tibaldi, M.D.	Internal Medicine/Hospitalist
Lambert Wu, M.D.	Cardiovascular Diseases

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SECTION 10

QUALITY ASSURANCE/RISK MANAGEMENT

10 - Quality Assurance/Risk Management

SHL's quality assurance methodology is based on: 1) reviews of adverse medical and dental outcomes as well as appropriateness and quality of care; 2) focused reviews of high volume/high risk diagnoses or procedures; 3) monitoring for trends; 4) peer review of the clinical process of care; 5) development and implementation of improvement action plans (corrective action plans), as appropriate; 6) monitoring compliance/adherence to improvement action plans; and 7) assessment of the effectiveness of the improvement action plans.

10.1 Quality of Review Structure

SHL uses a defined structure to conduct quality assurance activities. This structure includes:

- The Quality of Care Department serves as staff to the Peer Review Committee. This department is staffed by nurse reviewers trained to identify, investigate and evaluate potential quality of care issues.
- A Quality medical director conducts peer review on potential quality of care issues and may refer cases to the Peer Review Committee. This individual also chairs the Peer Review Committee.
- A dental director who conducts peer review on potential quality of care issues and may refer cases to the Peer Review Committee.
- The Peer Review Committee, which is composed of participating practitioners who represent primary medical and dental care and commonly used specialties.

10.2 Quality of Care Reviews

SHL uses a defined process to conduct quality of care reviews. This process includes:

Identification

SHL identifies areas for review through multiple avenues, including internal and external complaints that are forwarded from the Customer Response and Resolution (CRR) Department or submitted directly to the Quality of Care Department. Complaints may be solely medical or may have a behavioral health component.

The Quality of Care Department systematically monitors all complaints and concerns for the identification of potential trends.

Issue Coding

Each individual quality of care issue that is investigated is coded by category. These categories are used in tracking to identify provider-specific and system-wide trends that may need improvement action plans implemented.

Severity Leveling

Upon completion of the investigation, the individual case is assigned a severity level according to the attached Quality of Care Severity Levels. The table identifies criteria for each severity level, associated improvement action plan and the level of reviewer authorized to assign it.

Quality of Care Severity Levels

Level	Criteria	Assigned by	Improvement Action Plan Options (including but not limited to)
0	No quality of care issue identified.	Quality of Care Nurse Medical Director Peer Review Committee	2001: None (Track & trend)
1	Minor quality of care issue identified. (Generally a Level 1 case will be a minor departure from the Standard of Care with a low likelihood of a potential serious adverse outcome.)	Quality of Care Nurse Medical Director Peer Review Committee	2001: None (Track & trend) 2002: Education letter and/or materials 2003: Policy & procedure 2004: Verbal or written counseling 2005: Site visit
2	Moderate quality of care issue identified. (Generally a Level 2 case will be a moderate departure from the Standard of Care with a moderate likelihood of a potential serious adverse outcome.)	Medical Director Peer Review Committee	2003: Policy & procedure 2004: Verbal or written counseling 2005: Site visit 2006: Formal education/mandatory CME 2008: Focused medical care review
3	Serious quality of care issue identified. (Generally a Level 3 case will be a serious departure from the Standard of Care with a high likelihood of a potential serious adverse outcome.)	Peer Review Committee	2003: Policy & procedure 2004: Verbal or written counseling 2005: Site Visit 2006: Formal education/mandatory CME 2007: Medical system review 2008: Focused medical care review 2009: Report to State Licensing Authority 2011: Restriction, Suspension or Termination

Improvement Action

Peer review is the mechanism to review potential substandard or inappropriate care or inappropriate professional behavior by a SHL participating provider while providing care to a SHL member. If the findings of an investigation indicate that a participating provider has provided substandard or inappropriate care, or has exhibited inappropriate professional conduct, SHL will take appropriate action as defined by policies addressing quality of care referrals and applicable state of Nevada and federal laws. The scope of improvement action plans that may be taken if a quality issue is identified include, but are not limited to, education, policy and procedure revisions and counseling.

Participating provider performance related to quality of care is monitored on an ongoing basis. Any potential provider trends identified are evaluated further for additional action warranted. Issues that involve substandard care that are unable to be remediated with improvement action plans are considered for disciplinary action up to and including termination as a participating network provider. All peer review information is confidential.

10.3 Tracking for Trends/Patterns

Quality of care investigations are tracked to identify trends or patterns of issues that may be either provider specific or system-wide.

Thresholds have been established to evaluate potential provider trends and/or patterns

Further review with the potential for additional improvement action will be evaluated. At a minimum of semi-annually: Physicians and other Health Care Professionals that exceed the following thresholds within a six (6) month period of time will be reported:

- More than one (1) Level 3 case assigned
- More than one (1) Level 2 case assigned
- More than three (3) Level 1 cases assigned
- More than five (5) Level 0 cases assigned

Upon reaching any of these thresholds, the information is forwarded to the Peer Review Committee for review and further trend analysis. After review by the Peer Review Committee, additional improvement action may be required.

Adverse Professional Review Action

In cases in which the Peer Review Committee has determined it is necessary to take disciplinary action against a practitioner, SHL affords the affected practitioner the fair hearing/review process described in the Quality of Care Appeal policy. (For purposes of such termination review process, an "adverse professional review action" is an action or recommendation for disciplinary action that is based on the competence or professional conduct of the affected practitioner and that has the effect of suspending, restricting or terminating the affected practitioner's participation in the SHL networks.)

Coordination with Credentialing

To promote coordination with the SHL credentialing process, the Quality of Care Department shares historical quality of care case findings with the Credentialing Department for consideration during the credentialing/recredentialing process.

Feedback to Providers

Providers receive feedback on quality assurance activities, including results of quality reviews. Feedback may occur as written counseling, notification of improvement action plans, notification of system-wide policy and procedure changes, or provider profiling reports.

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SECTION 11

QUALITY IMPROVEMENT PROGRAM

11 - Quality Improvement Program

Sierra Health and Life (SHL) promotes continuous improvement in the quality of member care and service through the health plan's Quality Improvement (QI) Program. As part of the health plan's QI Program, SHL routinely monitors and evaluates indicators of performance, such as mammography screening rates, wait times for routine appointments, and member satisfaction. Health care and service outcomes are also measured through special projects or quality initiatives (QI studies). Providers can view quality improvement initiatives and documents through the Quality Corner section of the SHL Provider Web site (<https://myshlonline.com/provider>) or for a hardcopy, call (702) 242-7735.

11.1 Sierra Health and Life NCQA Accreditation

SHL is accredited by the National Committee for Quality Assurance (NCQA), and independent not-for-profit organization dedicated to measuring the quality of America's healthcare. Accreditation is for the commercial Preferred Provider Organization (PPO) product line in Nevada

NCQA accreditation surveys include rigorous on-site and off-site evaluations of over 60 standards, selected Healthcare Effectiveness Data and Information Set (HEDIS®) performance measures and member satisfaction survey measures. A team of physicians and managed care experts conducts accreditation surveys. A national oversight committee of physicians analyzes the survey team's findings and assigns an accreditation status based on the performance level of each plan being evaluated to NCQA's standards.

NCQA's accreditation standards are publicly reported in five categories:

- Access and Service
- Qualified Providers
- Staying Healthy
- Getting Better
- Living with Illness

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)

11.2 QI Program Structure

The SHL Quality Improvement Program structure includes a Quality Improvement Committee and several quality improvement subcommittees and task forces. The Quality Improvement Committee is made up of practitioners, medical directors, SHL administrators and other staff throughout the health plan.

The Quality Improvement Committee is responsible for setting quality improvement goals for the health plan, monitoring indicators of performance, and approving and evaluating quality improvement initiatives.

Some of the areas the QI subcommittees, and related task forces, address include:

- Health outcomes and preventive services,

- Management of chronic conditions related to medical and behavioral health,
- Child and adolescent health,
- Women's and neonatal health and
- All areas affecting health care and services related to federal and state regulatory requirements and voluntary accreditation.

Members of the Quality Improvement subcommittees and task forces are carefully selected to ensure representation by providers, multiple disciplines, administrators, and hands-on staff.

The most important component of the health plan's QI Program is the active participation of the health plan's provider network. SHL providers have the opportunity to participate on QI subcommittees and task forces or serve as "champions" for QI studies. If you are interested in participating in the quality improvement program, or would like more information on the program, please contact the Quality Improvement Department at: (702) 242-7735.

11.3 QI Initiatives

QI Initiatives include methodologically sound research projects focusing on areas of high volume, high-risk or state/federally mandated projects. Annually, SHL reviews a profile of its membership in an effort to design initiatives that represent the demographic and epidemiological characteristics and needs of health plan members. As a result, SHL carefully selects clinical, preventive health and service improvement areas for study.

11.4 Member and Practitioner Satisfaction Surveys

Member and practitioner satisfaction surveys provide important feedback on performance in a number of areas. SHL conducts an annual member satisfaction survey entitled the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey using an NCQA-Certified survey vendor. Routine patient satisfaction surveys are also conducted of SHL members who access primary and specialty care. In addition, SHL conducts annual satisfaction surveys of its provider network. Data collected from these surveys are analyzed by SHL and opportunities for improvement are identified. The member and practitioner satisfaction surveys frequently result in the creation and implementation of focused quality improvement activities.

11.5 HEDIS® Measures

Annually, SHL collects and reports on data to prepare a full set of Healthcare Effectiveness Data and Information Set (HEDIS®) performance indicators. HEDIS is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare health care quality. HEDIS is also the measurement tool used by the nation's health plans to evaluate their performance in terms of clinical quality and customer service. The following is a list of key HEDIS Effectiveness of Care Measures:

- Adult BMI Assessment.
- Ambulatory Care-ED Visits
- Breast Cancer Screening.
- Children and Adolescents' Access to Primary Care ages 12-24 months, 25 months to 6 years, 7 to 11 years, and 12 to 19 years.
- Colorectal Cancer Screening.

- Comprehensive Diabetes Care (i.e., Hemoglobin A1C testing, Retinal Eye Exam, Cholesterol Screening, Medical Attention for Nephropathy and Blood Pressure Control).
- Controlling High Blood Pressure.
- Follow-up after Hospitalization for Mental Illness (7-days).
- Osteoporosis Management in Women Who Had a Fracture
- Plan All-Cause Readmissions
- Prenatal and Postpartum Care
- Rheumatoid Arthritis Drug Therapy
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth years of life.

SHL prepares a full set of HEDIS measures annually through the analysis and reporting of data collected through medical record review and claims and encounters data, (such as laboratory, pharmacy and health care utilization) for commercial, Medicare and Medicaid members. SHL looks to the network of providers to share health care data with SHL in order to generate accurate reports. As part of this annual data collection, the SHL's Quality Improvement Department may request access to medical records and charts to abstract specific HEDIS® information.

11.6 Quality and Patient Safety Reminders

Maintaining high quality and promoting optimal patient safety are critical goals for the entire health care system. SHL supports physicians and other health care professionals within the health plan network in their crucial roles to achieve these objectives.

Tips and Tools for Health Care Providers about Patient Safety

1. Promote health literacy and greater understanding of medical information by patients.

Why Promote Health Literacy?

- People with low health literacy are: often less compliant with treatment and medications; fail to seek preventative care; at higher risk for hospitalization; remain in the hospital longer; and often require additional health care treatment.
- A provider may not be aware that individuals have low health literacy because individuals may be embarrassed or ashamed to admit when they have difficulty understanding their doctors or they may use well-practiced coping mechanisms that mask their problems.

Simple Approaches to Health Literacy

- Create a comfortable environment to encourage open communication with patients.
- Use simple language/terms instead of medical or technical descriptions.
- Communicate with the patient at eye level (e.g., sit instead of stand).
- Use visual aids in teaching your patient about the procedure or medical condition.
- Have your patients demonstrate or verbally repeat back what they understood.

Additional Tips:

- Use "I speak cards" to identify languages spoken by your patients
- Use symbols for signage in your office.
- Record primary language and ethnic background information in patient charts.
- Educate your front-office staff on health literacy and cultural competency.

Encourage patients to ask three questions to ensure compliance with medical instructions given.

- What is my main problem?
- What do I need to do?
- Why is it important for me to do this?

Provide patients with the brochure “Ask Me 3” or direct them to the Web site at: <https://npsf.site-ym.com/default.asp?page=askme3>. These brochures, available in English and Spanish, were created by the Partnership for Clear Health. Brochures can be used by patients to track the answers to the three questions during each office visit.

Additional Resources:

- Georgetown University National Center for Cultural Competence: <https://nccc.georgetown.edu/>
- U.S. Department of Health & Human Services, Quick Guide to Health Literacy and Older Adults: <http://www.health.gov/communication/literacy/olderadults/literacy.htm>

2. Promote Medication Safety

- Perform a complete medication history, including current and past medications, including prescription medications, over the counter medications and herbal products.
- Ask your patient during each visit the medications they take and if they are experiencing any side effects.
- Document and update allergies and adverse reactions in the patient's medical record.
- Educate patients about medications, including risks, benefits, possible side effects, actions, appropriate administration and what to do if they miss a dose.
- Encourage patients to keep current lists of their medications with them.
- Avoid unnecessary antibiotic use.

Educational materials on appropriate antibiotic use are available from Nevadans for Antibiotic Awareness collaborative's Web site at:

<http://www.nevadapublichealthfoundation.org/programs/nevadans-for-antibiotic-awareness/>

3. Facilitate Continuity and Coordination of Care

- Obtain and include in the medical record, copies of discharge summaries, laboratory/radiology results, consultation reports and other related documents from facilities and health care providers who perform services for individual patients.
- Forward copies of patient's critical health information such as: the results from the history and physical examination, list of current medications, documentation of major illnesses/surgeries (including allergies) and current treatment plan when transferring a patient to another practitioner.

SHL conducts an annual audit to ensure that appropriate information is being communicated to different health care providers. During the audit, a review is conducted on a random sample of primary physician medical records for health plan members who have received services from home health agencies, skilled nursing facilities, hospitals and ambulatory surgical centers. The goal of this initiative is to ensure that the appropriate discharge summaries and/or operative

reports have been disseminated to primary care providers. Results of this annual audit demonstrate that opportunities for improvement still exist. If you have any recommendations to improve this communication process, please contact the SHL Quality Improvement Department at: (702) 242-7735.

11.7 Disease Management Program

SHL works to improve the health status of members with chronic conditions through its Disease Management Program. The Disease Management Program includes member and practitioner education and targeted interventions for members who are at higher risk for complications or future health care utilization.

The goal of the Disease Management Program is to partner with network providers to help members better self-manage their health. Below is an overview of the components in the Sierra Health & Life's current Disease Management Program.

Evidence-Based Clinical Practice Guidelines

SHL uses evidence-based clinical practice guidelines as the basis for its Disease Management Program. You may access these guidelines on the provider section of the SHL website at: www.mySHLprovider.com, "I need help with", select "Clinical Guidelines". For a hardcopy of a guideline, call (702) 242-7735.

Identification for the Disease Management Registry

Members are identified for the Disease Management Program systematically by using criteria developed under the guidance of primary and specialty care practitioners. SHL uses one or more of the following data sources to identify members with specific chronic conditions such as asthma (pediatric and adult) and diabetes for Disease Management Program interventions. These sources include laboratory, pharmacy and claims/encounter (including in-patient and out-patient utilization) data. Once identified, members are stratified according to levels of risk for future health care utilization and potential complications.

How SHL Works with Members in Disease Management Program

Members identified for the Disease Management Program receive mailings from SHL advising them of the benefits of the programs and a contact number to call if the members do not wish to participate or have been identified in error. Individuals who participate in the Disease Management Program automatically receive certain benefits directly from the health plan and may access other benefits directly or through their primary physicians.

Benefits provided to members directly by the health plan:

- Member-friendly guidelines to help them better manage their conditions.
- Annual flu shot reminders.
- Reminders for important services, such as diabetes eye exams.
- General mailings with condition-specific education at least once a year.
- Telephone calls from R.N. health coaches for individuals at high and moderate risk for future health care utilization.

Benefits available to members through primary physicians:

- Referral to the health plan's specialty clinics.
- Referral to the health plan's Tobacco Cessation Program (members may also self-refer to the program).
- Case management for high-risk members.

Benefits that may be directly accessed by members:

- Participation in the health plan's Health Education and Wellness classes and one-on-one consultations on a variety of subjects including the management of chronic conditions, preventive health and additional topics.
 - Health plan providers may also make referrals to HEW services.
- 24-hour Telephone Advice Nurse service.
- Urgent Care after hours.

How Practitioners Can Use Disease Management Services

SHL issues member-specific "Gaps in Care" reports to primary physicians on a quarterly basis. Members in the SHL Disease Management registry who are impaneled to each primary physician will appear on these reports. These profiles highlight whether individual members have received important condition-specific tests and preventive services. These reports allow providers to follow-up with individuals to schedule necessary appointments.

The gaps in care reports supply a variety of information, such as relevant medical test dates and results, flu shot status, utilization information (e.g., ER and UC visits), preventive services (e.g., diabetes eye exams) and/or medication usage and compliance in the previous 12 months. This information will be focused on each individual's specific chronic condition.

Providers may refer individuals for Health Education and Wellness (HEW) classes or the Tobacco Cessation Program -

3 ways to refer patients to Health Education and Wellness

- 1.) Call 702-877-5356
- 2.) Fax to 702-838-1404
- 3.) Visit mySHLonline.com and sign in to the online provider center (@ your service).

Primary Components of SHL's Disease Management Program

Diabetes

- Clinical guidelines for providers are available to assist in the management of diabetes. These guidelines can be found in the provider section of the SHL Web site.
- Member-specific gaps in care reports supply providers with detailed information, at the individual patient level, based on their level of risk of future health care utilization and complications and the numbers of diabetes-related services for impaneled members.
- Educational opportunities are available for members including Health Education and Wellness classes that focus on:
 - Diabetes. Classes and one-on-one or group consultations are designed to help members better understand diabetes, how it affects them and how to take control.
 - Smoking cessation. The behavior modification program is designed to help people learn how to make it through the quitting process.

- Annual flu vaccination reminders help members remember to take advantage of this important preventive health service.
- R.N. health coaches are available for people with diabetes at high and moderate risk of future health care utilization. Follow-up phone call contact frequency is determined on member needs.
- Diabetes retinal exam reminders help members take advantage of this important screening exam for early identification of eye problems.
- Complex Case Management services are provided for members who are at high risk of hospitalization or emergency care. The health plan's case managers coordinate services and promote communication among the different providers and facilities. Case Managers help members adhere to treatment plans and facilitate needed services.

Pediatric and Adult Asthma

- Clinical guidelines for providers are available to assist in the management of pediatric and adult asthma. These guidelines can be found in the provider section of the SHL Web site.
- Member-specific gaps in care reports supply providers with detailed information, at the individual patient level, based on the patient's level of risk for future health care utilization and complications and the numbers of pediatric and adult asthma-related services for impaneled members.
- Educational opportunities are available for members including Health Education and Wellness classes for adults and parents with children that focus on:
 - Pediatric and adult asthma. Classes and one-on-one or group consultations are designed to help parents and children, and adults better understand asthma, how it affects children and their families and how to take control.
 - Smoking cessation. The behavior modification program is designed to help individuals learn how to make it through the quitting process and thus provide a smoke-free home.
- Annual flu shot reminders help members take advantage of this important preventive health service.
- Telephone calls from R.N. health coaches are available for parents of children with asthma and adults at high and moderate risk of future health care utilization. Follow-up calls are scheduled according to the member's or child's needs.
- Complex Case Management services are provided for children and their parents and adults who are at high-risk of hospitalization or emergency care. R.N. case managers coordinate services and promote communication among the different providers and facilities. Case managers help adults and families adhere to treatment plans and facilitate services.

If you have an individual who would benefit from participation in the SHL's Disease Management Program, please contact the Disease Management Department at (702) 242-7346 or (877) 692-2059.

Disease Management Program Member Education Materials

The Disease Management Program offers free educational materials for providers. These brochures are designed to help educate health plan members on how to self-manage their health. Many brochures are available in both English and Spanish. Examples of available information includes: Advanced Directives; Ask Me 3 brochures that assist individuals in asking the right questions of health care providers during office visits; and Anti-depressant Medication

Management flyers to help members understand depression. To find out what materials are available and place an order, please call: (702) 242-7346.

11.8 Complex Case Management Program

SHL offers a comprehensive Complex Case Management (CCM) program free of charge to its health plan members. This program is designed to complement the care provided by physicians and other healthcare professionals while encouraging individuals to become more active participants in their health care.

- The definition of the CCM Program is the coordination of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.
- The goal of the CCM Program is to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member's condition; determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow-up.

The Complex Case Management Programs works with the following individuals:

- Members with high cost and frequent utilization patterns. These members include individuals who have been hospitalized and/or have used the Emergency Department frequently and/or are taking multiple and potentially high cost medications.
- Members diagnosed with neurological diseases and spinal cord injuries.
- Members diagnosed with cancer who are either being treated outside the service area or are not being managed under a contracted cancer program within the health plan's service area.
- Members with multiple diagnoses who are seeing multiple specialists and require coordination of care.
- Members who have experienced severe trauma (e.g., burns, motor vehicle accidents, etc.).
- Members with chronic illnesses not managed by the health plan's Disease Management Program.
- High risk children and adolescents (e.g., individuals with congenital anomalies, individuals with severe asthma, and individuals on home ventilators).
- High risk pregnant women (e.g., individuals with congenital anomalies, individuals at risk of premature delivery, and individuals presenting with others high risk diagnoses).
- New Medicare enrollees who are identified through the health risk screen process as high risk for future hospitalization.
- Members with complex medical and psychosocial issues who are referred to Complex Case Management.

If you have an individual who would benefit from participation in the SHL's Complex Case Management Program, please contact the CCM Department at: (702) 242-7423 or (877) 692-2058.

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SECTION 12

CLAIMS

12 - Claims

For several years, Sierra Health and Life (SHL) has been developing and refining a comprehensive policy on medical claim coding and adjudication. The goal of the policy is to fairly and consistently pay claims. SHL's claims processing time frames have been defined based upon Nevada State Statutes and Regulations.

12.1 Claims Adjudication and Payment

For levels of care and up-to-date procedural coding, SHL relies upon the codes in the latest edition of Current Procedural Terminology (CPT). The Resource Based Relative Value Scale (RBRVS) along with other guidelines are used for the adjudication of claims. The following guidelines will explain how certain levels of service are evaluated to pay correctly for care provided to SHL members:

Office Visits- Code 99211: for evaluation and management of established patient that may not require the presence of a physician. Typically 5 minutes are spent performing or supervising these services.

- Blood pressure determination for adequacy of control

Office Visits- Codes 99201, 99212: Usually the presenting problem(s) are self-limited or minor. Physicians typically spend 10 minutes face to face with patient and/or family. **An established patient requires two of the three components and a new patient requires all three components.**

- A problem focused history
- A problem focused examination
- Straightforward medical decision making

Office Visits- Codes 99202, 99213: Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes, face to face with an established patient and/or family and 20 minutes, face to face, with a new patient and/or family.

An established patient requires two of the three components and a new patient requires all three components.

- An expanded problem focused history
- An expanded problem focused examination
- Straightforward medical decision making (New Patient)
- Medical decision making of low complexity (Est. Patient)

Office Visits- Codes 99203: Usually the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face to face with a new patient and/or family. **For new patients, all three components must be met.**

- A detailed History
- A detailed Examination
- Medical decision making of low complexity

Office or Other Outpatient Consultations – Consult Code 99241: Usually the presenting problem(s) are self-limited or minor. Physicians typically spend 15 minutes face to face with patient and/or family. **For new or established patients all three components must be met.**

- A problem focused history
- A problem focused examination
- Straightforward medical decision making

Office or Other Outpatient Consultations – Consult Code 99242: Usually the presenting problem(s) are of low severity. Physicians typically spend 30 minutes face to face with patient and/or family. **For new or established patients all three components must be met.**

- An expanded problem focused history
- An expanded problem focused examination
- Straightforward medical decision making

Office or Other Outpatient Consultations – Consult Code 99243: Usually the presenting problem(s) are of moderate severity. Physicians typically spend 40 minutes face to face with patient and/or family. **For new or established patients all three components must be met.**

- A detailed history
- A detailed examination
- Medical decision making of low complexity

Medical Records Required –

Codes 99204, 99214, 99205, 99215, 99244, 99245

If you use these billing codes, SHL **requires a copy of the chart/progress note** to accompany the billing. The issue of confidentiality is strictly maintained by having only medical personnel review the chart/progress note.

Office Visits– Code 99204: Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes, face to face, with a new patient and/or family; which **require these three components.**

- A comprehensive history
- A comprehensive examination; and
- Medical decision making of moderate complexity

Office Visits– Code 99214: Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes, face to face, with an established patient and/or family. **An established patient requires two of the three components.**

- A detailed History
- A detailed Examination
- Medical decision making of moderate complexity

Office Visits– Code 99205, 99215: Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes, face to face, with an established patient and/or family; 60 minutes face to face with a new patient and/or family. **An established patient requires two of the three components and a new patient requires all three components.**

- A comprehensive history
- A comprehensive examination
- Medical decision making of high complexity

Office or Other Outpatient Consultations – Consult Code 99244: Usually the presenting problem(s) are of moderate severity. Physicians typically spend 60 minutes face to face with patient and/or family. **For new or established patients all three components must be met.**

- An comprehensive history
- An comprehensive examination
- Medical decision making of moderate complexity

Office or Other Outpatient Consultations – Consult Code 99245: Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes face to face with patient and/or family. **For new or established patients all three components must be met.**

- An comprehensive history
- An comprehensive examination
- Medical decision making of moderate complexity

As outlined above, **if a chart/progress note is required with the billing but one is not included by the physician's office, the claim will be coded to the appropriate level of service.** The claim can be re-submitted for consideration, send a copy of the EOP together with the appropriate chart/progress note and indicate "resubmission" on the EOP.

SHL recognizes that claim problems occur from time to time. We appreciate our physicians and providers bringing them to our attention. We handle these claims as expeditiously as we can. Reasonable procedural guidelines are established to manage them fairly.

Dental Claims Guidelines

Sierra Health and Life (SHL) applies the following guidelines for dental claim processing:

- Periodontal charting is required for periodontal scaling and root planning, as well as periodontal surgeries. If charting is not available, duplicate x-rays can be submitted.
- Duplicate x-rays are required for crowns as well as documentation regarding whether the placement is an initial or a replacement including the age of the existing crown(s).
- Duplicate x-rays and a narrative are required for non-cosmetic inlays and onlays when covered.
- Duplicate x-rays are required for bridges, as well as documentation regarding whether the placement is an initial or a replacement including the age of the existing bridge(s).
- Extraction dates or treatment plan for extractions are required for dentures and partials, as well as documentation regarding whether the placement is an initial or a replacement including the age of the existing denture/partial.

12.2 Billing Procedures

A managed system of health care necessitates that all providers be accountable for both the treatment dispensed to the patient and the charges billed to the payer for this treatment

Plan Providers agree to accept the contracted amount paid by SHL as payment in full. The patient may be billed for the following:

- co-payment
- deductible
- coinsurance
- non-covered services - as defined in the member's Evidence of Coverage. All such services must be fully explained to members prior to providing the services.

Billings for some members may involve coordination of benefits. For example:

If the member is covered as a dependent under SHL and an employee under other group coverage, the other group coverage has primary responsibility for the costs of services.

Dependent children carried on two plans may be primarily covered by either SHL or the other group coverage.

When a member is injured through the actions of another person (third party) and is entitled to compensation from that third party, members are asked to assign SHL any compensation for which they are entitled from the third party. This will allow SHL to seek reimbursement from the third party for claims it paid on behalf of the member.

Please follow these simple steps when billing SHL:

- Verify eligibility by using one of the following three options:
 - Calling the Member Services Department. Please refer to Section 3 Frequently Called Numbers for the appropriate Member Services Department phone number.
 - @YourService – online eligibility system. *(For information or access to @YourService, please refer to section 6.4)*
 - Interactive Voice Response SHL **(702) 242-7724** or **(800) 768-2808**
 - *(For more information about IVR, please refer to section 6.3)*
- Check the back of the member's ID card for claim and billing information.
- Note the member number listed on the SHL ID card on the claim.
- Collect the applicable co-payment, deductible and/or coinsurance from the member. Check with the Member Services Department on any questions about the member's coverage.
- Use industry standard EDI transactions or claim forms to bill HPN making sure to include the information below. *(Clean Claim elements can be found at the end of this section)*
 1. Patient's name
 2. Date of Birth
 3. Member number(s)
 4. Other insurance information
 5. Diagnosis(es) and ICD-10 code(s)
 6. Date(s) of service
 7. Services provided, CPT code(s), and appropriate modifiers and units
 8. Copy of chart/progress note*
 9. Amount charged
 10. Provider's signature and tax ID number
 11. National Provider Identification Number (NPI)
- *All billings for an extended or comprehensive level of service require a chart/progress note. If the documentation does not substantiate the code used, the claim will be coded

to the appropriate level of service. The claim can be reconsidered by sending a copy of the EOP together with the additional chart/progress notes and indicate "resubmission" on the EOP.

- Submit claim(s) to:

Sierra Health and Life
Attention: Claims Department
P.O. Box 15645
Las Vegas, NV 89114-5645

12.3 Dental Predetermination of Benefits

Dental predetermination of benefits is recommended for the treatment of any dental disease, defect, or injury. Predetermination of benefits is processed at the claim level and should be submitted to the claims billing address. Predetermination is not mandatory and benefits are not reduced as a result of predetermination not being submitted.

To submit a predetermination of benefits, prepare a standard claim form using American Dental Association (ADA) codes and submit the predetermination to:

Sierra Health and Life
Attention: Dental Claims
P.O. Box 15645
Las Vegas, NV 89114-5645

Predetermination of Dental Benefits - Sample Copy

ADA American Dental Association* Dental Claim Form																
HEADER INFORMATION																
1. Type of Transaction (Mark all applicable boxes): ☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization ☐ BPSDT/ TDR XXX																
2. Predetermination/Preauthorization Number																
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION																
3. Company/Plan Name, Address, City, State, Zip Code																
POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)																
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																
13. Date of Birth (MM/DD/YYYY) 14. Gender ☐ M ☐ F 15. Policyholder/Subscriber ID (SSN or ID#)																
16. Plan/Group Number 17. Employer Name																
OTHER COVERAGE (Mark applicable box and complete items 5-11, if none, leave blank.)																
4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)																
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)																
6. Date of Birth (MM/DD/YYYY) 7. Gender ☐ M ☐ F 8. Policyholder/Subscriber ID (SSN or ID#)																
9. Plan/Group Number 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other																
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code																
PATIENT INFORMATION																
18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other																
19. Reserved For Future Use																
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																
21. Date of Birth (MM/DD/YYYY) 22. Gender ☐ M ☐ F 23. Patient ID/Account # (Assigned by Dentist)																
RECORD OF SERVICES PROVIDED																
24. Procedure Code (MM/DD/YYYY)	25. Area of Oral Care	26. Tooth System	27. Tooth Number(s) or Location	28. Tooth Surface	29. Procedure Code	30. Drug Prescribed	31. Qty	32. Description	33. Fee							
1																
2																
3																
4																
5																
6																
7																
8																
9																
10																
34. Missing Teeth Information (Place an "X" on each missing tooth.)					34a. Diagnosis Code List Qualifier ☐ (ICD-9 = B; ICD-10 = AE)					34b. Other Fee(s)						
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
35. Remarks										32. Total Fee						
AUTHORIZATIONS										ANCILLARY CLAIM/TREATMENT INFORMATION						
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dental or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.										38. Place of Treatment ☐ (e.g. In-office, 22=OP Hospital; Use "Place of Service Codes for Professional Claims")						
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.										39. Enclosures (Y or N) ☐						
X Patient/Guardian Signature _____ Date _____										40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)						
X Subscriber Signature _____ Date _____										41. Date Appliance Placed (MM/DD/YYYY)						
42. Months of Treatment Remaining ☐ No ☐ Yes (Complete 44)										43. Replacement of Prosthesis						
44. Date of Prior Placement (MM/DD/YYYY)										45. Treatment Resulting from ☐ Occupational Illness/Injury ☐ Auto accident ☐ Other accident						
45. Date of Accident (MM/DD/YYYY)										47. Auto Accident State						
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured subscriber.)										TREATING DENTIST AND TREATMENT LOCATION INFORMATION						
48. Name, Address, City, State, Zip Code										52. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed. X _____ (Signed Treating Dentist) _____ Date _____						
49. NPI										54. NPI						
50. License Number										55. License Number						
51. SSN or TIN										56. Address, City, State, Zip Code						
52. Phone Number										57. Phone Number						
53. Additional Provider ID										58. Additional Provider ID						

© 2012 American Dental Association
 J439 (Replaces ADA Dental Claim Form - J431, J432, J433, J434, J435)

To reorder call 800.947.4746
 or go online at ada.org

12.4 National Provider Identifier (NPI)

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses use the NPIs in the administrative and financial transactions adopted under HIPAA. A valid NPI is required on all covered claims (paper and electronic) in addition to the TIN.

What is the NPI – National Provider Identifier?

- The NPI is a 10-digit, intelligence free numeric identifier (10 digit number). Intelligence free means that the numbers do not carry information about health care providers, such as the state they practice or their provider type or specialization.
- The NPI replaces health care provider identifiers in use today in HIPAA transactions. Those numbers include Medicare legacy IDs (UPIN, OSCAR, PIN and National Supplier Clearinghouse or NSC).
- The provider's NPI does not change and remains with the provider regardless of job or location.

For more information regarding NPI you can contact CMS at **(800) 465-3203**, Provider Services at **(702) 242-7088 or (800) 745-7065**, or information is available on a CMS web page- <https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/>

12.5 Timely Filing Period

Claims for covered services shall be submitted within 30 calendar days of the date of service, and in no event later than 90 calendar days. If a claim is submitted more than 90 calendar days after the date of service, that claim will be considered stale dated. Claims not submitted within this timely filing period will not be honored for payment. Re-considerations or resubmission or any follow-up must be clearly identified and submitted within one year from the date of service. Submit claims(s) to:

Sierra Health and Life
Attention: Claims Reconsideration
P. O. Box 15645
Las Vegas, NV 89114-5645

You will be notified of any denials of requested covered services. You may request an appeal by the SHL Medical Director and/or the peer review committee.

12.6 Coordination of Benefits

When SHL is the secondary insurance payer, claims are allowed up to 6 months beyond the timely filing period. This allows for up to 9 months for secondary claims to process.

12.7 Imaging, Batch Processing, Claims Processing

All claims are scanned into the work flow system within 7-8 business days of receipt. To assist in the scanning process of your claim, avoid the following:

- light images
- red ink
- printing alignment where the print is on the line
- highlighting on the claim
- font sizes smaller than 10 pt.

They make the image illegible and may result in the claim being delayed or returned. Images of the claims are keyed into our work flow system. The claims are then automatically adjudicated nightly through batch processing on our claims payment system. Pended claims are reviewed using the image, not the paper claim.

The system improves our overall efficiency and turnaround time, as well as enables all departments within SHL to provide our customers with superior service.

12.8 Altered Claim Images

Federal requirements regarding fraud review have prompted the need for restrictions regarding altered claim images. All claim images received which have an apparent alteration (i.e. handwritten dates of service, charges, diagnosis, CPT code information, and/or information crossed out, etc.) will be returned to the provider's office with a cover letter stating,

"This claim cannot be processed for payment. It is apparent that some of the information on the claim form has been altered. Pursuant to company policy we cannot accept altered claim forms or photocopies of claim forms. All claims must be submitted on the correct form with clean unaltered information."

This process allows Sierra Health and Life to follow industry standard guidelines with regard to altered claim images and ensures that SHL maintains compliance with Federal Regulations.

12.9 Electronic Claims Submission

As you aware, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 included administrative simplification provisions requiring standards be adopted for electronic health care transactions.

The transaction with the most discussion has been electronic claim submission. Any claim submitted by a provider to a health plan must be in the HIPAA approved ANSI 837 format as of October 16, 2003. Many plans and providers have opted to use intermediaries to meet this deadline.

SHL has chosen to use intermediaries for the receipt of electronic claims data. SHL has completed compliancy testing and is able to receive HIPAA compliant electronic claims from the following clearinghouse:

OptumInsight
1755 Telstar Drive, #400
Colorado Springs, CO 80920

(800) 341-6141

**For Electronic Claims Submission, please use the following Payor ID:
Claims – Payor ID 76342**

Although the Health Plan has one contracted clearinghouse, you may coordinate with your clearinghouse to transmit your electronic claims to OptumInsight.

SHL will continue to receive paper claims. Any claim requiring attachments should be submitted hard copy. If an electronic claim is received which requires an attachment, the claim will be adjudicated without the attachment and the explanation of payment will need to be submitted with the attachment for reconsideration of the claim.

Please check our website for continual updates regarding electronic claims submission and the addition of new clearinghouses.

12.10 Electronic Explanation of Payment (EOP) Requests

Explanations of Payments (EOP's) are generated each time a claim or encounter is processed by the Health Plan. EOP's contain detailed information such as claim adjudication, processed date and check numbers, as applicable.

An electronic copy of the EOP may be obtained through [@YourService](#), which offers providers the opportunity to view the EOP on line. For more information regarding [@YourService](#) see Section 6.4.

Explanation of Payments can be printed by logging into your [@YourService](#) account. If you do not have an [@YourService](#) account, please go to www.myaysonline.com and click on "Create an Account" and follow the instructions

For additional information or questions please contact your Provider Advocate.

12.11 Electronic Funds Transfer (EFT's)

HPN/SHL offers free electronic funds transfer (EFT) through InstaMed, a new EFT/ERA Provider. InstaMed offers the free Payer Payments solution to deliver your payments as electronic remittance advice (ERA) and electronic funds transfer (EFT). To receive your HPN and SHL payments as free ERA/EFT, please register at www.instamed.com/eraeft.

You may also contact InstaMed directly at (866) 945-7990 or connect@instamed.com with any questions.

12.12 HIPAA 5010

The Centers for Medicare & Medicaid Services (CMS) mandated that all physicians/hospitals and payers (including clearinghouses and health plans) exchange key business transactional data using the HIPAA 5010.

5010 is the newest version of the HIPAA electronic transaction standards. The 5010 standards include improvements in health care transactions such as structural, scope and overview of the transaction (also known as front matter), technical and data content such as improved eligibility responses and better search options. The 5010 standards are more specific in requiring the data that is needed, collected and transmitted in a transaction. The new claims transactions standard contains significant improvements for reporting of clinical data, by requiring diagnosis codes and procedure codes to be captured based on principle diagnosis, admitting diagnosis, external cause of injury and patient reason for visit codes. These distinctions are intended to improve the understanding of clinical data and to improve monitoring of mortality rates for certain illnesses, outcomes for specific treatment options, hospital lengths of stay for certain conditions, and clinical reasons for patients' decisions to seek hospital care.

CMS requires that all 5010 data elements are included in each claim submission, therefore SHL will not accept 5010 claim submissions if data elements are missing.

To learn more about the 5010 mandate please visit the government website at:

https://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/Version_5010.html

The 5010 requirements apply to all types of claims and claim related transactions, including claims that are reimbursed through capitated payment arrangements or claims from delegated entities.

12.13 Claim Reconsideration Process

A Claim Reconsideration request is typically the quickest way to address any concern you have with how we processed your claim. With a Claim Reconsideration request, we review whether a claim was paid correctly and confirm your contract is set up correctly in our system.

Sierra Health and Life has developed a Quick Reference Guide for our Providers to assist you in the reconsideration process. Please visit our website at www.myshlprovider.com, click on "I need help with", then "Submit/Appeal a Claim" to access the Quick Reference Guide.

The Quick Reference Guide will outline instructions for submitting Claim Reconsideration requests using the 3 following methods.



Mail: Using the Claim Reconsideration form you can submit a claims reconsideration request and include all pertinent documentation for reconsideration. The claim reconsideration form is available for download on www.myshlprovider.com, click on "I need help with" then "Frequently Used Forms" or in the Frequently Used Forms, Section 23.6, of this summary guide.



Telephone: You can call Member Services to request an adjustment for a claim that does not require written documentation. For SHL members please call **(800) 888-2264**.



Claims Project: If you have a request involving 20 or more paid or denied claims, you may send a claims project request to us. The project may be sent via secure email to pri@sierrahealth.com. An Excel template is available for download on www.myshlprovider.com. Click on "I need help with", then "Submit/Appeal a Claim". Please follow the instructions in the Claims Quick Reference Guide.

Please allow 30 days from the received date of the claims reconsideration for review.

If you have any questions, please contact Provider Services at 702-242-7088 or 1-800-745-7065, Monday – Friday from 8:00 AM to 5:00 PM PST.

12.14 Clean Claim Elements

NAC 686A.280 Definitions. (NRS 679B.130, 686A.015) As used in **NAC 686A.280** to **686A.306**, inclusive, unless the context otherwise requires, the words and terms defined in **NAC 686A.282**, **686A.284** and **686A.286** have the meanings ascribed to them in those sections.

(Added to NAC by Comm'r of Insurance by R175-01, eff. 5-23-2002)

NAC 686A.282 "Clean claim" defined. (NRS 679B.130, 686A.015) A "clean claim" means a claim:

1. That contains the information required to be included for the applicable use of a form prescribed in **NAC 686A.288**; and
2. For which any additional information that has been requested pursuant to subsection 2 of **NRS 683A.0879**, **689A.410**, **689B.255**, **689C.485**, **695B.2505** or **695C.185** because of any particular or unusual circumstances that would have impeded the payer from paying the claim has been received.

(Added to NAC by Comm'r of Insurance by R175-01, eff. 5-23-2002; A by R026-12, 9-14-2012)

NAC 686A.284 "Health care practitioner" defined. (NRS 679B.130, 686A.015) "Health care practitioner" means a person licensed to practice one of the health professions regulated by title 54 of NRS.

(Added to NAC by Comm'r of Insurance by R175-01, eff. 5-23-2002)

NAC 686A.286 "Payer" defined. (NRS 679B.130, 686A.015) "Payer" includes administrators, individual health insurers, group health insurers, nonprofit hospitals, medical and dental service corporations and health maintenance organizations who pay claims under any contract for health insurance.

(Added to NAC by Comm'r of Insurance by R175-01, eff. 5-23-2002)

NAC 686A.288 Forms for submission of claims. (NRS 679B.130, 679B.138, 686A.015)

1. The payer of a claim under a contract for health insurance:
 - (a) Shall accept a claim submitted on a form that:
 - (1) Has been approved by the United States Department of Health and Human Services for the filing of a claim under a contract for health insurance; and
 - (2) Contains the information necessary to constitute a clean claim.
 - (b) Shall not require the completion of any other form for the purpose of processing the claim.
2. For the purposes of this section, a "form that has been approved by the United States Department of Health and Human Services" means:
 - (a) For claims submitted by a hospital or other institutional provider, Centers for Medicare and Medicaid Services Form CMS-1450, which is commonly referred to as UB-04, or its successor form; and
 - (b) For claims submitted by a health care practitioner or other person entitled to reimbursement, Centers for Medicare and Medicaid Services Form CMS-1500, or its successor form.
3. Form CMS-1450, also known as the UB-04 claim form, published by the National Uniform Billing Committee, is available from the American Hospital Association on the Internet at <http://aha.org/>, by telephone at (800) 242-2626, or by mail at 155 North Wacker Drive, Chicago, Illinois 60606, at the price of \$46 for members and \$56 for nonmembers. Copies of the form may also be available through office supply stores.
4. Form CMS-1500, published by the National Uniform Claim Committee, is available from the United States Government Printing Office on the Internet website <http://bookstore.gpo.gov>, by mail at P.O. Box 979050, St. Louis, Missouri 63197-9000, or by toll-free telephone at (866) 512-1800, at the price of \$29. Copies of the form may also be available through local printing companies and office supply stores.

(Added to NAC by Comm'r of Insurance by R175-01, eff. 5-23-2002; A by R026-12, 9-14-2012)

NAC 686A.290 Commencement of time for adjudication and payment of claims. (NRS 679B.130, 686A.015) The time for a payer to adjudicate and pay claims pursuant to **NRS 683A.0879, 689A.410, 689B.255, 689C.485, 695B.2505** and **695C.185** begins when the payer receives a clean claim.

(Added to NAC by Comm'r of Insurance by R175-01, eff. 5-23-2002)

NAC 686A.302 Claim by hospital or other institutional provider: Prohibited use of field; optional inclusion of additional data. (NRS 679B.130, 679B.138, 686A.015)

1. A payer shall not use or require a hospital or other institutional provider to use any field for purposes that are inconsistent with the data required for the submission of a clean claim, or in addition to the applicable standard code set.

2. A hospital or other institutional provider may elect to include data in addition to the data required for the submission of a clean claim.

(Added to NAC by Comm'r of Insurance by R175-01, eff. 5-23-2002; A by R026-12, 9-14-2012)

NAC 686A.303 Coverage for dental procedures for children. (NRS 679B.130, 686A.015)

1. A policy or contract of health insurance issued pursuant to **chapter 689A, 689B, 689C, 695B or 695C** of NRS which is delivered or issued for delivery in this State and which provides coverage for medically required hospital services must not deny coverage for a dependent child covered by that policy or contract who is referred by a dentist to a hospital, a surgical center for ambulatory patients, an independent center for emergency medical care or a rural clinic, licensed pursuant to **chapter 449** of NRS, for general anesthesia and associated care and is being referred because, in the opinion of the dentist, the child:

- (a) Has a physical, mental or medically compromising condition;
- (b) Has dental needs for which local anesthesia is ineffective because of an acute infection, an anatomic anomaly or an allergy;
- (c) Is extremely uncooperative, unmanageable or anxious; or
- (d) Has sustained extensive orofacial and dental trauma to a degree that would require unconscious sedation.

2. An insurer may:

(a) Require prior authorization for the provision of general anesthesia and for hospitalization or the use of a surgical center for ambulatory patients for dental procedures in the same manner that the insurer requires prior authorization for hospitalization for the provision of general anesthesia for other diseases or conditions covered by the policy or contract of health insurance;

(b) Require that the benefits paid be adjusted according to the policy or contract of health insurance if the services are rendered by a provider who is not designated by or associated with the insurer, if applicable; and

(c) Restrict coverage to include only general anesthesia provided during procedures performed by:

- (1) A qualified specialist in pediatric dentistry;
- (2) A dentist who is qualified, by virtue of education, in a recognized dental specialty for which hospital privileges are granted; or
- (3) A dentist who is certified by a hospital, by virtue of completion of an accredited program of postgraduate hospital training, and is granted hospital privileges.

3. The failure of an insurer to comply with the provisions of this section constitutes an unfair trade practice pursuant to **NRS 686A.170**.

4. A policy or contract of health insurance subject to the provisions of this section that is delivered, issued for delivery or renewed on or after April 24, 2003, has the legal effect of including the coverage required by this section, and any provision of such a policy or contract that conflicts with the provisions of this section is void.

(Added to NAC by Comm'r of Insurance by R088-02, eff. 4-24-2003)

NAC 686A.304 Processing of claims: Duties of payer; date of receipt of claim. (NRS 679B.130, 679B.136, 679B.138, 686A.015)

1. Each payer shall establish a tracking system to monitor the timeliness of the payer's processing of a claim.

2. Each payer shall:

- (a) Maintain a written or electronic record of the date of receipt of a claim;
- (b) For receipt of a written claim, date-stamp the claim with the date received; and
- (c) For receipt of an electronic claim, assign the document a batch number that includes the date received.

3. Except as otherwise provided in subsection 5, a claim is deemed to have been received by a payer on the date of receipt of the claim stated in the written or electronic record required pursuant to subsection 2.

4. A payer shall provide, within 20 working days after a request by a health care practitioner, hospital, institutional provider or person entitled to reimbursement, verification of the date of receipt of a claim as stated in the written or electronic record pursuant to subsection 2, in:

- (a) Electronic form, if the request was for electronic verification; or
- (b) Written form, including microfilm, if the request was for written verification.

5. A claim shall be deemed received by a payer:

(a) Five working days after the date the health care practitioner, hospital, institutional provider or person entitled to reimbursement placed the claim in the United States mail, if the health care practitioner, hospital, institutional provider or person entitled to reimbursement possesses the receipt of mailing the claim; or

(b) On the date the receipt of the claim is recorded by a courier, if the claim was delivered by a courier.

(Added to NAC by Comm'r of Insurance by R175-01, eff. 5-23-2002)

NAC 686A.306 Proof of compliance by payer. (NRS 679B.130, 679B.136, 679B.138, 686A.015) The Commissioner, when deemed appropriate, will require a payer to report substantial compliance with the provisions of **NAC 686A.280** to **686A.306**, inclusive. Proof that claims are being paid by a payer within the specified limits includes, without limitation, records demonstrating that a tracking system required by **NAC 686A.304** has been developed and implemented.

(Added to NAC by Comm'r of Insurance by R175-01, eff. 5-23-2002; A by R129-03, 4-16-2004)

**SHL
PROVIDER SUMMARY
GUIDE**

**SECTION 13
CONFIDENTIALITY**

13 - Confidentiality

It is the policy of Sierra Health & Life (SHL) to protect the confidentiality of enrollee and patient information in a manner that is consistent with the needs to conduct business, but does not divulge more information than is necessary to accomplish the task. SHL routinely shares information with individuals or entities when necessary to coordinate enrollee health care or administer enrollee health benefits. We also share enrollee information when required by state or federal law or regulation. In all other instances, SHL requests authorization from the individual before we share protected health information. Our Notice of Privacy Practices, which is delivered to enrollees upon their enrollment, available upon request, and posted on our website, describes in detail the ways in which we use protected health information.

SHL has implemented mechanisms to guard against unauthorized or inadvertent disclosure of confidential information to persons inside and outside the organization to whom such disclosure is not authorized in accordance with plan policies and procedures. SHL uses a variety of security precautions to protect any information or data that contains personal facts and health information about our enrollees, including medical records, claims, benefits and other administrative data that are personally identifiable, either implicitly or explicitly. Just a few of the precautions SHL takes include electronic security systems and release of information only by certain levels of management. For example, when transmitting data, SHL operates under policies and procedures that may require dedicated fax lines, use of an encryption format, password protection or other secured methods.

It is also SHL's policy to afford enrollees the opportunity to authorize to or deny the release of personally identifiable medical or other information by SHL, except when such authorization is not required by law or regulation. When enrollees request specific enrollee-identifiable records be shared with others for reasons other than treatment, payment, or health care operations, SHL will require them to sign an Individual Authorization Form. SHL may also ask enrollees to allow release of personal data for non-routine uses of personal data. Of course when we ask our enrollees for individual authorization forms, they have the right to refuse. This step authorizes SHL to release protected health information and explains to enrollees how and with whom their personal information will be shared.

SHL may share protected health information with an enrollee's employer (if the enrollee is covered a group health plan) only if the employer agrees to use the information exclusively for plan administration functions. Plan administration functions include actions such as eligibility and enrollment functions, claims processing, auditing, monitoring, and management of carve-out plans - such as vision and dental benefits. In order to receive protected health information from SHL, employers must certify that they will not use the information for employment-related activities.

SHL uses medical data to monitor and improve the quality of care our enrollees receive. Our Quality Initiatives must be approved by our Quality Improvement Committee and our Privacy Officer must approve the use and release of any personal information. When conducting research and measuring quality, SHL does so using summary information whenever possible, not individual patient information. When SHL does use patient information, we take steps to protect it from inappropriate disclosure. For example, we use blinded medical records when possible and we require everyone involved in collecting data to sign a confidentiality agreement.

We do not allow individually identifiable data to be used for research by organizations outside SHL without our enrollees' authorization.

SHL's policy to protect the confidentiality of enrollee/patient information impacts all internal departments that use enrollee identifiable information, external entities to which enrollee identifiable information is released, and any entities to which health plan functions have been delegated.

SHL also requires contracted providers of care to take similar steps to ensure that enrollee/patient health care information remains confidential. SHL requires practitioners and institutional providers take steps to:

- Protect all confidential information concerning SHL enrollees.
- Protect the privacy of all enrollees and third parties, including families of enrollees.
- Maintain confidentiality of all health related information, except when disclosure is needed for emergency care and/or treatment, or required by law.
- Disclose patient-identifiable information for any reason other than treatment, payment or health care operations only upon receipt of a valid authorization, or as stipulated by law.
- Apply confidentiality procedures to any information that could disclose medical conditions, such as claims or case management notes.
- Have specific procedures to provide for confidentiality of electronic records, mail, e-mail, and facsimiles.
- Promote patient privacy, dignity and respect, such as positioning exam tables face away from doors and placing curtains, doors, blinds, etc., in exam rooms to protect privacy.
- Provide an area where financial, insurance, or medical discussions will not be overheard by other patients.
- Identify a person responsible for maintaining the confidentiality of medical records.
- Provide for secure storage of confidential information.
- Store records in a separate room or area without public access and ensure they cannot be removed without being seen.
- Release medical records according to written policy that includes tracking and confidentiality of the record.
- Implement procedures to disclose information on an identified need-to-know basis only.
- Prior to the release of personal health information, obtain a signed authorization to release information from the enrollee or their authorized representative when such authorization is required by law or regulation.
- Release information only to authorized individuals.
- Allow patients to add a statement to their record upon request.
- Provide for secure disposal of confidential information that is no longer needed, such as shredding of obsolete documents.
- Have a policy in place that describes where records will be stored if the office practice is permanently closed.
- Require that employees sign confidentiality statements.

**SHL
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SECTION 14

MEMBERS ACCESS TO MEDICAL RECORDS

14 - Members Access to Medical Records

It is SHL's policy that enrollees have a right to access their medical records, as allowed by law. Members who contact SHL requesting access to their medical records will be instructed to contact their providers of care, and when necessary, SHL will assist the member in obtaining their records.

SHL requires its contracted practitioners and institutional providers to have policies and procedures that describe how and under what circumstances medical records are made available to their patients.

Providers are expected to remain in compliance with CMS guidelines and retain patients' medical records in compliance with the Centers for Medicare and Medicaid Services (CMS) medical record retention requirement. As of January 2009 the CMS medical record retention requirement is (ten) 10 years. Please understand that this medical record retention requirement is subject to change at the discretion of CMS and it is each provider office's responsibility to ensure compliance with any future modified medical record retention requirements mandated by CMS.

**SHL
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SECTION 15

**MEMBERS' RIGHTS AND
RESPONSIBILITIES**

15 – Members' Rights and Responsibilities

Sierra Health and Life (SHL) is committed to treating members in a manner that respects their rights and promotes effective health care. SHL has also identified its expectations of members' responsibilities in this joint effort. SHL is committed to maintaining a strong relationship with its members that promote quality health care.

15.1 SHL Commercial PPO

Member Rights:

- To receive information about the plan, its services, its providers and practitioners and members' rights and responsibilities
- To be treated with respect and recognition of your dignity and the member's right to privacy.
- To participate with practitioners in the decision making process regarding your health care.
- To have a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- To voice complaints or appeals about the plan and/or the care provided.
- To make recommendations regarding the organization's members' rights and responsibilities policy.
- To select a primary care provider from SHL's extensive provider list including the right to refuse care from specific practitioners.
- To have direct access to women's health services for routine and preventive care.
- To have access to medically necessary specialist care, in conjunction with an approved treatment plan developed with the primary care physician. Required authorizations should be for an adequate number of direct access visits.
- To have access to emergency health care services in cases where "prudent layperson" acting reasonably, would believe that an emergency existed.
- To formulate Advanced Directives.
- To have access to your medical records in accordance with applicable state and federal laws, including the ability to request and receive a copy of your medical records, and request that the medical records be amended or corrected, as specified in federal regulation.
- To have available oral interpretation services free of charge for all non-English languages.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulation on the use of restraints and seclusion.

Member Responsibilities:

- To supply information, to the extent possible, that the health plan and its practitioners and providers need in order to provide care.
- To follow plans and instructions for care that has been agreed upon with your practitioner.
- To understand individual health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- To know how SHL's Managed Care Program operates.
- To participate in developing and following mutually agreed-upon treatment goals established by the member and provider.

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- To consult your primary care physician and SHL before seeking non-emergency care in the service area. We urge you to consult your physician and SHL when receiving urgently needed care while temporarily outside the SHL service area.
- To obtain prior authorization from SHL and your physician for any routine or elective surgery, hospitalization, or diagnostic procedures.
- To be on time for appointments and provide timely notification when canceling any appointment you cannot keep.
- To pay all applicable co-payments at the time of service.
- To avoid knowingly spreading disease.
- To recognize the risks and limitations of medical care and the health care professional.
- To be aware of the health care provider's obligation to be reasonably efficient and equitable in providing care to other patients in the community.
- To show respect for other patients, health care providers and plan representatives.
- To abide by administrative requirements of SHL, health care providers, and government health benefit programs.
- To behave in a manner that supports the health care provided to the member and other patients in any location, whether it is the member's home, a provider's office or at a health care facility.
- To report wrong doing and fraud to appropriate resources or legal authorities.
- To know the medications you are taking. Keep a list of current medications, including over the counter drugs, vitamins and supplements to bring with you to appointments with your providers.
- To address medication refill needs at the time of your office appointment. When you obtain your last refill, notify the office that you will need refills at that time. Do not wait until you are out of your medication.
- To report all side effects of medications to your primary care provider. Notify your primary care provider if you stop taking your medications for any reason.
- To ask questions during appointment time regarding physical complaints, medications, any side effects, etc.

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**SECTION 16
MEMBER COMPLAINTS**

16 - Member Complaints

As a provider for Sierra Health & Life (SHL) members, there may be occasions in which you or your staff might be the recipient of complaint information. This could include dissatisfaction with benefit or claims payment issues, services or care issues, or other topics related to your patient's insurance plan. It is in all of our best interest to address any issues that are expressed and we would like the opportunity to do so.

If a SHL member does express a complaint to you or your staff, please ask them to complete the SHL Complaint Form, located in section 23.4 so that we have adequate information to conduct an investigation of the concern. If the member does not wish to fill out a form, they can also contact Member Services to file a complaint.

As it is our intent to provide benefits, services and care that meet the expectations of our members, we appreciate the opportunity to review any concerns that are expressed.

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SECTION 17

NEW MEDICAL TECHNOLOGY

17 - New Medical Technology

To keep pace with developments in new medical technology and to ensure that members receive safe and effective care, Sierra Health & Life (SHL) has a formal process to evaluate and address emerging medical discoveries and new uses for existing technologies before they can be offered as a benefit to SHL members. This process includes the review of medical procedures, drugs, devices, diagnostic tests and new applications for existing technologies.

Conducted by a highly skilled technical staff, including physicians, new medical technology is reviewed against specific criteria and clinical research for its effectiveness and safety. SHL solicits input from local and national specialists, as applicable including the UnitedHealthcare Medical Technological Advisory Committee during the review process.

The new technology must:

- be approved by the appropriate government regulatory body (for example, Food and Drug Administration approves new medical devices),
- demonstrate a positive effect and improve health outcomes,
- be as beneficial as any established alternatives,
- be able to demonstrate improvement outside the investigational setting and
- demonstrate cost effectiveness.

Physicians, SHL members, and other interested parties may submit requests for review of a new medical technology. To submit a request for the review of new medical technology, please contact Provider Services for provider requests or have the member contact Member Services for member requests.

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**SECTION 18
PHARMACY SERVICES**

18 - Pharmacy Services

The role of Sierra Health and Life Insurance Company's (SHL) Pharmacy Services is to evaluate and determine the appropriateness of quality drug therapy while maintaining and improving therapeutic outcomes. Listed below are the functions performed by SHL's Pharmacy Services Department.

- Prior authorization of medications
- Call center for providers and pharmacies
- Maintenance of Preferred Drug Lists
- Drug member reimbursement/Coordination of Benefits
- Concurrent Drug Utilization Review
- Retrospective Drug Utilization Review

18.1 Prior Authorization of prescription drugs

The prior authorization process involves assessing and screening requests for prescription drug coverage from providers and members. A prior authorization is required for prescription drugs when it is indicated as a requirement per protocol guidelines, the drug is not on the members' formulary, or the request exceeds the plan's quantity limits. The screening process assists SHL in determining if the requested prescription drug is an appropriate therapy for the given diagnosis based on clinical information such as chart notes, lab reports and clinical rationale that is submitted by the provider, current Food and Drug Administration approved diagnosis, and SHL's protocols. The prior authorization process for our Commercial line of business is handled locally by the HPN/SHL Pharmacy Services Department.

18.2 How to Obtain Prior Authorization for prescription drug coverage

The member, a member's appointed representative or prescribing physician can initiate a prior authorization request. **Prior authorization** is a process by which a drug must be approved for coverage before the plan will pay for it. It is the responsibility of the requesting provider to provide pertinent case specific clinical information to support the request for prescription drug coverage. The prior authorization form can be found in the **Frequently Used Forms** at the end of this section and must be completely filled out.

Exception and Prior Authorization Requests

To submit a *prior authorization request by phone*, call 702-242-7050 or 1-800-443-8197. Hours of operation are 8 a.m. - 5 p.m., Monday through Friday.

To submit a *prior authorization request by fax*, fax (702)-242-6751 or 1-(800)-997-9672. Hours of operation are 8 a.m. - 5 p.m., Monday through Friday.

To submit a *prior authorization request by mail*, mail to SHL - Pharmacy Services, Attn: Medical Necessity, P.O. Box 15645, Las Vegas, NV 89114-5645.

If you have questions on Commercial requests, need assistance filling out a form, or would like to inquire about the status of an exception or prior authorization request, call Pharmacy Services at 702-242-7050 or 1-800-443-8197, 8:00 a.m. – 5:00 p.m. Monday through Friday.

18.3 Prior Authorization Timeframes

Standard Requests:

Routine requests are reviewed with a determination rendered within 72 hours. If additional clinical information is needed to render a decision, the provider will be contacted by fax to supply the necessary information. We make every effort to complete all requests that include receipt of ALL necessary clinical information within the allotted timeframe.

Expedited Requests:

Expedited requests are for those services which are related to urgent prescription drug coverage that have the potential to become an emergency in the absence of treatment. Expedited requests are reviewed with a determination rendered within 24 hours. If additional clinical information is needed to render a decision, the provider will be contacted by fax to supply the necessary information. We make every effort to complete all requests that include receipt of ALL necessary clinical information within the allotted timeframe.

18.4 Denial/Appeal Process

Once a prior authorization request has been denied, the provider has the option to appeal the request. Only a Member, a member's appointed representative, or prescribing physician may request an appeal.

To request an appeal, a signed written request for an appeal with evidence and allegations of fact or law related to the issues in dispute must be submitted. This means, please write a letter *requesting an appeal* and provide any and all information that you wish to be reviewed.

The number of available appeals is limited. Please ensure you include all information you wish to be reviewed the first time.

Oral requests for an expedited appeal are accepted but must be followed by a written request within 24 hours.

Appeals must be submitted within 180 calendar days from the date of the coverage determination notice.

To request an appeal, please see the contact information below.

Member Services	Member Services Phone	Member Services Fax (appeals)
Commercial	702-242-7300/800-777-1840	702-242-9431

18.5 Pharmacy Services Call Center

The Pharmacy Services call center can be reached 24 hours a day and 7 days a week at 1-800-443-8197.

The Pharmacy Services call center is a dedicated help desk for pharmacies and providers only. Call center representatives are able to assist **retail, hospital, and long term care facility pharmacies** with the following:

- Adjudicating claims online
- Providing eligibility information
- Checking the status of prior authorization

Call center representatives are also able to assist **providers and their staff** with the following:

- Formulary alternatives
- Prior authorization status
- Expedited phone prior authorizations

**Pharmacy Services Representatives are available from
Monday – Friday from 8:00 a.m. – 5:00 p.m. (Pacific Standard Time)**

	Telephone Number	Fax Number
Las Vegas Area	(702) 242-7050	(702) 242-6751 or (702) 341-7566
Toll Free	(800) 443-8197	(800) 997-9672 or (877) 219-1612

18.6 After Hours Call Center

From **5:00 p.m. to 8:00 a.m. PST Monday through Friday and all day Saturday and Sunday**, all telephone calls from pharmacists, providers, and health plan Member Services staff members are transferred to the claims processing call center staff who then handle all of the telephone calls. Since the claims processors house the claims processing system for SHL, call center staff members have access to information needed to handle the calls appropriately, such as eligibility, medication history, and length of health plan enrollment.

18.7 Pharmacy and Therapeutics Committee

SHL utilizes the UnitedHealthcare Enterprise P&T Committee to assist in the clinical management of the SHL custom Preferred Drug Lists. Additional operational committees exist that make additional recommendations on tier placement and other clinical programs. SHL pharmacy leadership is represented on these committees.

18.8 Changes to the Preferred Drug List

The P&T committee reviews requests for the addition or deletion of a drug from the Preferred Drug List and reviews the entire Preferred Drug List at least annually to maintain a clinically sound drug benefit. The P&T Committee may review drugs in response to:

- Provider requests,
- Member requests,
- Updated guidelines for disease treatment,

- New drug entities added to the market,
- Generic formulations added to the market,
- Products removed from the market due to safety or other concerns, and
- New Food and Drug Administration-approved indications or labeling changes.

Decisions to add or remove a drug from the Preferred Drug List are based on Food and Drug Administration-approved indications, efficacy, adverse effect profile, patient monitoring requirements, patient dosage and administration guidelines, impact on total healthcare costs, and comparison to other preferred agents.

18.9 Published Preferred Drug List

The SHL Preferred Drug List is updated regularly and is available on our web site at www.myshlonline.com/provider/Pharmacy-Benefits, click on **Prescription Drug Lists**. Preferred Drug List updates are sent via fax as needed throughout the year. Practitioners are encouraged to use the SHL Preferred Drug List to select the appropriate medications for the members' treatment. Printed copies of the PDL can be made available to members by calling member services.

Upon notification of a drug being withdrawn from the market for safety or other concerns, a notification letter will be sent to affected members and providers within 14 days of a Class I recall and 30 days for a Class II recall informing them of the market change.

18.10 Moratorium

SHL Commercial plans have a 12-month moratorium that may be exercised before new drugs introduced to the market will be reviewed for Preferred List inclusion or exclusion. This will exclude the coverage of new drugs on the market for less than 12 months and allows for additional safety and clinical data to become available.

18.11 Incentives

SHL **does not** provide incentives to members, providers, or pharmacists for the use of preferred medications. However, the member's co-pay is lower with the use of preferred medications included on the Preferred Drug List. SHL may institute quantity limits on medications if there is no data to support the continued high usage of the quantity/dosage being prescribed.

18.12 Generic Substitution for Commercial Plans

SHL has a mandatory generic substitution policy that requires the dispensing of the generic equivalent when available. A significant cost saving can be achieved through the use of safe, therapeutically equivalent generic drugs. If you or the member chooses the brand-name product when a generic equivalent is available the member is responsible to pay the difference between the cost of the generic and brand name product in addition to the generic co-payment.

18.13 Direct Member Reimbursement of Prescription Drugs

SHL will reimburse a patient for a prescription medication that was paid for in cash if the patient meets the criteria for prescription drug coverage.

Turnaround time is 30 days from the date the Reimbursement Request Form was received.

SHL members can call (702) 242-7300 or 1-800-777-1840 and request a Direct Member Reimbursement Form or go online to www.myshlonline.com/Member, click on **I Need Help with**, Click on **Health Plan Forms** then click on **Pharmacy Reimbursement Claim Form** to print out form.

Once the form has been filled out, please mail the form to: **OptumRx Claims Department, P.O. Box 29044, Hot Springs, AR 71903.**

18.14 Drug Utilization Reviews

Drug utilization reviews are performed periodically. These reviews monitor the members' medication usage and report any outliers to normal prescription therapy. Comparisons of provider prescribing patterns are made to other providers within the same specialty. Reports are sent to the prescribing provider and the Medical Director.

Concurrent Drug Review

SHL has systems, policies, and procedures in place to ensure concurrent drug utilization review prior to each prescription being dispensed to a health plan member at the point of sale. The pharmacy management system edits provide alerts and warning messages to pharmacists when medications that have been ordered may need prior authorization or must meet initial step therapy requirements before specific drugs are dispensed. In addition, other system edits alert pharmacists to potential duplicate drug therapy, possible drug to drug interactions, gender and/or age related contraindications, ordering of incorrect drug or dosages, possible misuse/abuse and over utilization, and underutilization for medications that are prescribed at levels less than the therapeutic recommended minimums.

Retrospective Utilization Review

Retrospective DUR activities are implemented after medications have been dispensed to health plan members. While not as effective as the real-time system edits that are in place in the health plan's pharmacy management system at the point of dispensing, retrospective DUR conducted by SHL Pharmacy Services staff can address specific medication management issues at the population level. The results of these activities can help further educate health plan management, members, practitioners, and/or pharmacists about important drug management issues.

To conduct retrospective DUR activities, Pharmacy Services staff request that data be extracted from the organization-wide Corporate Reporting Database, the health plan's data warehouse. Periodic DUR is conducted in response to identified medication management or quality issues may focus on:

- Drug-drug interactions
- Medication overuse and potential abuse
- Duplicate therapy

Once initial data analysis on the identified medication management issue has been completed, health plan Pharmacy Service management reviews the results of the analysis and work with Clinical Pharmacists to determine appropriate interventions that may include sending letters to affected members, prescribing physicians, and pharmacists. These letters educate the affected parties about the issue at hand and offer recommendations for change, as necessary.

18.15 Frequently Used Forms

- Medical Necessity Request Form
- MedWatch- For the most updated form, go to: <http://www.fda.gov/Safety/MedWatch/HowToReport/DownloadForms/default.htm>



Medical Necessity Request Form

[Applicable for HPN/SHL Commercial/Medicaid members only]

Member Name: _____ Date of Request _____

Primary Cardholder #: _____ M / F DOB: _____

Documented Allergies: _____

Physician Information - COMPLETE INFORMATION IS REQUIRED TO RECEIVE RESPONSE

Physician Name (please print clearly): _____

Physician Signature: _____ DEA No.: _____

Phone: _____ FAX: _____

Address: _____

Office Contact Person _____

Requested Medication

Drug name, strength, quantity and duration of treatment: _____

One drug request per form please

Additional Information: The following information must be included or request will be returned. (Please, when available, attach copies of office notes documenting prior therapy, diagnosis, lab results, etc.)

Diagnosis: _____

Medication History for this Diagnosis:

Drug	Daily Dose	Started	Stopped	Reason for discontinuing medication:
_____	_____	/	/	_____
_____	_____	/	/	_____
_____	_____	/	/	_____
_____	_____	/	/	_____

Clinical Rationale/Supporting Documentation: Why do you feel this drug is superior to current Preferred Drug(s)? (documented efficacy in this patient, documented failure or allergy of preferred meds, etc.)

PHONE: (702) 242-7050, option #6
(800) 443-8197, option #6
FAX to: (702) 242-6751 or (800) 997-9672

OR Mail to: HPN/SHL - PHARMACY SERVICES
Attn: Medical Necessity
P.O. Box 15645
Las Vegas, NV 89114-5645

Commercial and Medicaid Medical Necessity Request Form 12-15

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**SECTION 19
MENTAL HEALTH**

19 - Mental Health/Substance Abuse

Mental Health/Substance Abuse Utilization Management

Behavioral Healthcare Options (BHO) provides Mental Health and Substance Abuse services to Sierra Health and Live (SHL) members. Some of the services provided by BHO include:

- Mental health and substance abuse services
- Crisis intervention services 24-hours-a-day, 7-days-a-week
- Crisis stabilization
- Employee Assistance Programs

These services are offered by a comprehensive network of contracted specialty facilities and providers.

To access services please contact BHO directly at **(702) 364-1484 or (800) 873-2246**.

BHO offers three levels of care in order to meet every member's needs:

- Crisis – Access within 6 hours
- Urgent – Access within 48 hours
- Routine behavioral healthcare – Access within ten business days

The contracted provider network is utilized to help ensure that members will be seen within ten business days and to accommodate specialty referrals.

All requests for services are reviewed for medical necessity along with recommendations for the most appropriate setting and level of care. Reimbursement is certified only for covered services that have been determined to be medically necessary. In order for treatment to be considered medically necessary the following conditions must be met:

- The presence of a treatable psychiatric condition has been established through an appropriate evaluation.
- The patient can be expected to benefit from appropriate treatment.
- Any level of treatment should be based on necessity, not convenience, and cannot be safely or effectively provided in a less acute setting.
- A voluntary patient must comply with appropriate treatment recommendations or appropriate measures are to be instituted to insure treatment compliance for involuntary admissions.
- If inpatient psychiatric care is secondary to a physical condition putting the patient at risk, the care should be managed in a medical setting.

To verify that the requested Mental Health, Severe Mental Illness and/or Substance Abuse services are Covered Services as described in the HPN EOC/SHL COC and Attachment A, Benefit Schedule, and to ensure care will be provided at the appropriate level, Members/Insured's must contact Behavioral Health Care Options (BHO) for assistance with scheduling the first office visit appointment with the appropriate Plan Provider. All telephone calls from providers or members seeking assistance are received by an Associate Clinical Administrative Coordinator (ACAC) who will either assist in scheduling an appointment or make a referral to

the appropriate Plan Provider based on acuity. Further, certain covered Mental Health, Severe Mental Illness and/or Substance Abuse services require Prior Authorization in order for full benefits to be payable under the HPN or SHL health benefit plan.

The Associate Clinical Administrative Coordinator will provide the name and telephone number of consulting providers to the member with instructions to call for an appointment within 24 hours. BHO mails a certification letter to the member and provider including initial authorization, dates of service range for routine services and the name of the member.

Inpatient treatment is considered only when a member's condition is life threatening. BHO requires prior authorization for all inpatient admissions. BHO's clinical staff is available 24 hours a day, 7 days a week, at **(702) 364-1484 or (800) 873-2246**.

19.1 Emergency Care

"Danger to self" is defined as attempting or threatening to commit suicide or committing acts in furtherance of a threat to commit suicide, if there exists a reasonable probability that the person will commit suicide unless admitted to a mental health and/or substance abuse facility.

"Danger to others" is defined as inflicting or attempting to inflict serious bodily harm on any other person or making threats to inflict harm and committing acts in furtherance of those threats, if there exists a reasonable probability that the person will do so again unless the person is admitted to a mental health facility.

Emergency care does not necessarily require an inpatient admission. BHO's determination of medical necessity of an unauthorized admission is based on the appropriateness of the setting for care of the condition existing at the time of the admission. An admission through an emergency room does not automatically qualify as a medically necessary admission.

19.2 Concurrent Review

To provide a member with continued quality care, an assigned Sr. Care Advocate will monitor the case throughout the course of treatment. Through discussion with the provider and/or review of daily records, the Sr. Care Advocate will determine if clinical progress is being made or if an adjustment to the treatment plan is necessary. It is important that the provider furnish clear and concise clinical data to certify continued treatment.

19.3 Retrospective Review

To evaluate clinical processes and outcomes, member satisfaction, quality of care and completeness of documentation, a sample of cases will be reviewed retrospectively. When utilization or quality of care questions arise, either concurrently or after the fact, cases will be reviewed retrospectively. BHO will not reverse prior determination of clinical necessity unless a provider had pertinent clinical information and failed to provide it to the Care Advocate. A retrospective review may include onsite visits or a thorough review of clinical records.

19.4 Quality Assurance

BHO has a continuous quality improvement program that is overseen by the BHO Quality Improvement Committee (QIC). The role of the BHO QIC is to monitor the implementation of, and ongoing compliance with, BHO's quality assurance and improvement plans. The BHO Quality Improvement Program ensures the continuous evaluation and improvement of processes associated with the quality of mental health and addictions care received by our members. It also includes the retrospective monitoring and problem solving associated with the care and service delivered. BHO's Quality Improvement Program seeks to measure, monitor, and analyze the outcomes of mental health and addictions care and service, (where applicable), identify and track performance trends in the company and in the industry, and the communities BHO serves, and apply appropriate interventions that continuously improve the level of behavioral health care and service provided to patients.

The purpose of the quality assurance and improvement plans is to monitor delivery of clinical services to ensure quality and appropriate mental health and substance abuse care. This is accomplished through a systematic commitment to defining, measuring and solving problems associated with the quality of care delivered to our members.

One of the ways BHO assures quality is through its Chart Advisory Program. When a health plan member visits a behavioral healthcare provider, the behavioral healthcare provider asks the member if they will authorize their behavioral healthcare provider to provide confidential information about their medications and diagnoses to the member's primary care provider. The member is asked to sign a consent form. All Chart Advisory forms are faxed or sent via US Mail to BHO for confidential distribution to the member's primary care provider. Chart Advisory forms received for Southwest Medical Associates (SMA) patients are electronically input into Touchworks, so that the SMA provider will have access to the patient's shared information. Providing the primary care provider with behavioral healthcare information will allow the primary care provider to have more complete and comprehensive information when they treat the patient.

19.5 Non-Authorization and Appeal Procedure

Notification of Recommendation for Non-Authorization of Inpatient Cases:

- The Sr. Care Advocate will verbally inform the provider of the recommendation for non-authorization.
- The Sr. Care Advocate will complete the data entry; refer the case to the Utilization Representative who, with the Utilization Management secretary's assistance, will fax a copy of the letter to the facility business office; mail hard copy of the letter next working day to the facility, attending provider, and patient; print information as needed.
- The Sr. Care Advocate will log the case in the non-authorization log; will periodically call to verify the actual discharge date; enter the discharge date into the non-authorization log as well as the computer case. The information will be printed and forwarded to the Utilization Management Coordinator to complete the case and close the case.
- Non-authorization notification will include the administrative or clinical decision, clinical rationale and review criteria. Member appeal procedure information will be included.

The physician (M.D., D.O. or Addictionist) will be the only level of reviewer to issue formal non-authorizations for medical necessity reasons.

Appeal

1. Behavioral Healthcare Options (BHO) Physician/Peer Advisors and Medical Directors are available to discuss problems with non-authorizations during each working day.
2. When a provider, facility or patient requests an appeal of a review decision, the appeal process will be initiated.

Appeals Process - A BHO review decision may be appealed in writing or verbally through the Member Services Department at (702) 242-7700 or (800) 888-2264. Behavioral Healthcare Options, Inc. will utilize a Physician/Peer Reviewer other than the Physician/Peer Advisor who rendered the original decision to complete the appeal review. The Physician/Peer Advisor will be matched by specialty and, wherever possible, sub-specialty.

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SECTION 20

HEALTH EDUCATION & WELLNESS

20 - Health Education and Wellness

20 - Southern Nevada Health Education Program Offerings

Health Education and Wellness (HEW) provides programs that empower patients with the support, information and tools to prevent illness, manage existing health concerns, and overcome obstacles that allow them to live healthier lives.

Wellness Programs:

- Diabetes – 3-part class and 6-month program
- Exercise
- Grocery Shopping Tour
- Healthy Nutrition / Weight Management (*Consultation*)
Toddler [1-6], Child [7-11], Teen [12-17]
- Heart Health
- Lactation (*Support Group and Consultation*)
- Medical Nutrition (*Consultation*)
- Pre-diabetes
- Tobacco Cessation Program (TCP)
- Weight Management - Adult
- Weight Management Support Group - Adult

- The Health Education and Wellness Department is comprised of a dedicated team of Certified Health Education Specialists (CHES), Registered Dietitians (RD), Certified Diabetes Educators (CDE), Licensed Alcohol and Drug Counselors (LADC), Certified Lactation Counselors (CLC), and a Specialist in Gerontological Nutrition (CSG), Exercise Physiology, and Health Promotion.

- One-on-one Health Education Consultations are available as noted. Consultations are recommended for patients who are at high risk or may be having special health issues. Consultations require a physician referral.

- Three ways to refer patients to Health Education and Wellness:
 - 1.) Call 702-877-5356
 - 2.) Fax to 702-838-1404
 - 3.) Visit mySHLonline.com and sign in to the online provider center (@yourservice).

- Wellness programs and one-on-one consultations are available at the following locations:
 - ☞ Southwest Medical Associates Clinic – 2316 West Charleston Blvd.
 - ☞ Southwest Medical Associates Clinic – 4475 South Eastern Ave.
 - ☞ Southwest Medical Associates Clinic – 2704 North Tenaya Way
 - ☞ Southwest Medical Associates Clinic – 540 North Nellis Blvd.
 - ☞ Southwest Medical Associates Clinic – 2845 Siena Heights Ave.
 - ☞ Southwest Medical Associates Clinic – 7061 Grand Montecito Pkwy.
 - ☞ Southwest Medical Associates Clinic – 4750 West Oakey Blvd.
 - ☞ Southwest Medical Associates Clinic – 4835 S. Durango Drive

Wellness Programs Overview:

Diabetes – ADA Recognized Diabetes Self-Management Education

Diabetes 3 –part program (3 – 2-hour sessions)

This 3-part program helps patients learn how to self-manage their diabetes and keep symptoms at bay.

This program includes:

- Understanding the different types of diabetes, including signs and symptoms
- Complications of diabetes
- Taking medications
- Healthy eating for diabetes control
- Staying active

Diabetes - 6 Month Program taught by Certified Diabetes Educators (CDE)

HEW provides a 6-month diabetes program to help your patients manage their diabetes and improve their overall health and quality of life.

This program includes:

- Initial consultation to assess prior health history and determine individual program focus
- 3 group sessions on diabetes education
- Personal goal setting to help patients stay on track for successful diabetes self-management
- Follow up appointments with CDE as needed for 6-months

Exercise

HEW offers an exercise program for adults looking to incorporate physical activity safely and effectively into their daily lives. All fitness levels are encouraged to attend.

This program includes:

- Relationship between exercise and nutrition
- Thirty to forty-five minute workout
- How to engage and strengthen core muscles properly
- How to improve flexibility, mobility and balance
- How to fuel the body to ensure fat loss and muscle gain simultaneously
- How to exercise safely and effectively without relying on specialized equipment

Grocery Shopping Tour

This 2-part program helps patients make simple changes in food choices at the grocery store that can make a big impact on their overall health.

This program includes:

- The basics in meal planning and nutrition
- How to read a food label
- How to shop from a budget
- Selecting healthy foods for the entire family
- Navigating the grocery store and planning meals

Healthy Nutrition / Weight Management for Children - Consultations

Steps to Good Nutrition – Ages 1 to 6

A registered dietitian can help parents with a step- by-step approach to good nutrition, food choices, portion sizes, healthy activity levels and behavior modification for their child.

Building Blocks to Good Health - Ages 7 to 11

A registered dietitian can help families identify obstacles, find solutions, set goals, and make food and activity choices that support the entire family and reduce risks for future complications.

Healthy Nutrition - Ages 12 to 17

A registered dietitian can help teenagers make the necessary adjustments in their diet and lifestyle to support their health and wellness. *Parent participation is required.*

Heart Health

A registered dietitian can help patients make the necessary lifestyle adjustments to keep their heart health in control through improving nutrition, weight reduction, exercise, proper medication use, tobacco and alcohol reduction, and developing a balanced approach to staying well.

Lactation

Breastfeeding Solutions and Support Group

Certified Lactation Counselors (CLC) can provide patients with breastfeeding information through a support group or one-on-one consultation.

Lactation counselors can assist with the following:

- Positioning and latching-on
- Techniques to relieve soreness/pain
- Milk production
- Reducing fullness discomfort
- Safe handling of expressed milk
- Guidelines for storing and transporting milk
- Returning to work/school

Medical Nutrition - Consultations

Registered dietitians are available to help patients with medical nutrition topics, such as cancer nutrition, adult malnutrition, renal support, food allergies, gout, tube feeding and other gastrointestinal conditions.

Pre-diabetes

This class provides the basics of preventive care through understanding what pre-diabetes is, making healthy food and activity choices, reducing risks for future complications, and setting goals.

The class includes:

- Weight management
- Complications of diabetes
- Reading and understanding food labels
- Healthy nutrition
- Stress management

Tobacco Cessation Program (TCP)

This program provides guidance and support for patients who want to quit smoking and maintain a tobacco-free lifestyle.

Program Overview:

- One-hour program orientation
- One-on-one assessment and treatment plan developed for each patient
- Education, support, and possible medication therapy
- 3-month treatment program for medication includes Chantix, Zyban and Nicotine Replacement Therapies (NRT) of the patch, gum and lozenge.
- Zyban and Chantix prescriptions are authorized only for participants in conjunction with the patient's provider.
- Participants are encouraged to attend at least 10 of 12 educational sessions, but they may attend as many sessions as needed.
- Dedicated TCP scheduling phone line: 1-866-707-6056

Weight Management - Adult

Lean on Me is a weight management program focused on making lifestyle changes that result in losing weight and keeping it off.

Topics discussed in this 3-part class include:

- Nutrition
- Physical activity
- Stress reduction
- Goal setting and action planning
- Developing a wellness attitude

Weight Management Support Group - Adult

Weight Matters provides patients with nutrition and fitness support in a positive learning environment. Patients learn how to take charge of their health and make behavior modifications that support a lifetime of wellness. The program is currently 26 weeks.

20.2 Northern Nevada Health Education Program Offerings

Health Education and Wellness (HEW) provides programs that empower patients with the support, information and tools to prevent illness, manage existing health concerns, and overcome obstacles that allow them to live healthier lives.

Wellness Programs – Northern Nevada:

- Diabetes
- Grocery Shopping Tours
- Healthy Nutrition / Weight Management
Toddler [1-6], Child [7-11], Teen [12-17]
- Heart Health
- Lactation
- Nutrition Basics
- Pre-diabetes
- Pregnancy
- Senior Health
- Stress Management

- Tobacco Cessation Program (TCP)
- Weight Management - Adult
- The Northern Nevada HEW office has a full-time, bilingual Health Educator and Certified Lactation Counselor (*English/Spanish*).
- Wellness programs and one-on-one consultations are available at:
5470 Kietzke Lane, Suite 300, Reno, Nevada 89511
- Consultations are recommended for patients who are at high risk or may be having special health issues. Consultations require a physician referral.
- To refer patients to Health Education and Wellness:
 - 1.) Call 775-393-3107
 - 2.) Fax : Right fax 702-838-1404, HEW office fax 775-393-3110
 - 3.) Visit mySHLonline.com and sign in to the online provider center (@yourservice)

Wellness Programs – Overview, Northern Nevada

Diabetes – Diabetes Self-Management Education

Diabetes 3 –part program (3 – 2-hour sessions)

This 3-part program helps patients learn how to self-manage their diabetes and keep symptoms at bay.

This program includes:

- Understanding the different types of diabetes, including signs and symptoms
- Complications of diabetes
- Taking medications
- Healthy eating for diabetes control
- Staying active

Grocery Shopping Tour

This program helps patients make simple changes in food choices at the grocery store that can make a big impact on their overall health.

This program includes:

- The basics in meal planning and nutrition
- How to read a food label
- How to shop from a budget
- Selecting healthy foods for the entire family
- Navigating the grocery store and planning meals

Healthy Nutrition / Weight Management for Children - Consultations

Steps to Good Nutrition – Ages 1 to 6

A Health Educator can help parents with a step- by-step approach to good nutrition, food choices, portion sizes, healthy activity levels and behavior modification for their child.

Building Blocks to Good Health - Ages 7 to 11

A Health Educator can help families identify obstacles, find solutions, set goals, and make food and activity choices that support the entire family and reduce risks for future complications.

Healthy Nutrition - Ages 12 to 17

A Health Educator can help teenagers make the necessary adjustments in their diet and lifestyle to support their health and wellness. *Parent participation is required.*

Heart Health

A Health Educator can help patients make the necessary lifestyle adjustments to keep their heart health in control through improving nutrition, weight reduction, exercise, , tobacco and alcohol reduction, and developing a balanced approach to staying well.

Lactation

Breastfeeding Solutions and Support Group

A Certified Lactation Counselor (CLC) helps patients with breastfeeding information through a support group or one-on-one consultation.

Lactation Support includes help with:

- Positioning and latching-on
- Techniques to relieve soreness/pain
- Milk production
- Reducing fullness discomfort
- Safe handling of expressed milk
- Guidelines for storing and transporting milk
- Returning to work/school

Nutrition Basics

This program provides basic nutrition information and the importance of variety, balance, moderation and exercise. Patients will learn how to eat healthy by following the Healthy Plate guidelines.

Pre-diabetes

This program provides the basics of preventive care through understanding what pre-diabetes is, making healthy food and activity choices, reducing risks for future complications, and setting goals.

The class includes:

- Weight management
- Complications of diabetes
- Reading and understanding food labels
- Healthy nutrition
- Stress management

Pregnancy

This program focuses on good nutrition habits, proper weight gain, personal and home safety, exercise during pregnancy, coping with stress, emotions and some of the discomforts of being pregnant.

Senior Health

This program focuses on the fundamentals of staying well and creating healthy lifestyle habits that can improve quality of life. Nutrition, exercise, life-long learning, stress reduction, and nurturing human connections are all steps toward a lifetime of wellness.

Stress Management

This program helps patients identify, manage, and make lifestyle adjustments to help resolve stress that is negatively affecting their wellbeing. Patients learn the importance of Mindfulness to improve health.

Tobacco Cessation Program (TCP)

This program provides guidance and support for patients who want to quit smoking and maintain a tobacco-free lifestyle.

Program Overview:

- One-hour program orientation
- One-on-one assessment and treatment plan developed for each patient
- Education, support, and possible medication therapy
- 3-month treatment program for medication includes Chantix, Zyban and Nicotine Replacement Therapies (NRT) of the patch, gum and lozenge.
- Zyban and Chantix prescriptions are authorized only for participants in conjunction with the patient's provider.
- Participants are encouraged to attend at least 10 of 12 educational sessions, but they may attend as many sessions as needed.
- TCP scheduling phone line: 775-393-3107

Weight Management - Adult

Lean on Me is a weight management program focused on making lifestyle changes that result in losing weight and keeping it off.

Topics discussed in this 3-part class include:

- Nutrition
- Physical activity
- Stress reduction
- Goal setting and action planning
- Developing a wellness attitude

Weight Management Support Group - Adult

Weight Matters provides patients with nutrition and fitness support in a positive learning environment. Patients learn how to take charge of their health and make behavior modifications that support a lifetime of wellness. The program is currently 26 weeks.

20.3 Provider Communication

To assist patients in accomplishing behavior change a provider referral system is available through the Automated Referral System (ARS) in Touchworks. This referral system involves patients' participation in health education programs that tie directly to their physician's referral. Providers are sent information on their patients' progress through chart noting that includes: patient participation, concerns, and whether or not the patient completed the program.

20.4 Online Learning

HEW offers MyHEWOnline, a website with online learning modules that are free to HPN and SHL members. This product offers a computer-based, step-by-step program to help members better manage their health concerns. Each module includes health information, interactive tools and videos for further learning.

The *Online Learning Modules* include the following topics:

- Diabetes
- Heart Health
- Pregnancy
- Preventive Healthcare
- Tobacco Cessation
- Weight Management

There is also a personal Health Risk Assessment (HRA) available online. The HEW HRA is available for Medicare and Medicaid members. Commercial members are directed to complete the Rally HRA. The HRA can be the first step on the road to better health. It is designed to help identify and prioritize health and wellness goals. After completing the HRA, a profile will be generated automatically for the member to print. The profile provides the following information:

- Personal health risk factors
- Health and screening recommendations
- Programs and services that meet the member's needs

To access the *Online Learning Modules*, follow the steps below:

- Go to www.myAYSonline.com
- If the member already has an account on @YourService Online Member Center (through Health Plan of Nevada or Sierra Health and Life), the member would type in their username and password and select "submit."
- If the member does not have an account on @Your Service, the member would click the "Create an account" link and follow the instructions listed.
- The account type will be "member" and the username is the member's 11-digit member number (no dashes) found on their insurance card.
- Once the member is logged into @YourService Online Member Center, they can click the Health and Wellness tab at the top of the screen. This will automatically log them into MyHEWOnline and they can access the Health Risk Assessment (MyHRA), online learning modules, and various videos and health education tools.

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PROVIDER SUMMARY
GUIDE**

SECTION 21

ADVANCED DIRECTIVES

21 – Advanced Directives

In accordance with the applicable state law, members have the right to make health care decisions and to execute an Advance Directive. This section is designed to provide you with information regarding Advanced Directives should you receive questions from your patients.

What is an Advance Directive?

An Advance Directive is a formal document, written by the member in advance of an incapacitating illness or injury. As long as the member can speak for themselves, Contracting Providers will honor the member's wishes. But there may come a time when the member will be seriously injured or become gravely ill and unable to make health care decisions for themselves. They may wish to choose in advance what kinds of treatments are administered and whether or not life support systems should be maintained or withdrawn. This directive will guide you, the health care Providers, in treating them and will save family, friends and Physicians from having to guess what they would have wanted. While advances in medical technology have saved thousands of lives, sometimes the very capability of this technology to sustain life raises more questions than it answers.

States generally allow a competent adult to execute a document which allows an individual to accept or refuse treatment in the event that individual has a terminal condition and is not able to make decisions for him or herself.

Types of Advance Directives

There may be several types of advance directives members can choose from, depending on state law. They are referred to as:

- Durable Power of Attorney for Health Care
- Living Wills
- Natural Death Act Declaration

These documents allow members to appoint someone to make a variety of health care decisions for them when they are unable to do so. State laws are very specific for properly executing this document. Members may be able to purchase this form, or they can request that a Contracting Provider or Health Plan provide them a sample form.

(Samples 20.1 NV, 20.2 AZ, 20.3 UT)

How Long Is an Advance Directive Valid?

In most states, advance directives are effective until they are revoked. Members may revoke their advance directive at any time and in any manner, without regard to their mental or physical condition. A revocation is effective when the attending Physician or other health care provider receives notice of the revocation from member or from a witness to the revocation.

Advance Directive as Part of Permanent Medical Record

Members should provide copies of their completed directive to:

- PCP
- Agent (a person acting on your behalf)
- Family

Members are not required to complete an advance directive and can not be denied care if they do not have an advance directive.

Network Provider Implementation

In the event that a network provider cannot implement an advanced directive based on conscience, it is required that the network provider present a statement of any limitations to the member. Minimally, the provider's statement of limitations, if any must:

- Clarify any differences between institution wide conscience objections and those that may be raised by individual network providers
- Identify the State legal authority pursuant to NRS 449.628 permitting such objections
- Describe the range of medical conditions or procedures affected by the conscience objection

21.1 Advanced Directive Nevada

DECLARATION

If I should have an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment, I direct any attending physician, pursuant to NRS 449.535 to 449.690, inclusive, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.

If you wish to include the following statement in this declaration, you must INITIAL the statement in the box provided:

Withholding or withdrawal of artificial nutrition and hydration may result in death by starvation or dehydration. Initial this box if you want to receive or continue receiving artificial nutrition and hydration by way of gastrointestinal tract after all other treatment is withheld pursuant to this declaration
..... ☐

Signed this _____ day of _____, 19____

Signature: _____

Address: _____

The declarant voluntarily signed this writing in my presence.

Witness: _____

Address: _____

Witness: _____

Address: _____

DECLARATION

If I should have an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment, I appoint _____, or if he or she is not reasonably available or is unwilling to serve, _____, to make decisions on my behalf regarding withholding or withdrawal of treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain, pursuant to NRS 449.535 to 449.690, inclusive. (If the person or persons I have so appointed are not reasonably available or are unwilling to serve, I direct my attending physician, pursuant to those sections, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.) *Strike language in parenthesis if you do not desire it.*

If you wish to include the following statement in this declaration, you must INITIAL the statement in the box provided:

Withholding or withdrawal of artificial nutrition and hydration may result in death by starvation or dehydration. Initial this box if you want to receive or continue receiving artificial nutrition and hydration by way of gastrointestinal tract after all other treatment is withheld pursuant to this declaration

Signed this _____ day of _____, 19____-

Signature: _____

Address: _____

The declarant voluntarily signed this writing in my presence.

Witness: _____

Address: _____

Witness: _____

Address: _____

Name and address of each designee.

Name: _____

Address: _____

Name: _____

Address: _____

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

WARNING TO PERSON EXECUTING THIS DOCUMENT

This is an important legal document. It creates a Durable Power of Attorney for Health Care. Before executing the document you should know these important facts:

- This document gives the person you designate as your Attorney-in-Fact the power to make health care decisions for you. The power is subject to any limitations or statement of your desires that you include in this document. The power to make health care decisions for you may include consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. You may state in this document any types of treatment or placements that you do not desire.

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- The person you designate in this document has a duty to act consistent with your desires as stated in this document or otherwise made known, or, if your desires are unknown, to act in your best interest.
- Except as you otherwise specify in this document, the power of the person you designate to make health care decisions for you may include the power to consent to your doctor not giving treatment or stopping treatment which would keep you alive.
- Unless you specify a shorter period in this document, this Power will exist indefinitely from the date you execute this document and if you are unable to make health care decisions for yourself, this power will continue to exist until the time when you become able to make health care decisions for yourself.
- Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection, and health care necessary to keep you alive may not be stopped if you object.
- You have the right to revoke the appointment of the person designated in this document to make health care decisions for you by notifying that person of the revocation orally or in writing.
- You have the right to revoke the authority granted to the person designated in this document to make health care decisions for you by notifying the treating physician, hospital, or other provider of health care orally or in writing.
- The person designated in this document to make health care decisions for you has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.
- This document revokes any prior Durable Power of Attorney for Health Care.
- If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

1. DESIGNATION OF HEALTHCARE AGENT

I, _____ (insert your name) do hereby designate and appoint:

Name:

Address:

Telephone Number:

as my attorney-in-fact to make health care decisions for me as authorized in this document.

(Insert the name and address of the person you wish to designate as your attorney-in-fact to make health care decisions for you. Unless the person is also your spouse, legal guardian or the person most closely related to you by blood, none of the following may be designated as your attorney-in-fact: (1) your treating provider of health care; (2) an employee of your treating provider of health care; (3) an operator of a health care facility; or (4) an employee of an operator of a health care facility.)

2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE

By this document, I intend to create a Durable Power of Attorney by appointing the person designated above to make health care decisions for me. This power of attorney shall not be affected by my subsequent incapacity.

3. GENERAL STATEMENT OF AUTHORITY GRANTED

In the event that I am incapable of giving informed consent with respect to health care decisions, I hereby grant to the attorney-in-fact named above full power, and authority to make health care decisions for me before, or after my death, including: consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat physical or mental condition, subject only to the limitations and special provisions, if any, set forth in paragraph 4 or 6.

4. SPECIAL PROVISIONS AND LIMITATIONS

(Your attorney-in-fact is not permitted to consent to any of the following: commitment to or placement in a mental health treatment facility, convulsive treatment, psychosurgery, sterilization, or abortion. If there are any other types of treatment or placement that you do not want your attorney-in-fact's authority to give consent for or other restrictions you wish to place on your attorney-in-fact's authority, you should list them in the space below. If you do not write any limitations, your attorney-in-fact will have the broad powers to make health care decisions on your behalf which are set forth in paragraph 3, except to the extent that there are limits provided by law.)

In exercising the authority under this Durable Power of attorney for Health Care, the authority of my attorney-in-fact is subject to the following special provisions and limitations:

5. DURATION

I understand that this power of attorney will exist indefinitely from the date I execute this document unless I establish a shorter time. If I am unable to make health care decisions for myself when this Power of Attorney expires, the authority I have granted my attorney-in-fact will continue to exist until the time when I become able to make health care decisions for myself.

(IF APPLICABLE)

I wish to have this Power of Attorney end on the following date:

6. STATEMENT OF DESIRES

(With respect to decisions to withhold or withdraw life sustaining treatment, your attorney-in-fact must make health care decisions that are consistent with your known desires. You can, but are not required to, indicate your desires below. If your desires are unknown, your attorney-in-fact has the duty to act in your best interests; and, under some circumstances, a judicial proceeding may be necessary so that a court can determine the health care decisions that is in your best interest. If you wish to indicate your desires, you may INITIAL the statement or statements that reflect your desires and/or write your own statements in the space below.)

- a. I desire that my life be prolonged to the greatest extent possible, without regard to my condition, the chances I have for recovery or long-term survival, or the cost of the procedures..... ☐
- b. If I am in a coma which my doctors have reasonably concluded is irreversible, I desire that life-sustaining or prolonging treatments not be used. (Also should utilize provisions of NRS 449.535 to 449.690, inclusive, if this subparagraph is initialed.)..... ☐
- c. If I have an incurable or terminal condition or illness and no reasonable hope of long-term recovery or survival, I desire that life-sustaining or prolonging treatments not be used. (Also should utilize provisions of NRS 449.535 to 449.690, inclusive, and sections 2 to 12, inclusive, if this subparagraph is initialed.)..... ☐
- d. Withholding or withdrawal of artificial nutrition and hydration may result in death by starvation or dehydration. I want to receive or continue receiving artificial nutrition and hydration by way of the gastrointestinal tract after all other treatment is withheld..... ☐
- e. I do not desire treatment to be provided and/or continue if the burdens of the treatment outweigh the expected benefits. My attorney-in-fact is to consider the relief of suffering, the preservation or restoration of functioning, and the quality as well as the extent of the possible extension of my life..... ☐

(If you wish to change your answer, you may do so by drawing an "X" through the answer you do not want and circling the answer you prefer.

Other or Additional Statements of Desires:

7. DESIGNATION OF ALTERNATE ATTORNEY-IN-FACT

(You are not required to designate any alternative attorney-in-fact but you may do so. Any alternative attorney-in-fact you designate will be able to make the same health care decisions as the attorney-in-fact designated in paragraph 1 to act as your attorney-in-fact. Also, if the attorney-in-fact designated in paragraph 1 is your spouse, his or her

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designation as your attorney-in-fact is automatically revoked by law if your marriage is dissolved.)

If the person designated in paragraph 1 as my attorney-in-fact is unable to make health care decisions for me, then I designate the following persons to serve as my attorney-in-fact to make health care decisions for me as authorized in this document, such person to service in the order listed below:

A. First Alternative Attorney-in-Fact

Name: _____

Address: _____

Telephone Number: _____

B. Second Alternative Attorney-in-Fact

Name: _____

Address: _____

Telephone Number: _____

8. PRIOR DESIGNATIONS REVOKED

I revoke any prior Durable Power of Attorney for Health Care:

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY.)

I sign my name to this Durable Power of Attorney for HealthCare on (date) _____

at _____ (city), _____ (state).

(Signature)

(This power of attorney will not be valid for making health care decisions unless it is either (1) signed by at least two qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature, or (2) acknowledged before a notary public.)

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

(You may use acknowledgment before a notary public instead of statement of witnesses.)

State of Nevada)

: ss:

County of _____)

On this _____ day of _____, in the year _____, before me, _____ (here insert name of notary public) personally appeared _____ (here insert name of principal) personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it. I declare under penalty of perjury that the person whose name is ascribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

NOTARY SEAL

(Signature of Notary Public)

STATEMENT OF WITNESSES

(You should carefully read and follow this witnessing procedure. This document will not be valid unless you comply with the witnessing procedure. If you elect to use witnesses instead of having this document notarized, you must use two qualified adult witnesses. None of the following may be used as a witness (1) a person you designate as the attorney-in-fact; (2) a provider of health care; (3) an employee of a provider of health care; (4) the operator of a health care facility; (5) an employee of an operator of a health care facility. At least one of the witnesses must make the additional declaration set out following the place where the witnesses sign.)

I declare under penalty of perjury that the principal is personally known to me, that the principal signed or acknowledged the Durable Power of Attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney-in-fact by this document, and that I am not a provider of health care, an employee of a provider of health care, the operator of a community care facility, nor an employee of an operator of a health care facility.

Signature: _____

Print Name: _____

Residence Address: _____

Date: _____

Signature: _____

Print Name: _____

Residence Address: _____

Date: _____

(AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION.)

I declare under penalty of perjury that I am not related to the principal by blood, marriage, or adoption, and to the best of my knowledge I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature: _____

Print Name: _____

Date Signed: _____

Address: _____

Signature: _____

Print Name: _____

Date Signed: _____

Address: _____

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COPIES: You should retain an executed copy of this document and give one to your attorney-in-fact. The power of attorney should be available so a copy may be given to your providers of health care.

Under NRS 449.628, a health care provider is allowed to transfer care of a patient to another provider if the first provider objects on the basis of conscience to implementation of an advance directive.

21.2 Advanced Directive Arizona

OFFICE OF THE ARIZONA ATTORNEY GENERAL
Mark Brnovich



STATE OF ARIZONA
DURABLE HEALTH CARE POWER OF ATTORNEY
Instructions and Form

GENERAL INSTRUCTIONS: Use this Durable Health Care Power of Attorney form if you want to select a person to make future health care decisions for you so that if you become too ill or cannot make those decisions for yourself the person you choose and trust can make medical decisions for you. Talk to your family, friends, and others you trust about your choices. Also, it is a good idea to talk with professionals such as your doctor, clergyperson and a lawyer before you sign this form.

Be sure you understand the importance of this document. If you decide this is the form you want to use, complete the form. **Do not sign this form until** your witness or a Notary Public is present to witness the signing. There are further instructions for you about signing this form on page three.

1. Information about me (the Principal):

My Name: _____
My Address: _____

My Age: _____
My Date of Birth: _____
My Telephone: _____

2. Selection of my health care representative and alternate ("agent" or "surrogate")

I choose the following person to act as my representative to make health care decisions for me:

Name: _____
Address: _____

Home Phone: _____
Work Phone: _____
Cell Phone: _____

I choose the following person to act as an alternate representative to make health care decisions on my behalf if the first representative is unavailable, unwilling, or unable to make decisions for me:

Name: _____
Address: _____

Home Phone: _____
Work Phone: _____
Cell Phone: _____

3. I AUTHORIZE if I am unable to make medical care decisions for myself:

I authorize my health care representative to make health care decisions for me when I cannot make or communicate my own health care decisions due to mental or physical illness, injury, disability, or incapacity. I want my

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representative to make all such decisions for me except those decisions that I have expressly stated in Part 4 below that I do not authorize him/her to make. If I am able to communicate in any manner, my representative should discuss my health care options with me. My representative should explain to me any choices he or she made if I am able to understand. I further authorize my representative to have all access to and copies of my "personal protected health care information and medical records". This appointment is effective unless and until it is revoked by me or by an order of a court.

The types of health care decisions I authorize to be made on my behalf include but are not limited to the following:

- To consent or to refuse medical care, including diagnostic, surgical, or therapeutic procedures;
- To authorize the physicians, nurses, therapists, and other health care providers of his/her choice to provide care for me, and to obligate my resources or my estate to pay reasonable compensation for these services;
- To approve or deny my admittance to health care institutions, nursing homes, assisted living facilities, or other facilities or programs. By signing this form I understand that I allow my representative to make decisions about my mental health care except that he or she cannot have me admitted to a structured treatment setting with 24-hour-a-day supervision and an intensive treatment program – called a "level one" behavioral health facility – using just this grant of authority;
- To have access to and control over my medical records and to have the authority to discuss those records with health care providers.

4. DECISIONS I EXPRESSLY DO NOT AUTHORIZE my Representative to make for me:

I do not want my representative to make the following health care decisions for me (describe or write in "not applicable"):

5. My specific desires about autopsy:

NOTE: Under Arizona law, an autopsy is not required unless the county medical examiner, the county attorney, or a superior court judge orders it to be performed. See the General Information document for more information about this topic. Initial or put a check mark by one of the following choices.

- ☐ Upon my death I DO NOT consent to a voluntary autopsy.
- ☐ Upon my death I DO consent to a voluntary autopsy.
- ☐ My representative may give or refuse consent for an autopsy.

6. My specific desires about organ donation ("anatomical gift"):

NOTE: Under Arizona law, you may donate all or part of your body. If you do not make a choice, your representative or family can make the decision when you die. You may indicate which organs or tissues you want to donate and where you want them donated, [initial] or put a check mark by A or B below. If you select B, continue with your choices.

- ☐ **A.** I DO NOT WANT to make an organ or tissue donation, and I do not want this donation authorized on my behalf by my representative or my family.
- ☐ **B.** I DO WANT to make an organ or tissue donation when I die. Here are my directions.

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1. What organs/tissues I choose to donate: (Select a or b below)

- ☐ a. Whole body
- ☐ b. Any needed parts or organs:
- ☐ c. These parts or organs only:
- 1) _____
- 2) _____
- 3) _____

2. What purposes I donate organs/tissue for: (Select a, b, or c below)

- ☐ a. Any legally authorized purpose (transplantation, therapy, medical and dental evaluation, education or research, and/or advancement of medical and dental science).
- ☐ b. Transplant or therapeutic purposes only.
- ☐ c. Research Only
- ☐ d. Other: _____

3. Which organization or person I want my parts or organs to go to:

- ☐ a. I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution: (name) _____
- ☐ b. I would like my tissues or organs to go to the following individual or institution: _____
- ☐ c. I authorize my representative to make this decision, _____

7. Funeral and Burial Disposition (Optional):

My agent has authority to carry out all matters relating to my funeral and burial disposition wishes in accordance with this power of attorney, which is effective upon my death. My wishes are reflected below:

NOTE: If you choose whole body donation, cremation is the only burial disposition available.

Place your initials by those choices you wish to select.

- ____ Upon my death, I direct my body to be buried. (As opposed to cremated)
- ____ Upon my death, I direct my body to be buried in _____, (Optional directive)
- ____ Upon my death, I direct my body to be cremated.
- ____ Upon my death, I direct my body to be cremated with my ashes to be _____, (Optional directive)
- ____ My agent will make all funeral and burial disposition decisions. (Optional directive)

8. About a Living Will

NOTE: If you have a Living Will and a Durable Health Care Power of Attorney, **you must attach** the Living Will to this form. A Living Will form is available on the Attorney General (AG) web site. Initial or put a check mark by box A or B.

- ____ **A.** I have SIGNED AND ATTACHED a completed Living Will in addition to this Durable Health Care Power of Attorney to state decisions I have made about end of life health care if I am unable to communicate or make my own decisions at that time.
- ____ **B.** I have NOT SIGNED a Living Will.

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9. About a Prehospital Medical Care Directive or Do Not Resuscitate Directive:

NOTE: A form for the Prehospital Medical Care Directive or Do Not Resuscitate Directive is available on the AG Web site. Initial or put a check mark by box A or B.

☐ **A.** I and my doctor or health care provider **HAVE SIGNED** a Prehospital Medical Care Directive or a Do Not Resuscitate Directive on Paper with **ORANGE** background in the event that 911 or Emergency Medical Technicians or hospital emergency personnel are called and my heart or breathing has stopped.

☐ **B.** I have **NOT SIGNED** a Prehospital Medical Care Directive or Do Not Resuscitate Directive.

10. HIPAA WAIVER OF CONFIDENTIALITY FOR MY AGENT/REPRESENTATIVE

☐ **(Initial)** I intend for my agent to be treated as I would with respect to my rights regarding the use and disclosure of my individually identifiable health information or medical records. This release authority applies to information governed by the Health Insurance Portability and Accountability Act (HIPAA) of 1996, 42 USC 1320d, 45 CFR 160.184.

SIGNATURE OR VERIFICATION

A. I am signing this Durable Health Care Power of Attorney as follows:

My Signature: _____ Date: _____

B. I am physically unable to sign this document, so a witness is verifying my desires as follows:

Witness Verification: I believe that this Durable Health Care Power of Attorney accurately expresses the wishes communicated to me by the principal of this document. He/she intends to adopt this Durable Health Care Power of Attorney at this time. He/she is physically unable to sign or mark this document at this time, and I verify that he/she directly indicated to me that the Durable Health Care Power of Attorney expresses his/her wishes and that he/she intends to adopt the Durable Health Care Power of Attorney at this time.

Witness Name (printed): _____

Signature: _____ Date: _____

SIGNATURE OF WITNESS OR NOTARY PUBLIC:

NOTE: At least one adult witness OR a Notary Public must witness the signing of this document and then sign it. The witness or Notary Public CANNOT be anyone who is: (a) under the age of 18, (b) related to you by blood, adoption, or marriage; (c) entitled to any part of your estate; (d) appointed as your representative; or (e) involved in providing your health care at the time this form is signed.

- A. Witness:** I certify that I witnessed the signing of this document by the Principal. The person who signed this Durable Health Care Power of Attorney appeared to be of sound mind and under no pressure to make specific choices or sign the document. I understand the requirements of being a witness and I confirm the following:
- I am not currently designated to make medical decisions for this person.
 - I am not directly involved in administering health care to this person.
 - I am not entitled to any portion of this person's estate upon his or her death under a will or by operation of law.
 - I am not related to this person by blood, marriage or adoption.

Witness Name (printed): _____

Signature: _____ Date: _____

Address: _____

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Notary Public (NOTE: If a witness signs your form, you DO NOT need a notary to sign).

STATE OF ARIZONA } ss
COUNTY OF }

The undersigned, being a Notary Public certified in Arizona, declares that the person making this Durable Health Care Power of Attorney has dated and signed or marked it in my presence and appears to me to be of sound mind and free from duress. I further declare I am not related to the person signing above by blood, marriage or adoption, or a person designated to make medical decisions on his/her behalf. I am not directly involved in providing health care to the person signing. I am not entitled to any part of his/her estate under a will now existing or by operation of law. In the event the person acknowledging this Durable Health Care Power of Attorney is physically unable to sign or mark this document, I verify that he/she directly indicated to me that this Durable Health Care Power of Attorney expresses his/her wishes and that he/she intends to adopt the Durable Health Care Power of Attorney at this time.

WITNESS MY HAND AND SEAL this day of , 20

Notary Public _____ My Commission Expires: _____

OPTIONAL:
STATEMENT THAT YOU HAVE DISCUSSED YOUR
HEALTH CARE CHOICES FOR THE FUTURE WITH YOUR
PHYSICIAN

NOTE: Before deciding what health care you want for yourself, you may wish to ask your physician questions regarding treatment alternatives. This statement from your physician is not required by Arizona law. If you do speak with your physician, it is a good idea to have him or her complete this section. Ask your doctor to keep a copy of this form with your medical records.

On this date I reviewed this document with the Principal and discussed any questions regarding the probable medical consequences of the treatment choices provided above. I agree to comply with the provisions of this directive, and I will comply with the health care decisions made by the representative unless a decision violates my conscience. In such case I will promptly disclose my unwillingness to comply and will transfer or try to transfer patient care to another provider who is willing to act in accordance with the representative's direction.

Doctor Name (printed): _____

Signature: _____ Date: _____

Address: _____

OFFICE OF THE ARIZONA ATTORNEY GENERAL
Mark Brnovich



LIVING WILL (End of Life Care)
Instructions and Form

GENERAL INSTRUCTIONS: Use this Living Will form to make decisions now about your medical care if you are ever in a terminal condition, a persistent vegetative state or an irreversible coma. You should talk to your doctor about what these terms mean. The Living Will states what choices you would have made for yourself if you were able to communicate. It is your written directions to your health care representative if you have one, your family, your physician, and any other person who might be in a position to make medical care decisions for you. Talk to your family members, friends, and others you trust about your choices. Also, it is a good idea to talk with professionals such as your doctor, clergy person and a lawyer before you complete and sign this Living Will.

If you decide this is the form you want to use, complete the form. **Do not sign the Living Will until** your witness or a Notary Public is present to watch you sign it. There are further instructions for you about signing on page 2.

IMPORTANT: If you have a Living Will and a Durable Health Care Power of Attorney, you must attach the Living Will to the Durable Health Care Power of Attorney.

1. My information: (the "Principal")

Name: _____
Address: _____

Age: _____
Date of birth: _____
Phone: _____

2. My decisions about end of life care:

NOTE: Here are some general statements about choices you have as to health care you want at the end of your life. They are listed in the order provided by Arizona law. You can initial any combination of paragraphs A, B, C, and D. **If you initial Paragraph E, do not initial any other paragraphs.** Read all of the statements carefully before initialing to indicate your choice. You can also write your own statement concerning life-sustaining treatments and other matters relating to your health care at Heading 3 of this form.

_____ **A. Comfort Care Only:** If I have a terminal condition I do not want my life to be prolonged, and I do not want life-sustaining treatment, beyond comfort care, that would serve only to artificially delay the moment of my death. (NOTE: "Comfort care" means treatment in an attempt to protect and enhance the quality of life without artificially prolonging life.)

_____ **B. Specific Limitations on Medical Treatments I Want:** (NOTE: Initial or mark one or more choices, talk to your doctor about your choices.) If I have a terminal condition, or am in an irreversible coma or a persistent vegetative state that my doctors reasonably believe to be irreversible or incurable, I do want the medical treatment necessary to provide care that would keep me comfortable, but **I do not want the following:**

- _____ 1.) Cardiopulmonary resuscitation, for example, the use of drugs, electric shock, and artificial breathing.
- _____ 2.) Artificially administered food and fluids.
- _____ 3.) To be taken to a hospital if it is at all avoidable.

STATE OF ARIZONA LIVING WILL ("End of Life Care") (Cont'd)

C. Pregnancy: Regardless of any other directions I have given in this Living Will, if I am known to be pregnant I do not want life-sustaining treatment withheld or withdrawn if it is possible that the embryo/fetus will develop to the point of live birth with the continued application of life-sustaining treatment.

D. Treatment Until My Medical Condition is Reasonably Known: Regardless of the directions I have made in this Living Will, I do want the use of all medical care necessary to treat my condition until my doctors reasonably conclude that my condition is terminal or is irreversible and incurable, or I am in a persistent vegetative state.

E. Direction to Prolong My Life: I want my life to be prolonged to the greatest extent possible.

3. Other Statements Or Wishes I Want Followed For End of Life Care:

NOTE: You can attach additional provisions or limitations on medical care that have not been included in this Living Will form. Initial or put a check mark by box A or B below. Be sure to include the attachment if you check B.

☐ **A.** I have not attached additional special provisions or limitations about End of Life Care I want.

☐ **B.** I have attached additional special provisions or limitations about End of Life Care I want.

SIGNATURE VERIFICATION

A. I am signing this Living Will as follows:

Signature: _____ Date: _____

B. I am physically unable to sign this Living Will, so a witness is verifying my desires as follows:

Witness Verification: I believe that this Living Will accurately expresses the wishes communicated to me by the principal of this document. He/she intends to adopt this Living Will at this time. He/she is physically unable to sign or mark this document at this time. I verify that he/she directly indicated to me that the Living Will expresses his/her wishes and that he/she intends to adopt the Living Will at this time.

Witness Name (printed): _____

Signature: _____ Date: _____

SIGNATURE OF WITNESS OR NOTARY PUBLIC

NOTE: At least one adult witness OR a Notary Public must witness you signing this document. The witness or Notary Public CANNOT be anyone who is: (a) under the age of 18; (b) related to you by blood, adoption, or marriage; (c) entitled to any part of your estate; (d) appointed as your representative; or (e) involved in providing your health care at the time this document is signed.

A. Witness: I certify that I witnessed the signing of this document by the Principal. The person who signed this Living Will appeared to be of sound mind and under no pressure to make specific choices or sign the document. I understand the requirements of being a witness. I confirm the following:

- I am not currently designated to make medical decisions for this person.
- I am not directly involved in administering health care to this person.
- I am not entitled to any portion of this person's estate upon his or her death under a will or by operation of law.
- I am not related to this person by blood, marriage, or adoption.

Witness Name (printed): _____

Signature: _____ Date: _____

Address: _____

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STATE OF ARIZONA LIVING WILL ("End of Life Care") (Last Page)

B. Notary Public: (NOTE: a Notary Public is only required if no witness signed above)

STATE OF ARIZONA } ss
COUNTY OF _____ }

The undersigned, being a Notary Public certified in Arizona, declares that the person making this Living Will has dated and signed or marked it in my presence and appears to me to be of sound mind and free from duress. I further declare I am not related to the person signing above, by blood, marriage or adoption, or a person designated to make medical decisions on his/her behalf. I am not directly involved in providing care as a professional to the person signing. I am not entitled to any part of his/her estate under a will now existing or by operation of law. In the event the person acknowledging this Living Will is physically unable to sign or mark this document, I verify that he/she directly indicated to me that the Living Will expresses his/her wishes and that he/she intends to adopt the Living Will at this time.

WITNESS MY HAND AND SEAL this _____ day of _____, 20 ____

Notary Public: _____ My commission expires: _____

2018 SHL Provider Summary Guide

OFFICE OF THE ARIZONA ATTORNEY GENERAL
Mark Brnovich



LETTER TO MY REPRESENTATIVE(S) About Powers of Attorney Forms and Responsibilities

To My Representative:

Name: _____
Address: _____

To My Alternate Representative:

Name: _____
Address: _____

A. What I Ask You to Do For Me: Arizona law allows me to make certain medical and financial decisions as to what I want in the future if I become unable or incapable of making certain decisions for myself. I have completed the following document(s), and I want you to be my representative or alternate representative for the following purposes, (Initial or check one or more of the following):

- ____ 1. Durable Health Care Power of Attorney
- ____ 2. Durable Mental Health Care Power of Attorney

B. Why I Named an Alternate Representative: I chose two representatives in case one of you is unable to act for me when the time arises. I ask that you accept my selection of you as my representative or alternate. If you do not return the Power of Attorney form(s) and this letter to me or inform me differently, I will assume that you have agreed to be my representative.

C. Your Responsibilities as My Representative: By selecting you, I want you to make some very important decisions for me about my future health care needs if I become unable to make these decisions for myself. I might need you to carry out my medical choices as indicated in the enclosed Powers of Attorney, even if you do not agree with them. Please read the copies of the Powers of Attorney I am giving you. You will be my voice and will make medical decisions on my behalf. Other than what I have indicated in the Powers of Attorney as to my specific directions on certain issues, I am trusting your judgment to make decisions that you believe to be in my best interests. If at any time you do not feel that you can undertake this responsibility for any reason, please let me know. If you are unsure about any of my directions, please discuss them with me. If you are not willing to serve as my representative, please tell me so I can choose someone else to help me.

As to Health Care: You are not financially responsible for paying my health care costs merely by accepting this responsibility. Under Arizona law, you are not liable for complying with my decisions as stated in the Powers of Attorney or in making other health care decisions for me if you act in good faith.

D. What Else You Should Do: Please keep a copy of my Powers of Attorney and other documents in a safe place. Please read these documents carefully and discuss my choices with me at any time. I will give copies of my health care Powers of Attorney to my physician, and I will give copies of any or all of these Powers of Attorney to my family and any other representative I may choose. I authorize you to discuss with them the Powers of Attorney, including, as applicable, my medical situation, or any medical concerns about me. Please work with them and help them to act in accordance with my desires and in my best interests. I appreciate your support, and I thank you for your willingness to help me in this way.

Signature: _____ Date: _____

Printed Name: _____

PREHOSPITAL MEDICAL CARE DIRECTIVE (DO NOT RESUSCITATE)
(IMPORTANT—THIS DOCUMENT MUST BE ON PAPER WITH ORANGE BACKGROUND)

GENERAL INFORMATION AND INSTRUCTIONS: A Prehospital Medical Care Directive is a document signed by you and your doctor that informs emergency medical technicians (EMTs) or hospital emergency personnel not to resuscitate you. Sometimes this is called a DNR – Do Not Resuscitate. If you have this form, EMTs and other emergency personnel will not use equipment, drugs, or devices to restart your heart or breathing, but they will not withhold medical interventions that are necessary to provide comfort care or to alleviate pain. **IMPORTANT:** Under Arizona law a Prehospital Medical Care Directive or DNR must be on letter sized paper or wallet sized paper on an orange background to be valid.

You can either attach a picture to this form, or complete the personal information. You must also complete the form and sign it in front of a witness. Your health care provider and your witness must sign this form.

1. My Directive and My Signature:

In the event of cardiac or respiratory arrest, I refuse any resuscitation measures including cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, administration of advanced cardiac life support drugs and related emergency medical procedures.

Patient Signature: _____ Date: _____

PROVIDE THE FOLLOWING INFORMATION:

OR

ATTACH RECENT PHOTOGRAPH HERE:

My Date of Birth _____
 My Sex _____
 My Race _____
 My Eye Color _____
 My Hair Color _____



2. Information About My Doctor and Hospice (if I am in Hospice):

Physician: _____ Telephone: _____

Hospice Program, if applicable (name): _____

PREHOSPITAL MEDICAL CARE DIRECTIVE (DO NOT RESUSCITATE) (Last Page)

3. Signature of Doctor or Other Health Care Provider:

I have explained this form and its consequences to the signer and obtained assurance that the signer understands that death may result from any refused care listed above.

Signature of a Licensed Health Care Provider: _____ Date: _____

4. Signature of Witness to My Directive:

NOTE: At least one adult witness OR a Notary Public must witness the signing of this document. The witness or Notary Public CANNOT be anyone who is: (a) under the age of 18; (b) related to you by blood, adoption, or marriage; (c) entitled to any part of your estate; (d) appointed as your representative; or (e) involved in providing your health care at the time this form is signed.

I was present when this form was signed (or marked). The patient then appeared to be of sound mind and free from duress.

Signature: _____ Date: _____

21.3 Advanced Directive Utah

Utah Advance Health Care Directive

(Pursuant to Utah Code Section 75-2a-117, effective 2009)*

- Part I:** *Allows you to name another person to make health care decisions for you when you cannot make decisions or speak for yourself.*
- Part II:** *Allows you to record your wishes about health care in writing.*
- Part III:** *Tells you how to revoke or change this directive.*
- Part IV:** *Makes your directive legal.*

My Personal Information

Name: _____

Street Address: _____

City, State, Zip Code: _____

Telephone: (____) _____ Cell Phone: (____) _____

Birth Date: _____

Part I: My Agent (Health Care Power of Attorney)

A. No Agent

If you do not want to name an agent, initial the box below, then go to Part II; do not name an agent in B or C below. No one can force you to name an agent.

☐ I do not want to choose an agent.

B. My Agent

Agent's Name: _____

Street Address: _____

City, State, Zip Code: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Work Phone: (____) _____

C. My Alternate Agent

This person will serve as your agent if your agent, named above, is unable or unwilling to serve.

Alternate Agent's Name: _____

Street Address: _____

City, State, Zip Code: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Work Phone: (____) _____

Part I: My Agent (continued)

D. Agent's Authority

If I cannot make decisions or speak for myself (in other words, after my physician or another authorized provider finds that I lack health care decision making capacity under Section 75-2a-104 of the Advance Health Care Directive Act), my agent has the power to make any health care decision I could have made such as, but not limited to:

- Consent to, refuse, or withdraw any health care. This may include care to prolong my life such as food and fluids by tube, use of antibiotics, CPR (cardiopulmonary resuscitation), and dialysis, and mental health care, such as convulsive therapy and psychoactive medications. This authority is subject to any limits in paragraph F of Part I or in Part II of this directive.
- Hire and fire health care providers.
- Ask questions and get answers from health care providers.
- Consent to admission or transfer to a health care provider or health care facility, including a mental health facility, subject to any limits in paragraphs E or F of Part I.
- Get copies of my medical records.
- Ask for consultations or second opinions.

My agent cannot force health care against my will, even if a physician has found that I lack health care decision making capacity.

E. Other Authority

My agent has the powers below only if I initial the "yes" option that precedes the statement. I authorize my agent to:

- ☐ YES ☐ NO Get copies of my medical records at any time, even when I can speak for myself.
- ☐ YES ☐ NO Admit me to a licensed health care facility, such as a hospital, nursing home, assisted living, or other facility for long-term placement other than convalescent or recuperative care.

F. Limits/Expansion of Authority

I wish to limit or expand the powers of my health care agent as follows:

G. Nomination of Guardian

Even though appointing an agent should help you avoid a guardianship, a guardianship may still be necessary. Initial the "YES" option if you want the court to appoint your agent or, if your agent is unable or unwilling to serve, your alternate agent, to serve as your guardian, if a guardianship is ever necessary.

- ☐ YES ☐ NO I, being of sound mind and not acting under duress, fraud, or other undue influence, do hereby nominate my agent, or if my agent is unable or unwilling to serve, I hereby nominate my alternate agent, to serve as my guardian in the event that, after the date of this instrument, I become incapacitated.

H. Consent to Participate in Medical Research

- ☐ YES ☐ NO I authorize my agent to consent to my participation in medical research or clinical trials, even if I may not benefit from the results.

I. Organ Donation

- ☐ YES ☐ NO If I have not otherwise agreed to organ donation, my agent may consent to the donation of my organs for the purpose of organ transplantation.

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Part II: My Health Care Wishes (*Living Will*)

I want my health care providers to follow the instructions I give them when I am being treated, even if my instructions conflict with these or other advance directives. My health care providers should always provide health care to keep me as comfortable and functional as possible.

Choose only one of the following options, numbered Option 1 through Option 4, by placing your initials before the numbered statement. Do not initial more than one option. If you do not wish to document end-of-life wishes, initial Option 4. You may choose to draw a line through the options that you are not choosing.

Option 1	
Initial	I choose to let my agent decide. I have chosen my agent carefully. I have talked with my agent about my health care wishes. I trust my agent to make the health care decisions for me that I would make under the circumstances.
Additional comments:	
Option 2	
Initial	I choose to prolong life. Regardless of my condition or prognosis, I want my health care team to try to prolong my life as long as possible within the limits of generally accepted health care standards.
Additional comments:	
Option 3	
Initial	I choose not to receive care for the purpose of prolonging life, including food and fluids by tube, antibiotics, CPR, or dialysis being used to prolong my life. I always want comfort care and routine medical care that will keep me as comfortable and functional as possible, even if that care may prolong my life.
<i>If you choose this option, you must also choose either (a) or (b), below</i>	
Initial	(a) I put no limit on the ability of my health care provider or agent to withhold or withdraw life-sustaining care.
Initial	(b) My health care provider should withhold or withdraw life-sustaining care if <i>at least one</i> of the initialed conditions is met:
Initial	I have a progressive illness that will cause death
Initial	I am close to death and am unlikely to recover
Initial	I cannot communicate and it is unlikely that my condition will improve
Initial	I do not recognize my friends or family and it is unlikely that my condition will improve
Initial	I am in a persistent vegetative state
Additional comments:	
Option 4	
Initial	I do not wish to express preferences about health care wishes in this directive.
Additional comments:	

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Part II: My Health Care Wishes (*continued*)

Additional instructions about your health care wishes:

If you do not want emergency medical service providers to provide CPR or other life sustaining measures, you must work with a physician or APRN to complete an order that reflects your wishes on a form approved by the Utah Department of Health.

Part III: Revoking or Changing a Directive

I may revoke or change this directive by:

- Writing "void" across the form, burning, tearing, or otherwise destroying or defacing this document or directing another person to do the same on my behalf;
- Signing a written revocation of the directive, or directing another person to sign a revocation on my behalf;
- Stating that I wish to revoke the directive in the presence of a witness who: is 18 years of age or older; will not be appointed as my agent in a substitute directive; will not become a default surrogate if the directive is revoked; and signs and dates a written document confirming my statement; or
- Signing a new directive. (*If you sign more than one Advance Health Care Directive, the most recent one applies.*)

Part IV: Making My Directive Legal

I sign this directive voluntarily. I understand the choices I have made and declare that I am emotionally and mentally competent to make this directive. My signature on this form revokes any living will or power of attorney form naming a health care agent that I have completed in the past.

Date	Signature
	City, County, and State of Residence

I have witnessed the signing of this directive, I am 18 years of age or older, and I am not:

1. Related to the declarant by blood or marriage;
2. Entitled to any portion of the declarant's estate according to the laws of intestate succession of any state or jurisdiction or under any will or codicil of the declarant;
3. A beneficiary of a life insurance policy, trust, qualified plan, pay on death account, or transfer on death deed that is held, owned, made, or established by, or on behalf of, the declarant;
4. Entitled to benefit financially upon the death of the declarant;
5. Entitled to a right to, or interest in, real or personal property upon the death of the declarant;
6. Directly financially responsible for the declarant's medical care;
7. A health care provider who is providing care to the declarant or an administrator at a health care facility in which the declarant is receiving care; or
8. The appointed agent or alternate agent.

Signature of Witness	Printed Name of Witness
Street Address	City
	State
	Zip

If the witness is signing to confirm an oral directive, describe below the circumstances under which the directive was made.

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SECTION 22

Fraud Waste and Abuse Compliance Policy

22 – Fraud, Waste and Abuse Compliance Policy

Activities that are considered fraud, waste and abuse by members, practitioners or care providers hurts everyone – SHL, taxpayers, members and providers. Combating fraud, waste and abuse is the responsibility of members, healthcare providers and insurers alike. It is your responsibility to report members or other providers you suspect are committing fraud or abuse. Your assistance in notifying us and cooperating with any potential fraud or abuse occurrence is vital and appreciated in conjunction with our mutual ongoing efforts to coordinate the most effective health outcomes possible for our members.

Definitions of Fraud, Waste and Abuse

Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

Waste is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Abuse includes actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

Examples of Fraud, Waste and Abuse include:

Administrative or Financial

- Kickbacks.
- Falsifying credentials.
- Fraudulent credentials.
- Fraudulent enrollment practices.
- Fraudulent third party liability reporting.
- Fraudulent recoupment practices.

Falsifying Claims/Encounters

- Alteration of a claim.
- Incorrect coding.
- Double billing.
- False data submitted

Falsifying Services

- Billing for services or supplies not provided.
- Misrepresentation of services/supplies.
- Substitution of services.

Member issues

- Resource misrepresentation (transfer and/or hiding).
- Residency.
- Household composition.
- Citizenship status.
- Unreported income.

- Misrepresentation of medical condition.
- Failure to report third party liability.

If you identify potential fraud, waste or abuse, please report it to us immediately so that we can investigate and respond appropriately. There are multiple reporting methods including:

SHL Provider Services - 702-242-7088

The Compliance & Ethics Help Center

–Phone: 1-800-455-4521 (US)

–Online: www.uhghelpcenter.ethicspoint.com

–The Help Center is available 24 hours a day, 7 days a week.

Health Care Fraud Tip Line – 1-866-242-7727

UnitedHealth Group Compliance & Ethics Office

–Phone: 1-952-936-7463

–Email: ethicsoffice@uhg.com

Integrity of Claims, Reports and Representation to Government Entities

The Deficit Reduction Act of 2005 (DRA) was signed into law in early 2006. The DRA encourages states to have in place false claims legislation. It further requires that any entity receiving annual Medicaid payments of \$5 million or more to provide written policies available to all employees, contractors and agents (including providers), detailed information about the False Claims Act and any state laws that pertain to civil or criminal penalties for making false claims and statements, and the whistleblower protection under such laws, including the role of such laws in preventing and detecting fraud, waste and abuse in federal health care programs.

A number of federal and state regulations govern information provided to the government, including the Federal False Claims Act, State False Claims Acts and other regulations and protections. SHL requires compliance with the requirements of federal and state laws that prohibit the submission of false claims in connection with federal health care programs, including Medicare and Medicaid. Federal and state governments have adopted a number of statutes to deter and punish misrepresentations with regard to health care programs. Failure to comply with these laws could result in civil and criminal sanctions imposed by government entities and SHL.

Required Training

As part of an effective Compliance Program, CMS requires Medicare Advantage (MA) Organizations and Part D Plan Sponsors, including SHL, to annually communicate specific Compliance and Fraud, Waste and Abuse (FWA) requirements to their employees, including the CEO, senior administrators or managers, and for governing body members, and for first tier, downstream, and related entities" (FDRs), which include contracted physicians, health care professionals, facilities and ancillary providers, as well as delegates, contractors, and related parties.

The required education, training, and screening requirements to which we – and you – are subject include the following:

Standards of Conduct Awareness:

FDRs working on Medicare Advantage and Part D programs – including contracted providers – must provide a copy of their own or the UnitedHealth Group's (UHG's) Code of Conduct (found at <http://www.unitedhealthgroup.com/~media/UHG/PDF/About/UNH-Code-of-Conduct.ashx>)

to their employees (including temporary workers and volunteers), the CEO, senior administrators or managers, governing body and sub delegates who have involvement in or responsibility for the administration or delivery of UnitedHealthcare MA or Part D benefits or services within 90 days of hire and annually thereafter (by the end of the year).

What You Need to Do for Standards of Conduct Awareness: Provide your own or the UHG's Code of Conduct as outlined above and maintain records of distribution standards (i.e. in an email, website portal or contract, etc.) for 10 years. Documentation may be requested by UnitedHealthcare or CMS to verify compliance with this requirement.

Fraud, Waste, and Abuse and General Compliance Training: FDRs working on Medicare Advantage and Part D programs – including contracted providers – must provide Fraud, Waste, and Abuse (FWA) and General Compliance training within 90 days of employment and annually thereafter (by the end of the year) to their employees (including temporary workers and volunteers), CEO, senior administrators or managers, and sub delegates who have involvement in or responsibility for the administration or delivery of UnitedHealthcare MA or Part D benefits or services.

Effective January 1, 2016, CMS has amended the regulations to mandate only the use of CMS published training materials by FDRs of a contracted Medicare plan sponsor. FDRs cannot alter the published CMS training material content; however, CMS will allow FDRs to download CMS training material and add content and topics specifics to your organization. The CMS standardized FWA training and education module is available through the CMS Medicare Learning Network (MLN) at cms.gov.

FDRs meeting the FWA certification requirements through enrollment in the fee-for-service (Parts A or B) Medicare program or accreditation as durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) Provider are deemed by CMS rules to have met the training and education requirements.

It is our responsibility to make sure that your organization has access to appropriate training. To facilitate that, we are providing you information on the CMS Parts C and D FWA and General Compliance training module. This module is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html>.

What You Need to Do for FWA and Compliance Training: Administer FWA and General Compliance training as outlined above and maintain a record of completion (i.e., method, training materials, dated employee sign-in sheet(s), employee attestations or electronic certifications from employees that include the date of the training) for 10 years. Documentation may be requested by UnitedHealthcare or CMS to verify compliance with this requirement.

Exclusion Checks: FDRs must review federal exclusion lists (HHS-OIG and GSA) and state exclusion lists, as applicable, prior to hiring/contracting with employees (including temporary workers, volunteers, and consultants), the CEO, senior administrators or managers, and sub delegates who have involvement in or responsibility for the administration or delivery of UnitedHealthcare MA and Part D benefits or services to make sure that none are excluded or become excluded from participating in Federal health care programs. FDRs must continue to review the federal and state exclusion lists on a monthly basis thereafter. For more information or access to the publicly accessible excluded party online databases, please see the following links:

Health and Human Services – Office of the Inspector General OIG List of Excluded Individuals and Entities (LEIE) at <http://oig.hhs.gov/exclusions/index.asp>

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General Services Administration (GSA) Excluded Parties Lists System
at <https://www.sam.gov/portal/public/SAM>

What You Need to Do for Exclusion Checks: Review applicable exclusion lists as outlined above and maintains a record of exclusion checks for 10 years. Documentation of the exclusion checks may be requested by UnitedHealthcare or CMS to verify that checks were completed.

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**SECTION 23
FREQUENTLY USED FORMS**

23-Frequently Used Forms

- 23.1 Requests for Allowables Form
- 23.2 @YourService Forms
 - A. Administrator Account Request Form
 - B. Terms of Use Acknowledgement Form
 - C. Penalties for Violations of Terms of Use
- 23.3 Provider Add Request Form
- 23.4 SHL Complaint Form
- 23.5 Claim Reconsideration Form
- 23.6 Nevada Universal Prior Authorization and Referral Form



HEALTH PLAN OF NEVADA
A UnitedHealthcare Company



SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

REQUEST FOR ALLOWABLES
(Fax Request to 702-266-8809)

Date: _____

Tax ID#: _____

Provider/Group Name: _____

Specialty: _____

Contact Name: _____ Phone#: _____ Fax#: _____

E-Mail: _____

Contact is from which of the following? ☐ Billing Service ☐ Provider's office ☐ Other

Type of Code(s): ☐ CPT ☐ HCPCS ☐ ASA

Please put a check mark next to each contracted line of business you are requesting.

- ☐ Health Plan of Nevada (HPN)
☐ Senior Dimensions; Medicare
☐ Sierra Health & Life (SHL)
☐ Sierra Healthcare Options (SHO)
☐ Medicaid and Nevada Check-up
☐ Prime Health
☐ Worker's Compensation; Sierra at Work (SAW)
☐ Northern Nevada Health Network (NNHN)

Requests are limited to a maximum of 40 codes. Requests submitted with more than 40 codes will only be processed up to the 40th code. Please maintain and use your EOPs for reference.

1.	2.	3.	4.	5.
6.	7.	8.	9.	10.
11.	12.	13.	14.	15.
16.	17.	18.	19.	20.
21.	22.	23.	24.	25.
26.	27.	28.	29.	30.
31.	32.	33.	34.	35.
36.	37.	38.	39.	40.

Please note: Allowable quotes do not guarantee payment. Claim processing is subject to member eligibility, benefits, claim processing guidelines, and contract limitations.

Network Development & Contracts/Provider Services
P.O. Box 15645, Las Vegas, NV 89114-5645
Phone: (702) 242-7088 (800) 745-7065

Please allow 30 Business days for processing



HEALTH PLAN OF NEVADA
A UnitedHealthcare Company



SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

@YourService Administrator Account Request Form

Please complete this form with the information for the individual your office has designated to be an Account Administrator.

- The Account Administrator will be responsible for creating profiles, editing profiles, and password reset of the individual accounts associated with their provider TIN.
- The Account Administrator will be responsible for ensuring that every employee ("individual account holder") has his/her own username and password for HPN/SHL @YourService and signs the Acknowledgement to Comply with HPN and/or SHL's @YourService Terms of Use. The signed Acknowledgements must be retained by the Account Administrator and produced to HPN/SHL upon request.
- The Account Administrator will be responsible for notifying HPN/SHL Provider Services at 702-242-7088 within 24 hours of designation of a new Account Administrator, an individual account holder's termination of employment and if termination of an individual's account is necessary for any other reason.

Billing offices must go through their physician office for access. NO EXCEPTIONS

Please complete and fax to (702) 242-9124 Attn: Provider Services

ALL REQUESTED INFORMATION IS REQUIRED

First & Last Name:	
Requestor DOB:	
Requestor Job Title:	
Office Name:	
Office Address:	
TIN:	
E-Mail:	
Phone Number:	
Fax Number:	

As an authorized user of the HPN/SHL @YourService application, the above named organization will be given access to private and confidential patient and health plan member data for the exclusive purpose of performing their professional responsibilities. The following rules will govern usage of the system named above at all times:

- Usernames and passwords are to be safeguarded. Disclosing the username and password information to anyone for any reason with the exception of authorized personnel of the entity providing access to the HPN/SHL @YourService application is **STRICTLY PROHIBITED**.
- The private and confidential data within the HPN/SHL @YourService application is to be safeguarded at all times. The HPN/SHL @YourService application contains information that is confidential and protected from disclosure by law (except for specific legal exception or with the individual's authorization). The Privacy Act of 1974, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Federal Privacy Rule all protect the confidentiality of all individually identifiable health information.
- Use of the HPN/SHL @YourService application is monitored and subject to audit review. Access to private and confidential data within the HPN/SHL @YourService application is to be limited to only such data as is required to carry out professional responsibilities. Improper disclosure or access to private and confidential information (obtained through the computer or otherwise) may result in immediate termination of system access privileges and possible legal action.

HPN/SHL expressly reserves the right to make any and all determinations concerning violation of the rules stated herein. Any determination made by us will be final and not subject to any formal review or appeal process.

Note: Please allow up to 10 business days for account set-up. The information will be sent to the above listed requestor(s).

SHL 2018 Section 23 Frequently Used Forms

23.2B



**Acknowledgement to Comply with Health Plan of Nevada, Inc.'s ("HPN")
and/or Sierra Health and Life Insurance Company, Inc.'s ("SHL")
@YourService Terms of Use**

- I acknowledge that I am responsible for my unique @YourService User ID ("User ID") and must not share or disclose my User ID. I acknowledge that I am responsible for my use of @YourService and that I may only access @YourService for job-related purposes.
- I hereby agree, as a condition of access to @YourService, that I will not access my own Protected Health Information ("PHI") or that of a family member or co-worker and will not ask a co-worker to do so either. I agree that I will not access the PHI of any individual without a job-related purpose.
- I understand that use of the HPN/SHL @YourService application is monitored and subject to audit review. Access to private and confidential data within the HPN/SHL @YourService application is to be limited to only such data as is required to carry out professional responsibilities. Improper disclosure or access to private and confidential information (obtained through the computer or otherwise) may result in immediate termination of system access privileges and possible legal action.
- I understand that access to @YourService is a privilege, which may be revoked at any time at the sole discretion of HPN or SHL.
- I also agree to promptly report all violations or suspected violations of these Terms of Use to HPN/SHL at 702-242-7186.

I have read and agree to comply with the above.

Signature of User: _____ Date: _____

Name of User (please print): _____

Network Contract Provider: _____

Administrator Name (please print): _____

Administrator's Signature: _____ Date: _____

23.2C



HEALTH PLAN OF NEVADA
A UnitedHealthcare Company



SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

Penalties for Violations of Health Plan of Nevada, Inc.'s ("HPN") and Sierra Health and Life Insurance Company, Inc.'s ("SHL") @YourService Terms of Use

1. As stated in the @YourService Terms of Use Acknowledgement Form, @YourService Users (collectively "Users" and individually a "User") are prohibited from accessing @YourService for any purpose that is not job-related. Users are also prohibited from sharing and/or disclosing their unique @YourService User ID ("User ID"). A violation of the Terms of Use will result in temporary suspension or termination of system access privileges as outlined below.
 - (a) Users are prohibited from using @YourService to access their own Protected Health Information ("PHI") or that of a family member, co-worker or any other individual other than for job purposes and must not ask a co-worker to do so either. A violation of this Term will result in immediate termination of the User's system access privileges. If more than one User was involved, each User's system access privileges will be terminated.
 - (b) An initial violation of the Terms of Use by an individual User which upon investigation is found to have resulted from an honest error made in good faith and that does not constitute a violation described in (a) above will not result in deactivation of the User's ID or termination of the User's system access privileges. A second violation by the same User will result in temporary deactivation of the User's ID, which may not be reactivated* for a period of at least one (1) month. A third violation will result in termination of the User's system access privileges.
 - (c) Each User is required to have his/her own unique @YourService User ID and password. Users are prohibited from sharing and/or disclosing their User ID. If a User is found to have shared or disclosed his/her User ID or used another User's ID, the involved Users' system access privileges will be terminated.
2. If an Account Administrator is found to have created an additional User ID for any User whose system access privileges were temporarily suspended or terminated, the Account Administrator's access privileges for creating and editing account profiles will be revoked and the provider will be required to designate another Account Administrator.
3. If any single User has had more than one violation of the Terms of Use in a calendar year or more than one User from the same provider office is found to have violated the Terms of Use in a single quarterly audit period, the provider will be required to submit a Corrective Action Plan ("CAP") to HPN/SHL Provider Services which should include, at a minimum, training for all employees on the @YourService Terms of Use. The provider will be required to submit a brief description of the training along with a list of all individuals in attendance to Provider Services.

* The Account Administrator is solely responsible for requesting reactivation of a User ID from HPN/SHL Provider Services.
SHL 2018 Section 23 Frequently Used Forms

23.4

Sierra Health and Life
COMPLAINT FORM

Member/Insured Name: _____

Member Number: _____ Date of Birth: _____

Description of the issue/concern (please include date(s), any known names of individuals involved; name of facility, if applicable):

Signature

Date

(If signed, a written response will be submitted to the member/insured)

WHEN COMPLETED, THIS FORM SHOULD BE SUBMITTED TO:

COMPANY NAME: Sierra Health and Life
DEPARTMENT: Customer Response and Resolution Department
MAILING ADDRESS: P.O. Box 14865
Las Vegas, NV 89114-4865

As always, the Member Services Department can be contacted directly by telephone at the following numbers:

SIERRA HEALTH AND LIFE: (702) 242-7700 or (800) 888-2264



Single Paper Claim Reconsideration Request Form

This form is to be completed by physicians, hospitals or other health care professionals for paper Claim Reconsideration Requests for our members.

- Please submit a separate claim reconsideration request form for each request
- No new claims should be submitted with this form.

Member Information (Required Information)			
Line of Business: (circle one) HPN SHL Senior Dimensions Medicaid			
Member ID and Date of Birth:	Claim #:	Date of Service:	Billed Amount:
Member Last Name	First Name	MI	Expected amount owed:

Physician/Health Care Professional Information			
Tax Identification Number (TIN):	Physician Name/Facility or other health care professional (as listed on Provider Remittance Advice (PRA)/Explanation of Benefits (EOB):	Email Address:	Contact Name and Telephone Number:

Reason for request: (please circle applicable reason)

- Exceeds Timely Filing
- Additional Information
- Coordination of Benefits
- Resubmission of a corrected claim
- Previously processed but rate applied incorrectly resulting in over/underpayment (Network Providers - Check your fee schedules)
- Prior Authorization/Referral denial
- Resubmission of "Bundled/Incidental" services
- Carve-Outs
(Explain below)

Please include what you are expecting from HPN/SHL regarding this Claim Reconsideration

Comments:

Required attachments:

- Copy of EOP - Claim Form is **ONLY** required for Corrected Claims Submissions
- Other required attachments as outlined in the Claims Reconsideration Reference Guide

2018 SHL Provider Summary Guide
NEVADA UNIVERSAL PRIOR AUTHORIZATION
AND REFERRAL FORM

23.6

HEALTH PLAN NAME & MEMBER HEALTH PLAN I.D. #:	Primary Care Provider Name / Address / Phone & Fax #:		
Health Plan Phone/Fax #:			
Date of Request:	Requesting Provider Name:		
Member Name & SS#:	Requesting Provider's Address & Phone #:		
Member's Address & Phone #:	Requesting Provider's Fax #:		
Member DOB:	Requesting Provider's Tax ID #:		
Employer Group's Name & Phone #:	HIPAA Provider Identification #:		
Other Insurance (s):	Contact Person (Name, Phone & Fax #):		
Requesting Provider's Signature or Stamped Signature:			
Diagnosis (inc. ICD code):	Procedure / Treatment Request (inc. CPT code):		
Number of Treatments Requested: _____ Inpatient / Outpatient Service Requested by Patient Yes No			
Service Provider / Address / Phone #:	Place of Service / Facility and Address:		
Requested Procedure Date / Start Treatment Date:			
Current Clinical Findings and Management All procedures/treatment requested require clinical information (may use this space - also see requirements below and attach to this form):			
<u>Pertinent Attachments</u> = Information to support the proposed diagnosis, treatment / procedure; i.e. current clinical findings (progress reports), results of laboratory testing, imaging studies (x-rays, etc.) must be submitted to prevent processing delays.			

Area for internal health plan use only	Authorization: Yes No	Date of Authorization:	Pended / Denied: (Reason):
Health plan contact name & phone #		Authorization Number:	

***All sections of this form must be completed.**

****On adverse determinations a reconsideration / expedited appeal may be requested.**

This referral/authorization is not a guarantee of payment. Payment is contingent upon eligibility, benefits available at the time the service is rendered, contractual terms, limitations, exclusions, and coordination of benefits, and other terms & conditions set forth in the member's Evidence of Coverage, Certificate of Coverage, or Self Insured Employer's Plan Documents.

The information contained in this form, including attachments, is privileged & confidential & is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If this communication has been received in error, the reader shall notify sender immediately and shall destroy all information received.

Revised 12/11/00



SIERRA HEALTH AND LIFE

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P.O. Box 15645 • Las Vegas, Nevada 89114-5645

mySHLonline.com

Insurance coverage provided by Sierra Health and Life.
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