

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 8 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 8 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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2018

PROVIDER SUMMARY GUIDE

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HEALTH PLAN OF NEVADA PROVIDER SUMMARY GUIDE

SECTION 1

INTRODUCTION

1 – Introduction



HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

Dear Provider:

Health Plan of Nevada, Inc. (HPN) thanks you for participating in our provider network. HPN has been serving Nevadan's for over 25 years and is the largest federally qualified health maintenance organization (HMO) in Nevada and is the state's oldest, and most experienced HMO.

To make your participation with HPN as easy as possible, our HPN Provider Summary Guide can be used as a quick reference tool for you and your office staff. Our goal is to make HPN's eligibility, billing, and managed care program procedures easy for you and your office staff to follow. By following the guidelines outlined in the HPN 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 HPN Provider Summary Guide may occur due to changes in policies and procedures. To remain current on HPN policies and procedures, we encourage you to visit our website at www.myhpnprovider.com and also watch for mailings and facsimiles.

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

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

Sincerely,

Your Provider Relations team

**HEALTH PLAN OF NEVADA
PROVIDER SUMMARY
GUIDE**

SECTION 2

OVERVIEW OF HEALTH PLAN OF NEVADA

Section 2 – Overview



HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

Health Plan of Nevada (HPN) is a UnitedHealthcare Company, serving Nevadans for over 25 years. Nevadans count on us to provide an innovative health care delivery system that focuses on quality, accessibility and cost effectiveness. That's why we offer a variety of medical and dental, group and individual, as well as Medicare and Medicaid 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.

HPN'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 Health Plan of Nevada's internal departments, and producing the provider network directories for HPN.

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

**HEALTH PLAN OF NEVADA
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, 8am – 5:00pm 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

Health Plan of Nevada	(800) 777-1840
My HPN (on exchange plan)	(877) 752-8026
HPN Medicaid and Nevada CheckUp	(800) 962-8074
Senior Dimensions	(800) 650-6232
TTY	711
Fax	(702) 240-6281

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

HPN/Senior Dimensions (702) 242-7724
(800) 768-2808

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

Medicare: You can reach a Customer Service representative at 1-800-650-6232, TTY: 711 From February 15th through September 30th, we are open Monday - Friday from 8 a.m. to 8 p.m. From October 1st through February 14th, we are open from 8 a.m. to 8 p.m., seven days a week.

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) 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

**HEALTH PLAN OF NEVADA
PROVIDER SUMMARY
GUIDE**

SECTION 4

**PROVIDER ADMINISTRATIVE
REQUIREMENTS AND
RESOURCES**

4 - Provider Administrative Requirements and Resources

4.1 Provider Educational Materials

HPN works hard to ensure our network of contracted providers is equipped with the information and tools necessary to deliver quality healthcare to our members. The HPN Provider Summary Guide is one of the many educational tools available to assist providers and their office staff. The Provider Summary Guide is published annually and is available in electronic format by visiting www.myhpnprovider.com. Additionally, important information is communicated between the annual guides by periodic updates on the HPN website, correspondence and faxes to all affected providers.

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

HPN Website

Another valuable tool available to providers and their office staff is the HPN website located at www.myhpnprovider.com. The HPN web-site has a section devoted entirely to providers and their office staff. By visiting the website, you'll gain access to:

- Online Provider Summary Guide
- Online provider directories
- HPN Preferred Drug Lists, mail-order pharmacy information and plan pharmacies
- HPN 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, HPN'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 Health Plan of Nevada 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 HPN 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.

Network CORE Reporting

Care Opportunities Reporting (CORE) is now available to Health Plan of Nevada HMO, Senior Dimensions and HPN Medicaid and Nevada Check-up Primary Care Physicians (PCP's) that hold a member panel.

CORE reporting will track 20 HEDIS measures and will identify for PCP's if a member has a gap in care. PCP's will be provided with information on how to effectively close the gap in care for the member through the detailed reporting. CORE Reporting is updated weekly through encounter/claims data. These reports are available in @YourService under the CORE Reports heading.

Below are the measures that are currently identified in the CORE Reporting tool.

- ✓ Drug Therapy – Rheumatoid Arthritis
- ✓ Diabetes Care – HbA1C Value > 9.0%
- ✓ Diabetes Care – Nephropathy
- ✓ Breast Cancer Screening
- ✓ Diabetes Care – HbA1C Screening
- ✓ Colorectal Cancer Screening
- ✓ Osteoporosis - Fracture Mgmt
- ✓ Access to Visits
- ✓ Annual Blood tests for Patients on ACE/ARB
- ✓ Annual Blood tests for patients on Digoxin
- ✓ Annual Blood tests for patients on Diuretics
- ✓ Cervical Cancer Screening Due
- ✓ Lead Screening in Children

Please contact your Provider Relations Advocate if you have any questions.

4.2 Provider Additions, Changes and Terminations

Provide timely notice of demographic changes

HPN 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 HPN online, or by mail or fax to Provider Services. In addition, you must proactively notify HPN 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 HPN 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 HPN members in our directories, HPN will take the following actions:

1. HPN 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 HPN members, and have voluntarily ceased participation in our provider network.
2. HPN 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 HPN 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 form 25.3 in Section 25 and fax it back to HPN at (702) 266-8809.

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

4.3 Access Standards

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

HPN's medical standards are outlined below.

Primary Care Physician Access Standards:

<i>Preventive:</i>	First available appointment is scheduled within 30 days from the date of referral/request.
<i>Routine:</i>	First available appointment is scheduled within 7 days from the date of referral/request.
<i>Urgent:</i>	There is appointment availability within 24 hours.
<i>Emergent:</i>	There is availability the same day/12 hours.

Specialist Physician Access Standards:

Specialist Consultation (Outpatient)

<i>STAT:</i>	Appointment is available within 24 hours.
<i>Expedited:</i>	Appointment is available within 72 hours.
<i>At Risk:</i>	Appointment is available within 14 days.
<i>Routine:</i>	Appointment is available within 30 days.

Specialist Consultation (Inpatient)

Consultation referral before 12:00 noon:	Same day
Consultation referral after 12:00 noon:	Next day

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.

Arrange substitute coverage:

If you are unable to provide care and are arranging for a substitute, we ask that you arrange for care from other physicians and health care professionals who participate with HPN so that services may be covered under the members in-network benefit. We encourage you to go to www.myhpnonline.com to find the most current directory of our network physicians and health care professionals.

Please see Section 8.6 for Medicaid Access Standards

Dental Access Standards:

DENTIST agrees to the following standards:

Health Plan of Nevada, Inc. (HPN) 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

4.4 Provider Medicare Advantage Requirements

If you participate in HPN's Medicare Advantage provider network(s), you must comply with the following additional requirements for services you provide to our Medicare Advantage members:

- You may not discriminate against members in any way based on health status.
- You must allow members to directly access screening mammography and influenza vaccination services.
- You may not impose cost-sharing on members for influenza vaccine or pneumococcal vaccine.
- You must provide female members with direct access to a women's health specialist for routine and preventive health care services.
- You must make sure that members have adequate access to covered health services.
- You must make sure that your hours of operation are convenient to members and do not discriminate against members and that medically necessary services are available to members 24 hours a day, 7 days a week. Primary Care Physicians must have backup for absences.
- You may not distribute marketing materials or forms to members without CMS approval of the materials or forms.
- You must provide services to members in a culturally competent manner, taking into account limited English proficiency or reading skills, hearing or vision impairment and diverse cultural and ethnic backgrounds.
- You must cooperate with our procedures to inform members of health care needs that require follow-up and provide necessary training to members in self-care.
- You must document in a prominent part of the member's medical record whether the member has executed an advance directive.
- You must provide covered health services in a manner consistent with professionally recognized standards of healthcare.
- You must make sure that any payment and incentive arrangements with subcontractors are specified in a written agreement, that such arrangements do not encourage reductions in medically necessary services, and that any physician incentive plans comply with applicable CMS standards.
- You must cooperate with our processes to disclose to CMS all information necessary for CMS to administer and evaluate the Medicare Advantage Program, and all information determined by CMS to be necessary to assist members in making an informed choice about Medicare coverage.
- You must cooperate with our processes for notifying members of network participation agreement terminations.
- You must comply with our Medicare Advantage medical policies, quality improvement programs and medical management procedures.

- You must cooperate with us in fulfilling our responsibility to disclose to CMS quality, performance and other indicators, as specified by CMS.
- You must cooperate with our procedures for handling grievances, appeals and expedited appeals.

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 Health Plan of Nevada 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

HPN 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 HPN 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.

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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:

HPN Provider Services
Attention: Provider Services Advocate
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**.

**HEALTH PLAN OF NEVADA
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 Health Plan of Nevada (HPN) 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 HPN's credentialing schedule. HPN'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), 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 HPN'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

HPN 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 HPN Credentialing Process

The HPN 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: HPN 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 HPN 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, HPN 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, HPN 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. HPN 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 HPN 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 HPN 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 HPN 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 HPN 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, HPN 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 HPN 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 HPN 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 HPN 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. 6) Peer References when requested.

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 Health Plan of Nevada.

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 HPN 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 presumption is rebutted by a preponderance of the evidence.

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Element	Procedure
	(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. (c) Adequate procedures in investigations or health emergencies

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Element	Procedure
	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, HPN ensures the confidentiality of information obtained in the credentialing process, except as otherwise provided by law. HPN 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

HPN 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 HPN 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.

HPN conducts an initial site visit for all locations at which PCPs, OB/GYNs, and high-volume behavioral healthcare practitioners provide services. HPN also conducts an initial site visit when

a practitioner relocates or opens a new site and the site has never been evaluated. HPN 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 HPN standards. HPN 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.

HPN 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 HPN 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. HPN 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
2.	✓ Doors open easily (automatic or semi-automatic or provisions have been made to provide assistance)
3.	✓ Door width is adequate for wheelchair

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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
2.	✓ Practice specific information available (days/hours of operation). Must be posted or in patient brochure/business card
3.	✓ Non-discriminatory practices based on race, age, sex or ethnicity must be posted or in patient brochure/business card
4.	✓ Health education information is available appropriate to practice
5.	✓ Routine housekeeping and maintenance are evident (office clean, uncluttered, comfortable)
6.	✓ Adequate seating in waiting room (no one standing)
7.	✓ Adequate lighting provided for reading
8.	✓ 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 ❖ Identification required to ensure release to patient or authorized representative
2.	✓ Process is in place to verify identity of an individual on the phone prior to releasing PHI
3.	✓ An area is provided where financial and insurance discussions will not be overheard by other patients
IV.	SYSTEMS/ADEQUACY OF EQUIPMENT
A.	Exam Room/Close Proximity
1.	✓ Exam tables are positioned away from exam door or privacy curtain/screen provides privacy when exam door is opened ✓ 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 ❖ Ophthalmoscope/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

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	❖ Disposable Covers/Gowns or Linen Service Y/N ❖ Sharps Disposal Receptacles Y/N (If Shots Given In The Exam Room)
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
3.	✓ 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

HPN 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. HPN 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. HPN 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 HPN Network; or
- Any practitioners deemed appropriate based on HPN's experience with their medical record documentation

HPN 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. HPN 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

	<i>ELEMENT</i>	<i>STANDARD</i>
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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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.

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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 HPN in accordance with provider contracting to allow for auditing related to quality assurance, quality improvement, utilization management and recredentialing.
- Medical records shall be available for review by duly authorized representatives of regulatory agencies in accordance with HIPAA regulations.



HEALTH PLAN OF NEVADA
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

**HEALTH PLAN OF NEVADA
PROVIDER SUMMARY
GUIDE**

SECTION 6

MEMBER RIGHTS AND RESPONSIBILITIES

6 - Member Rights and Responsibilities

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

HPN strives to create a solid partnership with members and their providers by establishing the following clearly defined members' rights and responsibilities. Due to differing regulatory requirements for members' rights and responsibilities, HPN has created the following members' rights and responsibilities statements as appropriate.

HPN's members' rights and responsibilities for commercial members are as follows:

6.1 HPN Commercial HMO

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 their dignity and their 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 physician/dentist from HPN'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.

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 the plan and instructions for care that they have agreed to with the practitioner.
- To understand individual health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- To know how HPN's Managed Care Program operates.

- To consult the member's primary physician and HPN before seeking non-emergency care in the service area. The member is urged to consult their physician and HPN when receiving urgently needed care while temporarily outside the HPN service area.
- To obtain prior authorization from HPN and the member's physician for any routine or elective surgery, hospitalization or diagnostic procedures.
- To review information regarding covered services, policies and procedures as stated in the member's Evidence of Coverage.
- To be on time for appointments and provide timely notification when canceling any appointment the member 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 HPN, 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 member's medications. Members should keep a list of all current medications including over the counter drugs, vitamins and supplements to bring to appointments with providers.
- To address medication refill needs at the time of the member's office appointment. When the member obtains their last refill, they should notify the office that they will need refills at that time. They are asked not to wait until they are out of medication.
- To report all side effects of medications to the member's primary care provider and to notify the primary care provider if they stop taking medications for any reason.
- To ask questions during appointment time regarding physical complaints, medications, any side effects, etc.
-

6.2 HPN Federal Members' Rights and Responsibilities

Member Rights:

- To receive information about the plan, its services, its practitioners and providers and members' rights and responsibilities.
- To be treated with respect and recognition of dignity and the member's right to privacy.
- To participate with practitioners in making decisions about their health care.
- To have a candid discussion of appropriate or medically necessary treatment options for the member's condition, regardless of cost or benefit coverage.
- To voice complaints or appeals about the organization and the care it provides.
- To make recommendations regarding the organization's members' rights and responsibilities policies.
- To select a primary physician from HPN's provider list.
- To have direct access to women's health services for routine and preventive care.
- To have direct access to medically necessary specialist care, in conjunction with an approved treatment plan developed with the member's primary physician. Required authorizations should be submitted for an adequate number of direct access visits.

- To have access to emergency services in cases where a "prudent layperson" reasonably would have believed that an emergency existed.
- To have assistance in developing transition of care plans if the member involuntarily changes health plans and is in a current treatment plan for chronic or disabling conditions or is in the second or third trimester of pregnancy.
- To have assistance in developing transition of care plans with providers whose participation with a plan is involuntarily terminated for reasons other than cause if the member is in current treatment for a chronic or disabling condition or are in the second or third trimester of pregnancy.
- To have all communications and records pertaining to the member's care treated confidentially.
- To have access to the medical records. HPN must provide the member with timely access to their records and any information that pertains to them. Except as authorized by State law, HPN must get written permission from the member or the member's authorized representative before medical records can be made available to any person not directly concerned with the member's health care or not responsible for making payments for the cost of such care.
- To extend these rights to any person who may have the legal responsibility to make decisions on the member's behalf regarding their medical care.
- To refuse treatment or leave a medical facility, even against the advice of physicians, providing the member accepts the responsibility and consequences of the decision.
- To be able to exercise these rights regardless of the member's race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or your national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for care.
- To be involved in decisions to withhold resuscitative services, or to forego or withdraw life-sustaining treatment.

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 their practitioners.
- To understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- To take responsibility for maximizing a healthy lifestyle and to follow the treatment plan that the member, Case Manager and Physician have agreed upon.
- To consult the member's primary physician and HPN before seeking non-emergency care in the service area. HPN urges the member to consult their primary physicians and HPN when receiving urgently needed care while temporarily outside the HPN service area.
- To obtain a written referral from a physician before going to a specialist unless the member is using a point of service benefit, if one is available under your benefit plan.
- To obtain prior authorization from HPN and the member's physician for any routine or elective surgery, hospitalization or diagnostic procedures and as required by the plan/managed care program.
- To be on time for appointments and provide timely notification when canceling appointments the member cannot keep.
- To accept financial responsibility for copayments, coinsurance and/or deductibles associated with Covered Services received.
- 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 behave in a manner that supports the health care provided to the member (this applies to care provided in any location, whether it be in the home, a provider's office or a health care facility) and behave in a manner that supports care provided to other patients and the general functioning of the facility.
- To abide by administrative requirements of HPN, health care providers, and government health benefit programs.
- To report wrongdoing and fraud to appropriate resources or legal authorities.
- To know medications the members takes and keep a list to bring to appointments with providers.
- To address medication refill needs at the time of an office appointment. When the member obtains the last refill, the member should notify the office that the member will need refills at that time. Do not wait until the member is out of medication.
- To report all side effects of medications to the member's primary physician and notify the primary physician if the member stops taking medications for any reason.
- To ask questions during an appointment time regarding physical complaints, medications, any side effects, etc.
- To review information regarding covered services, policies and procedures as stated in the Evidence of Coverage.
- To access or utilize HPN's internal complaint and appeal processes to address concerns that may arise to the extent applicable to the respective program.

6.3 HPN Medicare (Senior Dimensions) Members' Rights and Responsibilities

Member Rights:

- To receive information about the organization, its services, its providers and practitioners and members' rights and responsibilities.
- To be treated with respect and recognition of their dignity and the member's right to privacy.
- To participate with practitioners in making decisions about their health care.
- To have a candid discussion of appropriate or medically necessary treatment options, regardless of cost or benefit coverage.
- To voice complaints or appeals about the organization or the care it provides.
- To make recommendations regarding the organization's members' rights and responsibilities policies.
- To receive clear and simple information from HPN that will help members make health care decision. This includes benefits, financial responsibility and filing a complaint or appeal. The information is available in languages other than English that are spoken in HPN's service area, in Braille, in large print or audio format.
- To receive health care services in a language the member understand and in a culturally sensitive way.
- To get timely access to covered services and prescription drugs.
- To be told of the risks involved in the member's care, including advanced notice of any medical care or treatment that is a part of a research experiment. The member has the right to refuse any experimental treatments.
- To receive an explanation of denied care or coverage from HPN.

- To select a primary physician from HPN's provider list.
- To receive information about the plan, its services, its providers, and members' rights and responsibilities.
- 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 member's primary physician. Required authorizations should be submitted for an adequate number of direct access visits.
- To have access to emergency services in cases where a "prudent layperson" acting reasonably, would have believed that an emergency existed.
- To have assistance in developing transition of care plans if the member involuntarily changes health plans and is in a current treatment plan for chronic or disabling conditions.
- To have assistance in developing transition of care plans with providers whose participation with a plan is involuntarily terminated for reasons other than cause if the member is in current treatment for a chronic or disabling condition or are in the second or third trimester of pregnancy.
- To have all communications and records pertaining to the members care treated confidentially.
- To have access to the medical records. HPN must provide the member with timely access to their records and any information that pertains to them. Except as authorized by State law, HPN must get written permission from the member or the member's authorized representative before medical records can be made available to any person not directly concerned with the member's health care or not responsible for making payments for the cost of such care. Personal information, including prescription drug event data, will be released to Medicare, who may release it to researchers pursuant to all applicable privacy laws, for research purposes.
- To extend these rights to any person who may have the legal responsibility to make decisions on the member's behalf regarding their medical care.
- To refuse any recommended treatment, leave a hospital or medical facility or stop taking medication, even against the advice of physicians, provided the member accepts the responsibility and consequences of the decision.
- To be able to exercise these rights regardless of the member's race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or your national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for care.
- To be involved in decisions to withhold resuscitative services, or to forego or withdraw life-sustaining treatment.
- To formulate Advance Directives.
- To make recommendations regarding the organization's members' rights and responsibilities policies.

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 the plan and instructions for care that they have agreed to with the practitioner.
- To understand individual health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- To know how HPN's Managed Care Program operates.

- To consult the member's primary physician and HPN before seeking non-emergency care in the service area. HPN urges the member to consult their primary physicians and HPN when receiving urgently needed care while temporarily outside the HPN service area.
- To obtain a written referral from a physician before going to a specialist, unless the member is using benefit options that allow direct access to specialists.
- To obtain prior authorization from HPN and the member's physician for any routine or elective surgery, hospitalization or diagnostic procedures and as required by the plan/managed care program.
- To be on time for appointments and provide timely notification when canceling appointments the member cannot keep.
- To accept financial responsibility for copayments, coinsurance and/or deductibles associated with Covered Services received.
- To avoid knowingly spreading disease.
- 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 tell HPN if the member has any other health insurance or prescription drug coverage.
- To inform providers that the member is enrolled in an HPN health plan.
- To notify HPN by calling Member Services if the member moves either inside or outside of the HPN service area.
- To show respect for other patients, health care providers and plan representatives.
- To behave in a manner that supports the health care provided to the member and all other patients in any location, whether it be in the home, a provider's office or a health care facility.
- To abide by administrative requirements of HPN, health care providers, and government health benefit programs.
- To report wrongdoing and fraud to appropriate resources or legal authorities.
- To know all of the medications currently being taken including over-the-counter drugs, vitamins, and supplements. Keeps a list to bring to appointments with providers.
- To address medication refill needs at the time of an office appointment. When the member obtains the last refill, the member should notify the office that the member will need refills at that time. Do not wait until the member is out of medication.
- To report all side effects of medications to the member's primary physician. Notify the primary physician if the member stops taking medications for any reason.
- To ask questions during an appointment time regarding physical complaints, medications, any side effects, etc.
- To review information regarding covered services, policies and procedures as stated in the member's Evidence of Coverage.
- To access or utilize HPN's internal complaint and appeal processes as stated in the member's Evidence of Coverage.
- To call Member Services if the member has any questions or concerns about the health plan.

For Medicaid Member Rights and Responsibilities, see Section 8.

6.4 Member Access to Medical Records

It is HPN's policy that members have a right to access their medical records, as allowed by law. Members who contact HPN requesting access to their medical records will be instructed to

contact their providers of care and when necessary, HPN will assist the member in obtaining their records.

HPN 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.

6.5 Confidentiality

It is the policy of HPN to protect the confidentiality of member 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. HPN routinely shares information with individuals or entities when necessary to coordinate member health care or administer member health benefits. We also share member information when required by state or federal law or regulation. In all other instances, HPN requests authorization from the individual or authorized representative before we share protected health information. Our Notice of Privacy Practices, which is delivered to members upon their enrollment, available upon request, and posted on our Web site, describes in detail the ways in which we use protected health information.

HPN 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. HPN uses a variety of security precautions to protect any information or data that contains personal facts and health information about our members, including medical records, claims, benefits and other administrative data that are personally identifiable, either implicitly or explicitly. Just a few of the precautions HPN takes include electronic security systems and release of information only by certain levels of management. For example, when transmitting data, HPN 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 HPN's policy to afford members the opportunity to authorize or deny the release of personally identifiable medical or other information by HPN, except when such authorization is not required by law or regulation. When members request specific member-identifiable records be shared with others for reasons other than treatment, payment, or health care operations, HPN will require them to sign an Individual Authorization Form. HPN may also ask members to allow release of personal data for non-routine uses of personal data. Of course when we ask our members for individual authorization forms, they have the right to refuse. This step authorizes HPN to release protected health information and explains to members how and with whom their personal information will be shared.

HPN may share protected health information with a member's employer (if the member 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 HPN, employers must certify that they will not use the information for employment-related activities.

HPN uses medical data to monitor and improve the quality of care our members 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 HPN conducts research and measures quality, HPN does so using summary information, whenever possible, not individual patient information. When HPN 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 HPN without our members' authorization.

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

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

- Protect all confidential information concerning HPN members.
- Protect the privacy of all members and third parties, including families of members.
- Maintain confidentiality of all health related information, except when disclosure is needed for emergency care and/or treatment, or required by law.
- Not 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 member 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.

6.6 Member Complaints

As a provider for HPN 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 HPN member wants to file a complaint, please have them complete the HPN Complaint Form located in Section 25.4.

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.

6.7 Involuntary Disenrollment (Medicare plans)

HPN follows the Involuntary Disenrollment guidelines as set by Centers for Medicare and Medicaid Services (CMS).

Health Plan must disenroll members if:

- The member moves permanently out of the Service Area and does not voluntarily disenroll.
- The member does not have Medicare Part A and/or Part B.
- The contract between the Health Plan and CMS is terminated or the Health Plan Service Area is reduced.

The Health Plan *may* disenroll members under the following conditions:

- The member gives Health Plan fraudulent information or makes misrepresentations on the individual election form that affects their eligibility to enroll in Health Plan.
- The member is disruptive, unruly, abusive or uncooperative to the extent that their membership in Health Plan seriously impairs the ability to arrange Covered Services for themselves or other individuals enrolled in the plan.
- The member allows another person to use their Health Plan membership card to obtain Covered Services.

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SECTION 7

BENEFITS AND ELIGIBILITY

7 - Benefits and Eligibility

7.1 Enrollee Benefits

Medical

Health Plan of Nevada (HPN) provides medical services to seniors that are covered by Medicare, which is subject to revision throughout the year based upon the promulgation of national coverage decisions by the Centers for Medicare & Medicaid Services (CMS). In addition to Medicare, HPN offers a variety of benefit plans that are made available to eligible employees and their eligible family members for many employer groups.

Dental

Health Plan of Nevada (HPN) offers a variety of dental benefit plans that are made available to eligible employees and their eligible family members for many employer groups.

HPN provides Senior Dimensions' members with an added value dental benefit, allowing Senior Dimensions members to receive contracted rates when accessing HPN's expansive network of participating dental providers.

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

HPN	(800) 777-1840
My HPN (on exchange plan)	(877) 752-8026
Senior Dimensions	(800) 650-6232
Medicaid and Nevada Check Up	(800) 962-8074
TTY	711
IVR	(702) 242-7724
IVR Toll Free	(800) 768-2808

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

Medicare: You can reach a Customer Service representative at 1-800-650-6232, TTY: 711 From February 15th through September 30th, we are open Monday - Friday from 8 a.m. to 8 p.m. From October 1st through February 14th, we are open from 8 a.m. to 8 p.m., seven days a week.

7.2 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 HPN 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.

Primary Care Providers can verify assignment by referring to their monthly empanelment report issued by HPN. If not found, call Member Services Interactive Voice Response (IVR) system for verification of eligibility and primary care provider selection for HPN, Senior Dimensions and Medicaid and Nevada Check Up members at **(800) 768-2808**, or utilize HPN's online portal – [@YourService](#). See Section 7.4 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.

7.3 Interactive Voice Response (IVR) System

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

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

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

HPN	(702) 242-7724
HPN 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.

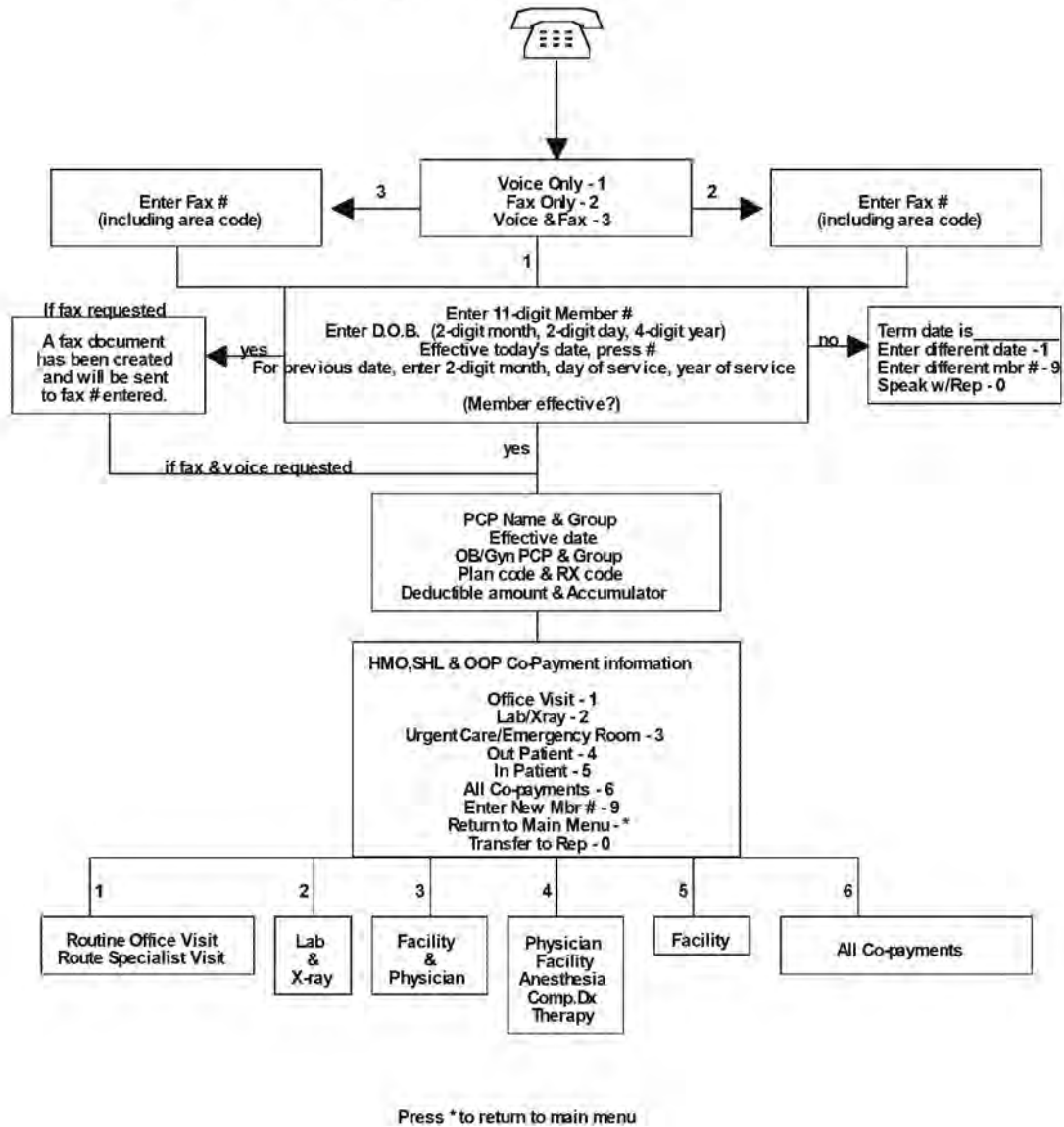


MEMBER SERVICES:

Interactive Voice Response System (IVR)	(702) 242-7724
Toll free	(800) 768-2808
HPN Telephone	(800) 777-1840
Senior Dimensions	(800) 650-6232
Medicaid and Nevada Check Up	(800) 962-8074

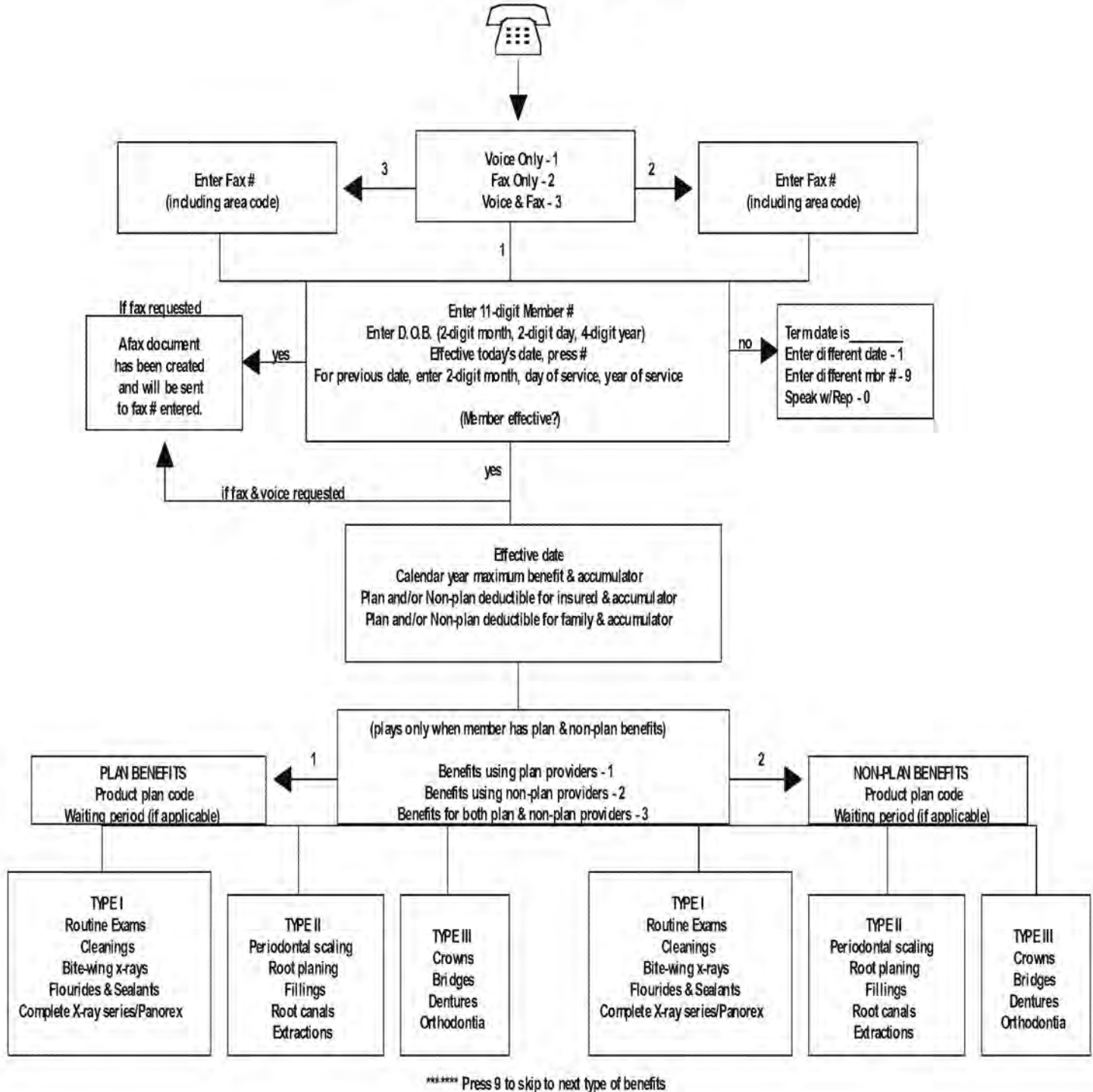
**MEDICAL ELIGIBILITY & BENEFITS IVR APPLICATION
(PROVIDERS)**

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



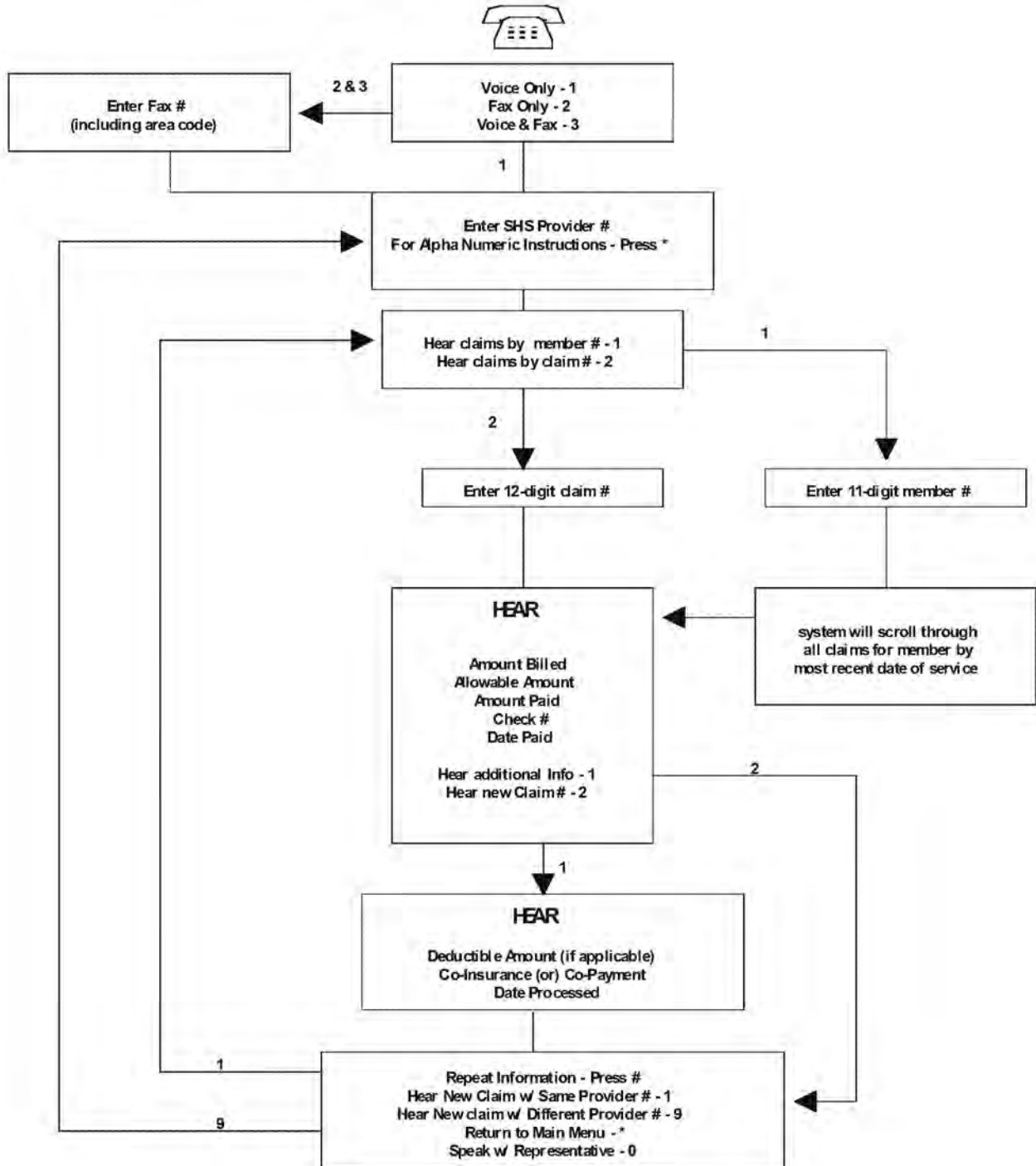
**DENTAL ELIGIBILITY & BENEFITS APPLICATION
(PROVIDERS)**

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



**CLAIMS STATUS IVR APPLICATION
(PROVIDERS)**

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



7.4 HPN @YourService

Convenient and available 24/7, Health Plan of Nevada's online provider center- [@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 electronic referrals and prior authorization requests. @YourService can reduce or avoid time spent on the telephone with HPN's Member Services Department.

For contracted provider that are not yet connected to @YourService, please submit a request online via the [@YourService](#) website (www.myaysonline.com) click on "Create an Account" and follow the on screen instructions. Or refer to **Section 25.2** of this guide for the @YourService Administrator Account request form. The @YourService Provider Tutorial is accessible on the HPN website and Provider Services is available to answer any specific questions you may have regarding the application.

7.5 Health Plan of Nevada Web Site

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

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

The HPN 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.

7.6 Primary Care Physician (PCP) Changes

If a member wishes to change their Primary Care Physician (PCP) they may contact the Member Services Department. The telephone numbers appear in Section 7.1 and on the back of the member's ID card. Commercial members may change their PCP at any time.

For Medicare and Medicaid members only:

PCP Change requests received before the 20th of the month, will be effective the first of the following month. If the request is received after the 20th of the month, the change will be effective the first of the next month. For example, if HPN receives a member's request to change their PCP on June 19th, it will be effective July 1st. If, however, HPN receives a member's request on June 21st, it will be effective August 1st.

7.7 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 9 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:	Health Plan of Nevada HMO, POS, Individual, Senior Dimensions

@YourService, IVR or Member Services can provide additional copay information

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

Disclaimer:	Instructions for the member and providers regarding eligibility & prior authorizations
Emergency:	Members are to call 911 or go to the nearest hospital in case of an emergency and contact Member Services as soon as reasonably possible
Claims Address:	Where to send claims
Benefit Questions:	Phone number to contact Member Services
Mental Health:	If the member has Mental Health Benefits through HPN, the name and number of the Mental Health Provider
Website:	Website address information
Network:	Plan Provider Network(s)

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

Sample ID Cards for plans that you may come in contact with have been included for your review.

Commercial Group (Non-Individual) HMO AND POS:

HEALTH PLAN OF NEVADA
A Division of Sun Life of Canada

HPN SOLUTIONS
GROUP HMO PLAN

Health Plan (80840) 911-76342-01

Member ID: 999000393-00 Group Number: 000000000000

Member: SAMPLE ID CARD_GV

Benefit Code: Medical 00000000 Rx 00000000

Copay: Office /Spec Tier 1 \$0 /\$0

Effective Date 01/01/2017

Payer ID 76342

YOU MUST SEE YOUR PCP FOR ROUTINE CARE

OPTUMRx

Rx BIN: 610279 Rx GRP: UNEVADA Rx PCN: 9999 Rx Cost share tiers: 1/1/1/1/1/1/1/1/1/1 Rx Cost share: \$0/\$0/\$0/\$0 Rx Deductible may apply.

DOI-6501 Underwritten by Health Plan of Nevada, 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.myHPNOnline.com or call Member Services.

Member Services: 1-800-777-1840
24 Hour Advice Nurse: 1-800-288-2264
Mental Health/Substance Abuse: 1-800-873-2246

For Providers: www.myHPNOnline.com 1-800-777-1840
Medical Claims: HPN Claims, PO Box 15645, Las Vegas, NV 89114-5645

USE CHOICE PLAN NETWORK
EMERGENCY SERVICES ONLY
OUTSIDE REGIONAL SERVICE AREA

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

2018 HPN Provider Summary Guide

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

**HPN SOLUTIONS
GROUP POS PLAN**

Health Plan (80840) 911-76342-01

Member ID: 999000396-00 Group Number: 000000000000

Member:
SAMPLE ID CARD_GY

Benefit Code: Payer ID
Medical 00000000 76342
Rx 00000000

Copay: Office /Spec
Tier I \$0 /\$0
Tier II \$0 /\$0

Effective Date
01/01/2017

OPTUMRx
Rx BIN: 610279
Rx GRP: UNEVADA
Rx PCN: 9999
Rx Cost share tiers: I / II / III / IV
Rx Cost shares: \$0/\$0/\$0/\$0
Rx Deductible may apply

DOI-0501 Underwritten by Health Plan of Nevada, 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.myHPNOnline.com or call Member Services.

Member Services: 1-800-777-1840
24 Hour Advice Nurse: 1-800-288-2264
Mental Health/Substance Abuse: 1-800-873-2246

For Providers: www.myHPNOnline.com 1-800-777-1840
Medical Claims: HPN Claims, PO Box 15645, Las Vegas, NV 89114-5645

UnitedHealthcare
Choice Plus Network
Outside Nevada

HPN HMO & Expanded
Plan Provider Networks
Within Nevada & Surrounding Areas

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

Individual HMO (Off Exchange):

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

**MyHPN SOLUTIONS
INDIVIDUAL HMO PLAN**

Health Plan (80840) 911-76342-01

Member ID: 999000391-00 Group Number: 000000000000

Member:
SAMPLE ID CARD_GT

Benefit Code: Payer ID
Medical 00000000 76342
Rx 00000000

Copay: Office /Spec
Tier I \$0 /\$0

Effective Date
01/01/2017

YOU MUST SEE YOUR
PCP FOR ROUTINE CARE

OPTUMRx
Rx BIN: 610279
Rx GRP: UNEVADA
Rx PCN: 9999
Rx Cost share tiers: I / II / III
Rx Cost shares: \$0/\$0/\$0
Rx Deductible may apply

DOI-0501 Underwritten by Health Plan of Nevada, 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.myHPNOnline.com or call Member Services.

Member Services: 1-800-777-1840
24 Hour Advice Nurse: 1-800-288-2264
Mental Health/Substance Abuse: 1-800-873-2246

For Providers: www.myHPNOnline.com 1-800-777-1840
Medical Claims: HPN Claims, PO Box 15645, Las Vegas, NV 89114-5645

UNITEDHEALTHCARE
CHOICE PLUS NETWORK
EMERGENCY SERVICES ONLY
OUTSIDE NEVADA SERVICE AREA

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

Individual (On Exchange) HMO:

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

**MyHPN
INDIVIDUAL HMO PLAN**

Health Plan (80840) 911-76342-01

Member ID: 999000442-00 Group Number: 200012261001

Member:
SAMPLE ID CARD_IS

Benefit Code: Payer ID
Medical 00000000 76342
Rx 00000000

Copay: Office /Spec
Tier I \$0 /\$0

Effective Date
01/01/2017

YOU MUST SEE YOUR
PCP FOR ROUTINE CARE

OPTUMRx
Rx BIN: 610279
Rx GRP: UNEVADA
Rx PCN: 9999
Rx Cost share tiers: I / II / III
Rx Cost shares: \$0/\$0/\$0
Rx Deductible may apply

DOI-0518 Underwritten by Health Plan of Nevada, Inc.

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

For eligibility, benefits, prior authorization requirements or to find a provider, visit myHPNOnline.com. For any questions, call:

Member Services/Servicio al Cliente: 702-838-8294 1-877-752-8026
24 Hour Advice Nurse: 702-242-7330 1-800-288-2264
Mental Health/Substance Abuse: 702-364-1484 1-800-873-2246

For Providers: Payer ID 76342 1-877-752-8026
Medical Claims: HPN Claims, PO Box 15645, Las Vegas, NV 89114-5645

UNITEDHEALTHCARE
CHOICE PLUS NETWORK
EMERGENCY SERVICES ONLY
OUTSIDE NEVADA SERVICE AREA

myHPNOnline.com

Pharmacy Claims: OptumRx, PO Box 29044, Hot Springs, AR 71903
For Pharmacists: 1-800-443-8197 Card does not guarantee coverage.

HMO Direct Access Plan:

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

**HPN SOLUTIONS
HMO DIRECT ACCESS PLAN**

Health Plan (80840) 911-76342-01

Member ID: 999000449-00 Group Number: 000000000000

Member:
SAMPLE ID CARD_IJ

Benefit Code: Payer ID
Medical 00000000 76342
Rx 00000000
Dental 00000000
Vision 00000000

Copay: Office /Spec
Tier I \$0 /\$0
Non-Referral \$0

Effective Date
01/01/2017

YOU MUST SEE YOUR
PCP FOR ROUTINE CARE

OPTUMRx
Rx BIN: 610279
Rx GRP: UNEVADA
Rx PCN: 9999
Rx Cost share tiers: I / II / III
Rx Cost shares: \$0/\$0/\$0
Rx Deductible may apply

DOI-0501 Underwritten by Health Plan of Nevada, 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.myHPNOnline.com or call Member Services.

Member Services: 1-800-777-1840
24 Hour Advice Nurse: 1-800-288-2264
Mental Health/Substance Abuse: 1-800-873-2246

For Providers: www.myHPNOnline.com 1-800-777-1840
Medical Claims: HPN Claims, PO Box 15645, Las Vegas, NV 89114-5645

UNITEDHEALTHCARE
CHOICE PLUS NETWORK
EMERGENCY SERVICES ONLY
OUTSIDE NEVADA SERVICE AREA

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

2018 HPN Provider Summary Guide

Senior Dimensions:



SENIOR DIMENSIONS
—UnitedHealthcare—

Health Plan (80840) 911-76342-01

Member ID: 999000163-00 Group Number: 100009050000

Member:
SAMPLE ID CARD_BV

Benefit Code:	Payer ID
Medical COVERED	76342
Rx COVERED	
Vision COVERED	



Rx BIN: 810097
Rx GRP: SIE
Rx PCN: 9999

CMS H2901/PBP 002 Senior Dimensions
Underwritten by Health Plan of Nevada, Inc.

www.seniordimensions.com Printed: 12/29/16

In a life-threatening emergency, call 911 or go to an emergency room. This card does not guarantee coverage. To verify benefits/obtain prior authorization, call Customer Service.

Customer Service:	(702) 242-7301	800-650-6232
TTY/TDD:	711	711
24 Hour Advice Nurse:	(702) 242-7330	800-288-2264

For Providers: 800-650-6232
Medical Claims: SD Claims, PO Box 15645, Las Vegas, NV 89114-5645

For Pharmacists: 1-800-443-8197
Pharmacy Claims: OptumRx, PO Box 29045, Hot Springs, AR 71903

**HEALTH PLAN OF NEVADA
PROVIDER SUMMARY
GUIDE**

SECTION 8

MEDICAID and NEVADA CHECKUP

8 – Medicaid and Nevada Check Up

8.1 Medicaid Overview

Health Plan of Nevada (HPN) has been providing Managed Care Medicaid services in Nevada since 1997. The service areas are metropolitan Clark and Washoe Counties.

HPN offers Medicaid and Nevada Check Up, which provide medical services to members that are covered by the applicable Medicaid and Nevada Check Up Programs through the Nevada Division of Health Care Financing and Policy (DHCFP). Applicable Medicaid programs include Child Health Assurance Program (CHAP), Temporary Assistance to Needy Families (TANF) and Medicaid Expansion. There are other Medicaid health programs available through DHCFP, which are not eligible for enrollment into our Managed Care Medicaid program.

CHAP, TANF, Expansion and Nevada Check Up members are required to select a managed care plan at the time of initial enrollment. Any new member who does not make a selection will be automatically assigned a managed care plan by DHCFP in conjunction with DXC Technology, DHCFP's administrator. There is an annual lock in period for Medicaid and Nevada Check Up Managed Care members. After their initial 90 days of enrollment, new members are "locked in" to the plan they have chosen. Once per year, DHCFP will hold an open enrollment period in which managed care Medicaid and Nevada Check Up members may switch plans if they desire. After the open enrollment period, all existing members will be "locked in" with the managed care plan they have chosen.

All Medicaid and Nevada Check Up members are required to designate a primary care physician and receive required care from this designated physician. If a member does not choose a primary care physician, one will be appointed by the health plan.

There continue to be changes to the operational processes for the Medicaid/Nevada Check Up program. To ensure all providers are aware of the process changes and how they are applicable to participation with HPN's network, the changes are outlined below in their respective subsections.

8.2 Enrollee Benefits

HPN receives member eligibility information on a monthly basis with daily updates from DXC Technology. This information is loaded into HPN's eligibility system. DXC Technology issues permanent plastic member identification cards to all Medicaid and Nevada Check Up members. Effective May 1, 2017, HPN deployed ID cards for HPN Medicaid, Nevada Check Up and Expansion members. Provider offices must verify continued eligibility in the program upon each member's encounter. To verify member eligibility and the selection of a Managed Care Medicaid plan, providers may contact DXC Technology at **1-800- 942-6511** or access the DXC Technology website at <http://www.medicaid.nv.gov>. Please refer to Section 8.15, ID Cards, to review sample copies of the DXC Technology member identification card and the HPN Medicaid and Nevada Check Up member identification cards.

It is important that a provider office verify which Managed Care Plan a member is enrolled in by using one of DXC Technology's eligibility verification tools listed above. Once the Managed

Care Plan is determined, the provider's office should contact the appropriate Health Plan for benefit information and verification of primary care physician selection.

Medicaid and Nevada Check Up offer many new technologies in order to obtain benefit and primary care physician verification such as the @YourService web based program and the Interactive Voice Response unit (IVR) – a telephonic eligibility/benefit system offering a fax back option. For information regarding these technologies, please refer to Section 7- Benefits & Eligibility.

Additionally, HPN has a dedicated Member Services department for Medicaid and Nevada Check Up. They can be reached via telephone at the following numbers:

Toll free	1-800-962-8074
Fax	702-240-6281

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

8.3 Provider Responsibilities and Network Information

Medicaid and Nevada Check Up have their own provider network, which differs from the HPN network servicing the Commercial and Senior Dimensions members. Before referring a member to a specialist, please refer to the Medicaid and Nevada Check Up provider directory. This information is also available on the HPN Medicaid website at www.myhpnmedicaid.com.

The Health Plan maintains and monitors the network of providers, and contracts with providers to ensure that appropriate providers are available to provide adequate access to all services covered under the contract for both the Medicaid and Nevada Check Up members. HPN monitors complaints against practitioners for both quality of care and quality of service issues. Site visits are conducted by the Provider Services Advocates annually; there are multiple areas of the operation that are reviewed in order to ensure compliance requirements are met. If there are negative findings providers will be made aware via a corrective action plan and will also be advised that per the contract disciplinary action can be initiated, which may lead to termination of the contract.

Primary Care Physicians (PCP) shall have the primary responsibility for managing and coordinating the overall health care of members. PCP's are responsible for providing, or arranging for, the appropriate and cost-effective provision of health care to members. All Network providers are expected to offer hours of operation that are no less than the hours of operation offered to any other line of business. Providers are required to meet State standards for timely access to care and services, taking into account the urgency of the need for services; twenty-four (24) hours per day, seven (7) days per week, when medically necessary. The hours of operation are reviewed during the annual site visit; any areas of concern are documented and addressed with each provider.

Provider Services Advocates are assigned to specific provider groups in order to help with any areas of education or inquiries related to HPN. Providers and their office staff have direct access to the assigned advocate. The Advocates are a direct Point of Contact. This individual will be responsible for monitoring compliance, education and providing support. Provider Services Advocates conduct site visits to ensure that access and availability standards are met. The advocates will address any areas of concern and follow up for resolution and/or to initiate disciplinary actions as determined appropriate.

HPN does not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his/her license or certification under applicable State law, solely on the basis of that license or certification. If HPN denies contracting with a provider and/or group, it gives the affected network providers written notice of the reason for its decision.

Please see Section 4 for detailed information about Provider Administrative Requirements and Resources.

8.4 Referrals, Prior Authorizations and Utilization Management

Medicaid and Nevada Check Up follow the same Managed Care Guidelines as HPN. Please refer to Section 9 for specific Prior Authorization and Utilization Management information and Section 11 for Referrals to Specialists information.

The following services however do not require prior authorization:

- Family Planning Measures Including Sterilization
- Initial Diagnostic Screenings at Nevada Early Intervention Services
- Emergency Services
- Procedures performed in the physician's office with billed charges less than \$750.00 per CPT code

8.5 Credentialing & Office Site Visits

- See Section 5 "Credentialing" for details.

8.6 Access Standards

HPN establishes standards for appointment access and after-hours care to ensure timely access for our Medicaid members. Performance against these established standards is measured continually by the Provider Services Department. Provider Services completes the initial reviews, with trended information reported to the HPN Quality Improvement Committee to identify performance improvement opportunities and to review corrective actions as determined appropriate. If monitoring indicates issues of non-compliance with the appointment requirements, Provider Advocates will increase face-to-face visits to assist the provider in determining a quick resolution and take corrective action if there is a failure to comply.

Providers must make sure that hours of operation are convenient to members and do not discriminate against members and that medically necessary services are available to members 24 hours a day, 7 days a week. Primary Care Physicians must have backup for absences.

HPN's appointment standards for Medicaid and Nevada Check Up members are outlined below.

Primary Care Physician (PCP) Standards

- Emergency PCP appointments are available the same day.
- Urgent care PCP appointments are available within two (2) calendar days.
- Routine care PCP appointments are available upon request within fourteen (14) days.
(This two- week standard does not apply to regularly scheduled visits to monitor a chronic

medical condition if the schedule calls for visits less frequently than once every two weeks.)

Specialty Standards

- Emergency appointments within twenty-four (24) hours of referral
- Urgent care appointments within three (3) calendar days of referral
- Routine appointments within thirty (30) calendar days of referral

Maternity Care

Initial prenatal care appointments for enrolled pregnant members will be as follows:

- First trimester within seven (7) calendar days of first request.
- Second trimester within seven (7) calendar days of first request.
- Third trimester within three (3) calendar days of first request.
- High risk pregnancies within three (3) calendar days of identification of high risk to HPN or maternity care primary care physician, or immediately if an emergency exists.

Office Waiting Times

Member's waiting time at the PCP or specialist office shall be no more than one hour from the scheduled appointment time, except when provider is unavailable due to an emergency. Acceptable delays can result when services are provided for urgent cases, when a serious problem with a patient is found, or when a patient had an unknown need that requires more services or education than was described at the time the appointment was made.

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.

Arrange substitute coverage:

If you are unable to provide care and are arranging for a substitute, we ask that you arrange for care from other physicians and health care professionals who participate with HPN so that services may be covered under the members in-network benefit. We encourage you to go to www.myhpnmedicaid.com to find the most current directory of our network physicians and health care professionals.

Provider Advocates conduct after-hours audits to ensure the providers are in compliance with after-hours access and substitute coverage.

Please see Section 4 for detailed information about Provider Administrative Requirements and Resources.

8.7 Medical Records

Medical records must be maintained in an organized and confidential manner. You are responsible for ensuring that you have mechanisms in place to guard against unauthorized or inadvertent disclosure of confidential information. All information obtained by personnel regarding members' examinations, care and treatment must be held confidential and may not be divulged without the members' authorization; except in the following situations:

- Required by law, or pursuant to a hearing request on the members behalf;
- When it is necessary to coordinate the members care with physicians, hospitals, or other health care entities, or to coordinate insurance or other matters pertaining to payment; or
- When necessary in compelling circumstances to protect the health or safety of an individual.

Records may be disclosed to qualified personnel, defined as a person or agency with the appropriate authorization to access confidential information. In accordance with auditing policies by Internal Quality Assurance, it is expected that you will fully cooperate in obtaining and/or allowing access to a member's medical records, upon written request, within ten (10) calendar days of request, whether electronic or paper. You will be responsible for providing one (1) copy of medical records free of charge, in a timely manner. The cost charged to members for additional copies cannot exceed the cost of time and materials used to compile, copy, and furnish such records. If a member changes providers, the provider must forward all records in their possession to the new provider within 10 working days from receipt of a member's request.

Medical records may be on paper or electronic. All medical records must be legible, current, detailed and organized in a comprehensive manner that permits effective patient care and quality review. Medical records must be maintained, at a minimum as follows:

- Patient Identification Information – Each page on electronic file in record contains the patient's name or patient ID number;
- Personal/Demographic Data – Personal/biographical data includes: age, sex, race, address, employer, home and work telephone numbers, and marital status;
- Entry Date – All entries are dated;
- Provider Identification – All entries are identified as to author;
- Legibility – The record is legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer;
- Allergies – Medication allergies and adverse reactions are prominently noted on the record. Absence of allergies (no known allergies – NKA) is noted in an easily recognizable location;
- Past Medical History [for patients seen three (3) or more times] – Past medical history is easily identified including serious accidents, operations, and illnesses. For children, past medical history relates to prenatal care and birth;
- Immunizations for Pediatric Records [ages twenty (20) and under] – There is a completed immunization record or a notation that immunizations are up to date with documentation of specific vaccines administered and those received previously (by history);
- Diagnostic information;

- Medication information;
- Identification of Current Problems – Significant illnesses, medical conditions and health maintenance concerns are identified in the medical record; Smoking, Alcohol or Substance Abuse – Notation concerning cigarettes, alcohol and substance abuse is present for patients twelve (12) years and over and seen three (3) or more times;
- Consultations, Referrals, and Specialist Reports – Notes from any consultations are in the record. Consultation, lab, and x-ray reports filed in the chart have the ordering physician's initials or other documentation signifying review. Consultation and significantly abnormal lab and imaging study results have an explicit notation in the record of follow-up plans;
- Emergency care;
- Hospital Discharge Summaries – Discharge summaries are included as part of the medical record for: 1) all hospital admissions that occur while the patient is enrolled with HPN; and 2) prior admissions as necessary; and
- Advance Directive – For medical records of adults, the medical record documents whether or not the individual has executed an advance directive and documents the receipt of information about advance directives by the recipient and confirms acknowledgment of the option to execute an advance directive. An advance directive is a written instruction such as a living will or durable power of attorney for health care relating to the provision of health care when the individual is incapacitated

In addition, documentation of individual encounters must provide adequate evidence of, at a minimum:

- History and Physical Examination – Comprehensive subjective and objective information is obtained for the presenting complaints;
- Plan of treatment;
- Diagnostic tests;
- Therapies and other prescribed regimens;
- Follow-up – Encounter forms or notes have a notation, when indicated, concerning follow-up care, call or visit. Specific time to return is noted in weeks, months, or PRN (as needed). Unresolved problems from previous visits are addressed in subsequent visits;
- Referrals and results thereof; and
- All other aspects of patient care, including ancillary services.

8.8 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 Health Plan of Nevada 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.

8.9 HPN Medicaid Members' Rights and Responsibilities

Member Rights:

- To be treated with respect and dignity and every effort made to protect their privacy.

- The freedom to select a primary care physician including specialists as their PCP if the recipient has a chronic condition from HPN's extensive provider list including the right to refuse care from specific practitioners. Members may contact Customer Service for assistance in making a selection or changes.
- To be provided the opportunity to voice grievances appeals about the plan and/or the care provided and to pursue resolution of the grievance or appeal.
- To receive information about the plan, its services, its providers, and members' rights and responsibilities in a manner and format that is easily understood and in languages (other than English) that are commonly used in the service area.
- To participate with their primary care physician in the decision making process regarding health care, including the right to refuse treatment.
- To have timely access to care and services, taking into account the urgency of their medical needs. The member has the right to direct contact with qualified clinical staff. Urgent coverage means those problems which, though not life-threatening, could result in serious injury or disability unless medical attention is received.
- To have a candid discussion of available treatment options and alternatives for your conditions, regardless of cost or benefit coverage.
- To have direct access to women's health services for routine and preventive care. Female members have access to the necessary providers for women's routine and preventive health care services. This is in addition to the member's designated PCP, if that source is not a women's health specialist. Customer Service can assist with this selection.
- To have direct access to medically necessary specialist care, in conjunction with an approved treatment plan developed with the primary care physician/dentist. Required authorizations should be for an adequate number of direct access visits.
- To have access to emergency health care services in cases where a "prudent layperson" acting reasonably would have believed that an emergency existed. Emergency care is available twenty-four (24) hours per day, seven (7) days per week. The member has access to emergency services after business hours and on weekends. Members and providers have the right to direct contact with qualified clinical staff. Unrestricted access to emergency services whether in or out-of-network.
- To have adequate and timely services outside the network, if HPN's network is unable to provide necessary services covered under your contract.
- To have a second opinion, at no cost, from a qualified health care professional within the network or arrangements made for you to obtain one outside the network.
- To formulate Advance Directives.
- To have access to medical records in accordance with applicable state and federal laws, including the ability to request and receive a copy of 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.
- To make recommendations regarding the organization's members' rights and responsibilities policies.

Member Responsibilities:

- To know how HPN's Managed Care Program operates.
- To provide, to the extent possible, information that HPN and its providers need in order to provide the best care possible.

- To follow instructions and guidelines given by those providing healthcare services.
- To take responsibility for maximizing health habits and to follow the health care plan that the member, physician and HPN have agreed upon.
- To consult with a primary care physician and HPN before seeking non-emergency care in the service area. We encourage members to consult their physician and HPN when receiving urgently needed care while temporarily outside the HPN service area.
- To obtain a written referral from a physician before going to a specialist.
- To obtain prior authorization from HPN and a 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 a member cannot keep.
- 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 HPN, health care providers, and government health benefit programs.
- To report wrongdoing and fraud to appropriate resources or legal authorities.
- To know their medications.
- To address medication refill needs at the time of an office appointment. To report all side effects of medications to their primary care provider and to notify their primary care provider/dentist if they stop taking their medications.
- To ask questions during an appointment regarding physical complaints, medications, any side effects, etc.
- To participate in understanding their health problems and developing mutually agreed upon treatment goals.

8.10 EPSDT/ Well-Baby/Well-Child Visit – Infant & Adolescent

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a screening assessment for children under age 21 who are enrolled in Medicaid. Nevada Check Up members are eligible to receive well-baby/well-child visits. Assessments should include documentation/charting of, at a minimum, the following components:

- A health and developmental history (physical and mental)
- A physical exam and findings
- Health Education/Anticipatory Guidance (i.e. nutrition, exercise, etc.)

Screenings include:

- | | | |
|---------------------------------------|--------------------|---|
| ✓ A medical and developmental history | ✓ Laboratory tests | ✓ Hearing services |
| ✓ An unclothed physical exam | ✓ Health education | ✓ Other medical needed services |
| ✓ Immunizations | ✓ Vision services | ✓ Comprehensive health and developmental/Behavioral History |

Please make sure that your Medicaid members and Nevada Check Up members have EPSDT screenings! We are conducting regular outreach programs to educate eligible parents/guardians about the EPSDT program.

Members that are due for this program are sent postcard notifications that their well-child screenings are due. They are encouraged to call their PCP to schedule an appointment.

Providers will also be provided quarterly reports of their members that are due for preventive care or disease management services per HEDIS performance measures as evidenced by claim submission. Providers are asked to review these reports and contact the patients to schedule an appointment.

Providers may also conduct EPSDT/well-baby/well-child exams on members, when needed and/or when the member makes such a request. Medicaid/Nevada Check Up members should have EPSDT/well-baby/well-child visits completed as listed in Attachment A of the Medicaid Services Manual (MSM) Chapter 1500 at the following intervals listed.

Age Range						
Under 1	1-2	3-5	6-9	10-14	15-18	19-20
1 month	12 months	3 years	6 years	10 years	16 years	20 years
2 months	15 months	4 years	8 years	12 years	18 years	
4 months	18 months	5 years		14 years		
6 months	24 months					
9 months						
5	4	3	2	3	2	1
Total						20

EPSDT/ Well-Baby/Well-Child Billing

EPSDT/Well-Baby/Well-Child services must be billed on a CMS 1500. Industry standard preventive visit codes must be used. The CPT codes acceptable for billing these services are 99381-99385 and 99391-99395. Please refer to your CPT book for descriptions of these codes.

Please utilize the following modifiers when billing EPSDT/well-baby/well-child services:

- EP to identify the visit as an EPSDT/Well-Baby/Well-Child exam
- FP to indicate family planning services were provided
- TS to indicate a referral to a specialist as a result of an EPSDT/well-baby/well-child exam

To assist provider office staff, we have clarified the EPSDT billing codes for easy reference.

NEW PATIENT

Description	Code	Modifier*
Infant (age under 1 year)	99381	EP or TS
Early Childhood (age 1 through 4 years)	99382	EP or TS
Late Childhood (age 5 through 11 years)	99383	EP or TS
Adolescent (age 12 through 17 years)	99384	EP or TS
Adult (age 18 through 20 years)	99385	EP or TS

ESTABLISHED PATIENT

Description	Code	Modifier*
Infant (age under 1 year)	99391	EP or TS
Early Childhood (age 1 through 4 years)	99392	EP or TS

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Late Childhood (age 5 through 11 years)	99393	EP or TS
Adolescent (age 18 through 20 years)	99394	EP or TS
Adult (age 18 through 20 years)	99395	EP or TS

* Modifiers EP or TS should only be used with the examination codes above. Modifier EP is for the normal screening examination. Modified TS indicates that follow-up treatment or referral is indicated. You will need to complete Field 21 on the CMS-1500 with the appropriate ICD-9 code to reflect conditions requiring follow-up.

OTHER

Description	Code	Modifier
Family Planning Services	99401	FP
Vaccines+	90476 through 90479	No modifier
Vaccine Administration – Single	90471	No modifier
Vaccine Administration - Multiple	90472	No modifier

+ Non-VFC providers should bill the vaccine at usual and customary charges. VFC providers should bill the vaccine at a zero dollar amount.

Billing for Well-Child and Sick Visits on the Same Day

HPN allows reimbursement for well-child visits and limited sick visits on the same day with appropriate billing. When a child presents for a sick visit and is due for a preventive visit, you may complete a well-child assessment, in addition to rendering care for the presenting problem.

What guidelines should be followed?

Early Periodic Screening, Diagnosis, and Treatment (EPSDT) criteria applies:

- › Health and developmental history
- › Physical exam
- › Laboratory tests as appropriate for the age of the child
- › Immunizations (use all visits, preventive and sick, if medically appropriate)
- › Health education and age-appropriate anticipatory guidance (including schedule of care and dental referral)

Allowable Sick Visit Code with Required Modifier

Time Description

Evaluation and Management (E&M) Description

99201-25	e.g., 10-minute	New patient E&M visit
99211-25	e.g., 5-minute	Established patient E&M visit
99212-25	e.g., 10-minute	Established patient E&M visit

Bill the age appropriate EPSDT visit ICD-10-CM codes (i.e. Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0 – Z02.6, Z02.71, Z02.79 – Z02.83, Z02.89, Z02.9) and the age appropriate CPT codes (99381-99385 and 99392-99395) using one of the appropriate sick visit E&M codes with the modifier 25.

Note: Modifier 25 must be billed with the applicable E&M code for the allowed sick visit. When modifier 25 is not billed appropriately, the sick visit is denied. Appropriate diagnosis codes must also be filed for both wellness and sick visits. Appropriate diagnosis codes must be billed for respective visits.

EPSDT/Well-Baby/Well-Child Referrals

When referring a child to a specialist as a result of an EPSDT/well-baby/well-child exam, please follow the steps outlined below:

- Assist the member in choosing a specialist from the HPN Medicaid-Nevada Check Up Provider Directories.
- Make an appointment with the specialist for the patient.
- If the referral was not submitted through @YourService, you must fax a copy of the referral to the specialist and give the patient the original copy of the referral form with instructions to take the referral form to the specialist appointment.

When submitting the claim to the Health Plan, please follow the steps outlined below:

- Attach a copy of the referral form to the CMS 1500 form and submit to HPN.
- Use the TS modifier with the EPSDT CPT code on the CMS 1500 form.
- Include the diagnosis code supporting the referral in Box 21 of the claim form.

Lead Testing as Part of EPSDT/Well-Baby/Well-Child

Lead testing is part of the EPSDT/well-baby/well-child visit. All Medicaid and Nevada Check Up children need to have blood lead testing completed at 12 months and 24 months of age. HPN has contracted with MedTox Laboratories to provide pediatric offices with *filter paper lead screening tests*. The filter paper kits provide a convenient testing method for providers and patients because the test can be performed in the pediatrician's office with a finger stick. To obtain filter paper test kits at no cost please contact MedTox Laboratories at 1-800-FOR-LEAD. Providers may also conduct lead testing in the office with the required Clinical Laboratory Improvement Amendment (CLIA) Waiver or refer members to the contracted laboratory.

Dental Services as Part of EPSDT/Well-Baby/Well-Child

Dental services are part of the EPSDT/well-baby/well-child screening. Please refer any child who needs preventative or restorative dental services to any of the contracted dentists listed in the applicable Provider Directory.

Hearing and Vision Services as Part of EPSDT/Well-Baby/Well-Child

Hearing and vision services are part of the EPSDT/well-baby/well-child screening. Upon completion of the screenings members requiring further testing or treatment need to be referred to a specialist. Please follow the steps outlined under, "**EPSDT/Well-Baby/Well-Child Referrals**". Please ensure the appropriate CPT code is used for the screening and use the TS modifier.

Developmental Assessment

Assessment of developmental and behavioral status should be completed at each visit by observation, interview, history, and appropriate physical examination. The developmental assessment should include a range of activities to determine whether or not the child has

reached an appropriate level of development for age. Developmental and behavioral assessments should include documentation/charting of at a minimum the following components:

- A health and developmental history (physical and mental)
- A physical Exam and findings
- Health Education/Anticipatory Guidance (i.e. nutrition, exercise, etc.)

Behavioral Health

Please refer any child who needs behavioral services to Behavioral Healthcare Options (BHO) at 702-364-1484 or 1-800-873-2246.

8.11 Vaccines for Children (VFC) Program

The VFC Program, administered by the Nevada Division of Public and Behavioral Health (DPBH), provides vaccine free-of-charge to providers. These vaccines may be administered to Medicaid and Nevada Check Up members through 18 years of age in accordance with the most current Advisory Committee on Immunization Practices (ACIP) schedule. This schedule can be found in the Medicaid Services Manual (MSM) Chapter 1500, Attachment B.

All Medicaid and Nevada Check Up primary care providers who are contracted with HPN must participate in the VFC Program. A primary care provider must complete an application and orientation program through the VFC Program. To obtain an application, please access the VFC website, <http://dpbh.nv.gov/Programs/VFC/VFC-Home/>. For assistance in completing the application please contact the State VFC Coordinator at **775-328-6179**. Once completed please mail the application to:

Vaccines for Children Coordinator
Nevada State Immunization Program
Bureau of Community Health
505 East King Street, Room 304
Carson City, NV 89701

Please follow the steps outlined below when billing immunizations:

- Include the CPT codes for the immunizations given on the CMS-1500 form with a \$0.00 charge.
- Include the injection administration code 90471/90472 for the injections given.

8.12 Nevada Division of Public and Behavioral Health's Immunization Registry

The Nevada Division of Public and Behavioral Health's Immunization Registry, known as WebIZ is a statewide registry that houses immunization information about Nevada's children. The goal is to ensure children up to age two are fully immunized HPN's Medicaid and Nevada Check Up contracted providers are required to participate in the Registry. NRS 439.265 requires that all providers who administer immunizations in Nevada to children under the age of 18 are required to report immunization data to the Registry effective 7/1/09. To enroll in this program please contact the registry coordinator at **775-684-4032**.

8.13 Children with Special Healthcare Needs (CSHCN)

Some Medicaid children have a special deeming known as, Children with Special Health Care Needs. Nevada Medicaid makes these determinations. Examples of CSHCN are:

- Medicaid members who receive services through Nevada Early Intervention Services for physical and developmental delays
- Medicaid members who receive services through the Division of Child and Family Services for mental health issues

• Medicaid members who receive medical services through the school-based health clinics
Some of these members are case managed by HPN's pediatric case management team. HPN's pediatric case management team will develop a treatment plan as needed and will coordinate medical services to follow the treatment plan. The treatment plan is developed with the member's primary care provider. The pediatric case management team works closely with the member's primary care provider and specialists to meet the member's needs.

8.14 The Patient Protection and Affordable Care Act (PPACA)

The Patient Protection and Affordable Care Act (PPACA) requires a change in the pharmacy rebate program for state Medicaid agencies. Consequently, Health Plan of Nevada (HPN) on behalf of the Division of Health Care Financing and Policy (DHCFP) requires National Drug Codes (NDC), NDC Units of Measure and NDC quantity on all out-patient administered drug claims. This requirement applies to paper and electronic claim forms to include CMS-1500, UB-04, 837I and 837P. Claims received without this information will be denied payment but may be corrected and resubmitted for payment. Please continue to include the HCPCS codes and HCPCS quantities on the claim form as HPN will continue to pay off the HCPCS codes.

Claims for the following services are exempt from the NDC coding requirements:

- Immunizations provided through the Vaccines for Children program
- Inpatient-administered drugs
- Radiopharmaceuticals billed with the procedure
- Claims from providers with a 340B designation

8.15 Claims

Please refer to the Claims section of this Guide for detailed information regarding claims submission requirements. The following requirements are specific to Medicaid and Nevada Check Up:

- Claims must be submitted within 180 calendar days from the date of service. Failure to submit the claim within the 180 calendar days will cause the claim to be stale dated.
- Emergency transportation providers have 180 calendar days to file a claim. Failure to submit the claim within the 180 days will cause the claim to be stale dated.
- Providers submitting claims must be Nevada Medicaid contracted providers.
- All claims must contain the provider's National Provider Identifier (NPI) or the claim will be denied.
- Claims for sterilization by the surgeon must include the Medicaid Sterilization Consent form.

- Claims for Durable Medical Equipment, Orthotics and Prosthetics must be accompanied by the manufacturer's invoice.

Claims, applicable records, and consent forms should be mailed to:

Health Plan of Nevada, Inc.
PO Box 15645
Las Vegas NV 89114-5645

To be a Nevada Medicaid provider, log onto:

http://www.medicaid.nv.gov/Downloads/provider/NV_provider_enrollment_instructions.pdf. All providers in a group practice billing for services rendered to a Medicaid member must be enrolled as a Nevada Medicaid provider and submit their individual NPI on the claim form.

8.16 Obstetrical Billing

The Division of Health Care Financing and Policy, which administers the Medicaid program, has mandated the method in which HPN will reimburse obstetrical providers for obstetrical services rendered to Medicaid members. Payment to the delivering obstetrician for pregnancy will be based upon the number of visits provided by the delivering obstetrician to the pregnant member throughout the course of the pregnancy.

The global payment will be paid to the delivering obstetrician when the obstetrician has seen the pregnant member for seven (7) or more prenatal visits, has delivered the baby and provided postpartum care. Under these circumstances, the provider would bill the global obstetrical codes 59400 or 59510.

If the obstetrical provider has provided less than seven (7) prenatal visits to the pregnant member, the provider will be paid according to the Medicaid Fee Schedule on a visit-by-visit basis. There are several scenarios, which fall under this category. They are as follows:

- If the obstetrical provider provides antepartum care only, the appropriate antepartum code should be billed.
 - For 1-3 antepartum visits bill with the appropriate evaluation and management code;
 - For 4-6 antepartum visits bill with the code 59425;
 - For 7 or more antepartum visits bill with the code 59426.
- If the obstetrical provider provides less than seven (7) antepartum visits and delivers the baby, the appropriate antepartum code and the appropriate delivery only code should be billed.
 - For 1-3 antepartum visits with a delivery bill the appropriate evaluation and management code and either 59409 or 59514;
 - For 4-6 antepartum visits with a delivery bill 59425 and either 59409 or 59514.
- If the obstetrical provider provides less than seven (7) antepartum visits, delivers the baby, and provides postpartum care, the appropriate antepartum care code and the appropriate delivery with postpartum care code should be billed.
 - For 1-3 antepartum visits and a delivery with postpartum care bill the appropriate evaluation and management code and either 59410 or 59515
 - For 4-6 antepartum visits and a delivery with postpartum care bill 59425 and either 59410 or 59515.

8.17 Maternity Risk Screen Form & Obstetrical Case Management

Nevada Medicaid has mandated that obstetrical providers complete a Maternity Risk Screen form during the first prenatal visit performed on all Medicaid patients. The intent of the assessment is to identify women with at-risk or high-risk pregnancies, who may benefit from medical and/or social case management. A copy of this form is included for your review. It can also be found in **Section 25.6**.

Once the form has been completed, please fax it to HPN's Obstetrical Case Management Team, at **702-804-3732**. The form may also be completed online through @YourService when submitting the prior authorization request for total obstetrical care. Our nurses will review the form and provide case management services, as needed.

For questions, additional copies or instructions on using the online form through @YourService, you may contact HPN's Provider Services department at **702-242-7088**.

MEDICAID MATERNITY RISK SCREEN

The risk screen is designed to identify pregnant women at risk for preterm birth or poor pregnancy outcome. Risks must not be altered. Please check all risks that apply to the recipient and make the appropriate referral(s).

Patient Name _____ Medicaid # _____ EDC _____

A. MEDICAL

1. _____ Hypertension, chronic or preg. Induced
2. _____ Gestational diabetes/diabetes
3. _____ Multiple gestation (twins, triplets)
4. _____ Previous preterm birth < 5 ½ lbs.
5. _____ Advanced maternal age, > 35 yrs.
6. _____ Medical condition, the severity of which affects pregnancy, document below diet pills
7. _____ Previous fetal death
8. _____ Vision Impairments
9. _____ Hearing Impairments

Substance Abuse

10. Alcohol
11. Cocaine/crack
12. Narcotics/Heroin
13. Marijuana/ Hashish
14. Sedatives/
Tranquilizers
15. Amphetamines
16. Inhalants/Glue
17. Tobacco/Cigarettes
18. Other, Please Specify

Days/Week
Used

Times/Day
Used

B. SOCIAL

1. _____ Teenager 18 yrs. or younger
2. _____ Non-compliant with medical directions or appointments
3. _____ Mental retardation or history of emotional/mental problems

- *4. _____ Abuse/neglect during pregnancy
- *5. _____ Shelter, homeless or migrant
- *6. _____ Lack of food

C. NUTRITION

1. _____ Teenager 18 years or younger
2. _____ Prepregnancy underweight/overweight inadequate or excessive wt gain

3. _____ Poor diet or pica
4. _____ Obstetrical/Medical condition requiring diet modification, document condition below

REFERRALS AND/OR SERVICE PLAN

1. _____ Care Coordination
2. _____ Smoking Cessation
3. _____ Homemaker
4. _____ Nutritional Counseling
5. _____ Glucose Monitor w/nutrition counseling
6. _____ Parenting/Childbirth Classes
7. _____ Substance Abuse TX
8. _____ No Care Coordination

PHYSICIANS COMMENTS OR SUGGESTIONS _____

SIGNATURE/TITLE _____ SCREENING DATE _____

SIGNATURE PRINTED _____ PHYSICIAN # _____

Once the form has been completed, please fax it to HPN's Obstetrical Case Management Team, at (702) 804-3732.

Assist Recipient in contacting Appropriate Agencies for Care Coordination of Non-Covered/Carved –Out Plan Services or Community Health Information

HPN obstetrical case management program is available to all pregnant Medicaid and Nevada Check Up members. The program is designed to help expectant women have healthy pregnancies and healthy babies. Registered nurses, social workers and care coordination assistants staff the program and provide information on prenatal and postpartum care as well as information on well-baby checkups, answer questions about pregnancy and the unborn baby, coordinate medical and social services and provide information regarding warning signs during pregnancy and transportation to medical services.

To refer a member to the obstetrical case management program call **844-851-7830**.

8.18 Action, Notice of Action and Appeals

Action

Definition: An action is the denial or limited authorization of a requested service, including: (1) the type or level of service; (2) the reduction, suspension, or termination of a previously authorized service; (3) the denial, in whole or in part, of payment for a service; and (4) the failure to provide services in a timely manner, as defined by the State.

Notice of Action

HPN will provide a notice of action to the requesting provider and the member when it takes an adverse action or makes an adverse determination. HPN will give at least 10 calendar days notice before the date of the action when the action is a termination, suspension, or reduction of previously authorized services.

HPN will provide standard authorization decisions as expeditiously as the member's health requires and within seven calendar days following receipt of the request for services, with a possible extension of up to fourteen (14) additional calendar days if the member or provider requests the extension. For cases in which a provider indicates or HPN determines that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function, HPN will make an expedited authorization decision and provide a notice of action as expeditiously as the member's health condition warrants and no later than three (3) calendar days after receipt of the request for service. HPN may extend the three (3) calendar days time period by up to fourteen (14) calendar days if the member requests an extension or if HPN justifies to the DHCFP a need for additional information and how the extension is in the member's interest.

Handling of an HMO Appeal

A member or provider on behalf of a member has the right to file an **appeal** within 60 calendar days of receiving a notice for any of the following issues:

- the services requested were denied or limited
- the services the member was receiving are reduced, suspended or stopped
- part or all of the payment for a service received is denied
- the request for services was not responded to timely
- HPN does not resolve the grievance or appeal timely

There are two kinds of appeals a member may file depending upon the service being appealed:

Standard (30 days)

A standard appeal may be requested for claim and authorization denials. HPN will send a letter within three calendar days informing the member that the appeal was received. HPN will provide a written decision no later than 30 calendar days after receipt of the appeal. (HPN may extend this time by up to 14 calendar days if the member requests an extension, or if additional information is needed and the extension benefits the member.)

Expedited (72 hour review)

An expedited appeal may be requested for authorization denials if the doctor believes that the member's health could be seriously harmed by waiting too long for a decision and is willing to support this. HPN will not take punitive action against a provider who supports an expedited appeal.

HPN will decide on an expedited appeal no later than 72 hours, **three calendar days** after we receive the appeal. (HPN may extend this time by up to 14 calendar days if the member requests an extension, or if we request an extension from the State, in order to obtain additional information, and the extension benefits the member.) We will call the member with the decision. HPN will send written notice of our decision within 72 hours of the appeal being received in company.

If HPN decides the request for an expedited appeal does not meet the criteria, it will be changed to a standard appeal. HPN will inform the member verbally, whenever possible and sends a written notice within two calendar days.

If any doctor asks for an expedited appeal, or supports the member in asking for one, and the doctor indicates that waiting for 30 calendar days could seriously harm a member's health, HPN will automatically provide an expedited appeal.

An appeal should include the member's name, address, Member ID number, reasons for appealing, and any evidence the member or provider wishes to attach. Supporting medical records, doctors' letters, or other information that explains why the service should be provided may be submitted. This information may be mailed, faxed or presented in person by the member or another adult authorized by the member.

Standard Appeals may be mailed or deliver to the address below:

Health Plan of Nevada, Inc.
P.O. Box 14865
Las Vegas, NV 89114-4865

Health Plan of Nevada, Inc.
2720 N Tenaya Way
Las Vegas, NV 89128

Standard appeals may also be filed by calling our Member Services Department at 1-800-962-8074, but must be followed by a written, signed appeal.

Expedited Appeals may be filed via fax or telephone to the following numbers:

Fax 702-266-8813
Toll free 1-800-962-8074
TTY/TTD: 1-800-349-3538

Filing a Provider Claim Reconsideration

A provider has the right to file a reconsideration when a disagreement occurs regarding the claims adjudication process. Additionally, appeal rights are offered after the provider has completed two (2) claim reconsideration processes. If the second claim reconsideration process is not favorable, the provider is provided with their appeal rights and an appeal may be followed as outlined in the section **Filing a Provider Appeal for Claim**.

An easy way to remember the claim reconsideration process is the "3 Step Rule". The following is an example of a claim denial that demonstrates the claims reconsideration.

1. Claim submission and claim denied for payment (Step 1 of 3)
2. Provider submits Claim Reconsideration including EOP with an explanation for the dispute (Step 2 of 3). Provider is notified of decision by EOP. Please see Claims Section 14.14, Claims Reconsideration Process for more information.
3. Provider must submit a second Claim Reconsideration requesting further review and includes any additional information and/or reiterates their reasons for dispute. Decision remains unchanged. Provider is informed of their appeal rights via EOP (Step 3 of 3)

After completing the claims reconsideration process above if the provider is not satisfied with the outcome of the claims reconsideration process an appeal may be filed. **See Filing a Provider Appeal for a Claim below for the appeal process.**

For claim reconsiderations, please submit your EOP with an explanation for the dispute and any supporting documentation to:

HPN
ATTN: Claim Reconsiderations
P.O. Box 15645
Las Vegas, Nevada 89114-5645

Filing a Provider Appeal for a Claim

Providers may file a claims appeal after following the process outlined above for claim reconsiderations. Claim-related appeals should be submitted to the HPN Customer Response and Resolution (CR&R) Department listed below. An appeal can be filed by sending a copy of the Explanation of Payment (EOP) along with the reason the claim is being appealed. The process is outlined below:

1. Provider submits appeal to the address listed below
2. The Health Plan acknowledges appeal request in writing
3. The Health Plan renders decision on appeal and notifies provider in writing of decision. If the decision is unfavorable, the correspondence provides the rationale and the right to a State Fair Hearing. **Please see the Fair Hearings section below for detailed information.**

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For appeals, please submit your written request explaining your reasons for dispute and any supporting documentation to:

HPN
ATTN: CR&R/Appeals
P.O. Box 14865
Las Vegas, Nevada 89114-4865

If you have any questions regarding claims payment, please contact the Member Services department **1-800-962-8074**.

Filing a Provider Grievance

Any grievance regarding quality of plan services, a policy and procedure issue or any other non-claim related issue may be submitted in writing to the Medicaid/Nevada Check Up Provider Services Department at the address listed below:

Provider Services Department
Medicaid/Nevada Check Up
P.O. Box 15645
Las Vegas, NV 89114-5645

HPN will respond in writing to all provider disputes within thirty (30) calendar days from receipt of the provider dispute.

Filing a Provider Grievance for a UM reconsideration

Reconsideration is a process in which the requesting physician provides NEW or ADDITIONAL clinical information that was not originally submitted with the initial request. The Medical Director making the initial decision to deny the services will review the additional information. It is preferable that the information be submitted prior to receipt of the denial letter (e.g., at the time of verbal notification of the denial). Thereafter, an appeal must be requested. If the information is received after the appropriate timeframe, Utilization Management will forward the case to The Customer Response and Resolution (CR&R) Department to initiate the formal appeal process. To file reconsideration, please submit the new or additional information via fax to:

Utilization Management: 1-800-282-8845

HPN will respond in writing to all provider disputes within thirty (30) calendar days from receipt of the provider dispute.

By separating these types of provider disputes, HPN can ensure appropriately and timely responses to provider's concerns.

Fair Hearings

A provider, member, member's representative or the representative of a deceased member's estate has the right to request a State Fair Hearing when they have exhausted HPN's appeal system without receiving a wholly favorable resolution decision. The appeal process consists of two requests for reconsideration of payment and one appeal.

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Provider appeals eligible for the State Fair Hearing process include:

- Denial or limited authorization of a requested service;
- Reduction, suspension or termination of a previously authorized service;
- Denial, in whole or in part, of payment for a service;
- Demand for recoupments; or,
- Failure of HPN to meet specified timeframes (e.g., authorization, claims processing, appeal resolution).

DHCFP will not accept requests for State Fair Hearings that address provider contractual disputes.

HPN will participate in the State Fair Hearing process for its members/patients and providers. HPN is bound by the decision of the Fair Hearing Officer.

A State Fair Hearing may be requested by contacting the Nevada Medicaid Hearings Unit at 1-800-992-0900, extension 43602 or 1100 East William Street, Suite 204, Carson City, NV 89701. This hearing may be requested within 90 days of receiving the final Appeal Notice from HPN. A State Fair Hearing may also be requested if HPN fails to make our decision in a timely manner. That is, within the time frames described in this section.

If information or help is needed, call the State Medicaid Office at:

Las Vegas: 702-486-3000, extension, 43602 or
1-800-992-0900, extension 43602
Carson City: 1-800-992-0900, extension 43602

If a member needs legal assistance, he may call the Legal Services Program in Clark County at 702-386-1070.

HPN will help providers and members through the Medicaid grievance and appeals process. If a provider or member needs information or help, contact HPN at:

Toll free: 1-800-962-8074
TTY/TTD 711: 1-800-349-3538

Business Hours: Monday – Friday, 8:00 a.m. – 5:00 p.m. (PST)

- Interpreter services are available upon request
- Members needing transportation to an appeal procedure may call MTM at 1-844-879-7341.

A member has the right to review the case file, including medical records and any other documents and records used during the appeals process.

Continuation of Benefits While HPN and State Hearings Are Pending

The member's benefits must be continued if the member requests that his benefits continue while the appeal is being considered. This request must be made within ten (10) calendar days of HPN mailing the notice of action to reduce, suspend or deny services the member is receiving if there is still time left in the authorization period.

If at the member's request the benefits are continued while the appeal is pending, the benefits will continue until one of the following occurs:

- The member withdraws the appeal;
- Ten (10) calendar days pass after the notice of action/notice of adverse benefit determination is mailed (unless the enrollee requests an Appeal and continuation of benefits until the hearing decision is reached);
- A State Fair Hearing office issues a hearing decision adverse to the member; and
- The time period of service limits of a previously authorized service has been met.

If the final resolution of the appeal is adverse to the member, HPN may recover the cost of the services provided to the member while the appeal was pending. If the final resolution is in favor of the member, HPN must authorize/furnish the services promptly.

8.19 Member Grievance

As a provider for HPN members, there may be occasions in which you or your staff might be the recipient of grievance 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 HPN member wants to file a grievance, please have them complete the HPN Member Grievance Form located in **Section 25.5**.

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.

A member has the right to file a **grievance** if the member has an issue with:

- services received through HPN
- the care or services received from one of the doctors, dentists or other health care providers

To file a grievance, the member may:

- call Member Services at **1-800-962-8074**, or
- write to us at: **Health Plan of Nevada**
PO Box 14865
Las Vegas, NV 89114-4865

We handle a grievance seriously and will try to resolve it to the member's satisfaction. A member, who needs help filing a grievance, can call our Member Services Department at **1-800-962-8074**. Oral interpreter services are also available.

Once we receive the grievance the following will occur:

The member will receive a letter from us within **three calendar days** stating that we have received the grievance. HPN's staff may also contact the member to clarify the situation. **Within 30 days** of the day we receive the grievance, we will send the member a letter with the outcome. We may extend this time up to 14 calendar days if additional information is needed and the extension will benefit the member. The member has the right to file a grievance if they disagree with the 14 day extension.

8.20 Quality Improvement

Health Plan of Nevada (HPN) 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, HPN 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 HPN Provider Web site (www.myhpnprovider.com) or for a hardcopy, call (702) 242-7735.

Please see Section 16 for detailed information about the Quality Improvement Program.

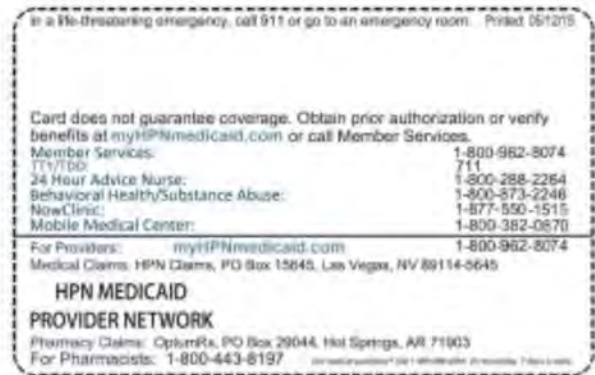
8.21 ID Cards

Effective May 1, 2017, Health Plan of Nevada issued ID Cards for HPN Medicaid, Nevada Check Up and Expansion members. Members should take their health plan ID card along with their or their child's State Medicaid ID card to all of their appointments and to fill prescriptions. They should also have it available when contacting Member Services. Sample ID cards have been included for your review. If there are any additional questions, please contact Member Services at **1-800-962-8074**.

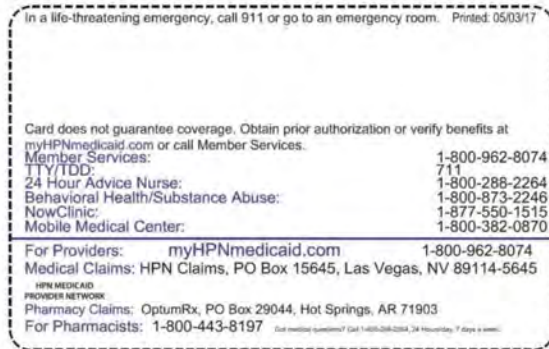
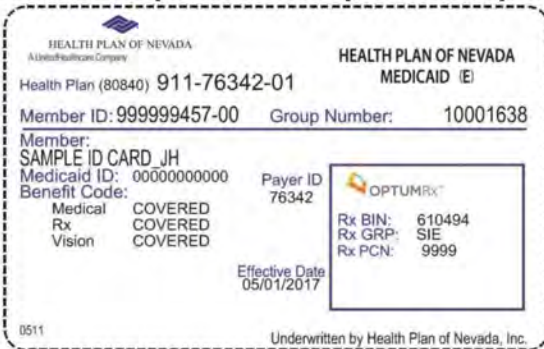
Medicaid sample health plan ID card



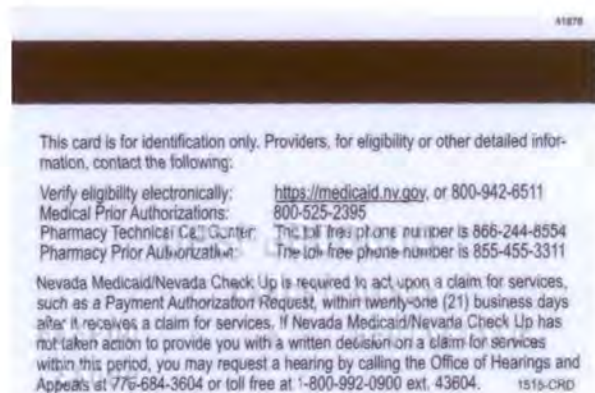
Nevada Check Up sample health plan ID card



Nevada Expansion sample health plan ID card



Sample State ID card



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SECTION 9

UTILIZATION MANAGEMENT

9 - Utilization Management

Health Plan of Nevada (HPN) 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)

9.1 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.

9.2 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.

9.3 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.myhpnprovider.com or upon request by contacting the Prior Authorization Department at (702) 243-8499 or (800) 288-2264.

HPN 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 for decisions involving medical necessity review. Notifications of denial with appeal rights are given to members in writing and to providers verbally, by fax and in writing.

The purpose of the prior authorization function is to ensure that every HPN 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.

9.4 Services That Require Prior Authorization

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

- Non-emergent/urgent elective admissions to an inpatient facility
- Skilled Nursing Facility and Rehabilitation
- Orthognathic surgery, including all TMJ (Most Orthognathic surgeries are excluded and TMJ has coverage limitations)
- Bariatric Surgery
- Transplants
- Out of Plan or out of area providers/facilities/services
- Custom DME and DME purchases (unless under capitation with HPN), Prosthetic/Orthotic devices
- Infertility services (excluded for Medicaid) and Sterilization Reversals (Sterilization reversals excluded for all products)
- All Perinatal Requests
- Level II Ultrasounds
- OB Delivery
- Sleep disorder studies and Surgeries
- Complex Radiology (e.g. MRI's, SPECT Scans, CT Scans, PET scans, and Nuclear Medicine)
- Selected outpatient facility-based procedures
- Selected injectable medications
- Therapies (Physical, occupational, and speech unless under capitation)
- Complex Diagnostic Testing (e.g. Echo-Cardiograms, Stress Tests, Nerve Conduction Studies, and EMG's.)
- Genetic lab testing
- Dental outpatient surgery site and anesthesia

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

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.

9.5 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.myhpnprovider.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 Department of Labor, the Centers for Medicare and Medicaid Services (CMS) and Nevada 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.

9.6 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 authorization 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 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.

- 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 25.2** of this guide for a request form. @YourService tutorials are available online through the HPN website. 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
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9.7 Patient and Provider Access Center (After Hours Admission and Healthcare Services/Telephone Advice Nurse)

Understanding the importance of quick and accurate information, the HPN 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 registered nurse professionals who work to meet the service and care needs of members and providers. As liaisons, Registered Nurse staff members are actively involved in coordinating care by assisting with admissions and healthcare services and health care triage advice to HPN members.

Staff assists 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 registered 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.

9.8 Inpatient Concurrent Review

At HPN, the Continuity of Care department provides initial and ongoing assessments of members receiving care in the inpatient setting in order to ensure the appropriate level of care the member is receiving based on medical necessity. In order to accomplish this task HPN provides hospitalists, case managers and Medical Director leadership to perform daily case reviews telephonically and/or on-site 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.

HPN'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**.

9.9 Denial, and Appeal Process (Commercial and Medicare Plans)

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 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/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. A provider can appeal on behalf of a member 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. Senior Dimensions 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.

9.10 Medicaid Action, Notice of Action and Appeals

Please see Section 8.18 for Medicaid Guidelines

9.11 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.

9.12 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.myhpnprovider.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 10

CLINICAL GUIDELINES

10 - Clinical Guidelines Summary

Health Plan of Nevada (HPN) 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 HPN providers, and others have been adopted from the larger UnitedHealthcare group. In most cases, national expert consensus recommendations provide the basis for the final HPN 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 HPN 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.

The following is a list of the current HPN Clinical Guidelines. To avoid outdated versions, you can find the current guidelines on the Health Plan of Nevada web site at www.myhpnprovider.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
- Hemophilia and von Willebrand Disease
- Human Immunodeficiency Virus (HIV)
- Hypertension
- Lifestyle Management to Reduce Cardiovascular Risk
- Mechanical Circulatory Support Device (MCS)
- Neonatal Abstinence Syndrome
- Neonatal Apnea and Bradycardia
- Neonatal Discharge Planning
- Obesity
- Physical Activity
- Preventive Services

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- Schizophrenia
- 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 11

REFERRALS

11 – Referrals to Specialists

When referring to a specialist, Primary Care Physicians should refer patients to designated specialists as listed in the applicable provider directory.

Primary care physicians may refer patients by:

- submitting an online referral through [@YourService](#); or
- Completing a hard copy referral form

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

A Nevada Universal Prior Authorization and Referral Form is included in Section 25.8 for use when referring to specialists or for prior authorization. Please refer to section 9 for specific prior authorization requirements.

Dental providers should refer patients to designated specialists listed in the applicable dental provider directory.

For a copy of the most current provider directory go to www.myhpnprovider.com, or for any questions regarding requirements, please contact the Provider Services Department at **(702) 242-7088 or (800) 745-7065**.

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SECTION 12

SOUTHERN NEVADA REFERRAL GUIDELINES

12 – SOUTHERN NEVADA REFERRAL GUIDELINES

(Not Applicable to Northern Nevada Providers)

In an effort to clarify referral protocol to Health Plan of Nevada (HPN) specialists, HPN in conjunction with our contracted specialists have developed Referral Guidelines.

Referral guidelines are designed to assist you in expediting and facilitating appropriate specialty care for our members and your patients. In the event you have a patient with specific needs that are not addressed by these guidelines, HPN recommends you contact the specialist(s) to discuss directly.

The following guidelines are available on the Health Plan of Nevada website at www.myhpnprovider.com.

If you have any questions please contact your Provider Services Advocate at (702) 242-7088 or (800) 745-7085

REFERRAL AND TREATMENT GUIDELINES

- 12.1 BARIATRIC SURGERY**
- 12.2 CARDIOLOGY**
- 12.3 CARDIOVASCULAR SURGERY**
- 12.4 DERMATOLOGY**
- 12.5 EAR NOSE AND THROAT**
- 12.6 ENDOCRINOLOGY**
- 12.7 GASTROENTEROLOGY**
- 12.8 GASTROENTEROLOGY - PEDIATRIC**
- 12.9 GENERAL SURGERY**
- 12.10 NEPHROLOGY**
- 12.11 NEUROLOGY**
- 12.12 OPHTHALMOLOGY**
- 12.13 ORTHOPEDIC**
- 12.14 PAIN MANAGEMENT**
- 12.15 PLASTIC SURGERY**
- 12.16 PODIATRY**
- 12.17 RHEUMATOLOGY**
- 12.18 UROLOGY - ADULTS**
- 12.19 UROLOGY - PEDIATRIC**



12.1 BARIATRIC SURGERY REFERRAL GUIDELINE
Contracted Group: Surgical Weight Control Center

Scheduling Seminar:

Surgical Weight Control Center
3802 Meadows Lane
Las Vegas, NV 89107
Phone: (702) 313-8446
Fax: (702) 221-8446

Please submit the referring patient's information to Surgical Weight Control Center. Patient must attend an informational seminar prior to proceeding with surgical guidelines. Please inform patient to bring Insurance card and ID to seminar appointment.

Dietary Guidelines:

The length of diet is dependent upon member's benefit plan:

HPN HMO/POS (Tier 1 benefit): requires 6 consecutive months of diet within the past 24 months.

Medicaid/Nevada Check-up: requires 3 consecutive months of diet within the year of surgery.

Senior Dimensions: requires 4 consecutive months of diet within the past 12 months (Gastric Sleeve, Gastric Band, and Gastric Bypass).

If diet requirement is not yet met, please refer member to Health Education and Wellness Center to schedule their medically supervised nutrition counseling appointment: (702) 877-5356

Inquiries regarding out of pocket member costs related to Gastric Bypass surgeries should be directed to Member Services:

HPN: (702) 242-7300

Medicaid/Nevada Check-up: (702) 242-7317

Senior Dimensions: (702) 242-7301

Additional items required

The following items must be completed before an office consultation can be scheduled:

***Psychological Evaluation:** (referral sent to BHO from SWCC)

***Surgery Clearance:** must be written on letterhead in letter format, stating that the patient is medically cleared to proceed with surgery.

***Last Progress/Visit note**

***Cardiac Clearance** (If applicable)

***Universal Referral Form** must be completed and sent with pre-operative testing
All tests outlined above

***Laboratory**

The following PREOP Laboratory Testing is required once nutrition classes are completed: **(good for 90 days)**

- Comprehensive Metabolic Panel
- Glycohemoglobin A1C
- Serum Insulin
- Lipid Panel
- Vitamin B-12
- Ferritin
- CBC
- Folate
- TSH
- Chest X-ray **(good for 6 months)**
- EKG **(good for 6 months)**



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12.2 CARDIOLOGY REFERRAL GUIDELINES

Contracted Group: Southwest Medical Associates

Adult Cardiology Patients (18 Years and Older) Referral Guidelines

For Appointments:

**888 S. Rancho
Las Vegas, NV 89109
Phone: (702) 877-8654
Fax: (702) 242-7998**

NOTE: A Cardiologist is available during clinic hours to discuss a case and make suggestions regarding work up.

The following diagnostics are needed prior to cardiology consultations:

Chest Pain

- ECG within 30 days
- Chest x-ray
- Lab work: CBC, Chemistry Panel, Lipid and Thyroid Panel, Hemoglobin
- Appropriate stress testing modality (only if patient has no known history of CAD or if pain is "low risk.")
- Echocardiogram (This test is only required if a new heart murmur is detected. This test is not required prior to consultation, if there is no detection of a new murmur and an echocardiogram was performed within the last year.)
- High risk chest pain (classic symptoms, risk factors, etc.) should be managed in UC or ER.

Congestive Heart Failure (CHF) with EF 40% or less

- Chest x-ray
- Lab work: CBC, Chemistry Panel, Lipid and Thyroid Panel, BNP CMP w/EGFR (#6200) and BNP within past 30 days
- EKG
- Echocardiogram within past 6 months

Congestive Heart Failure (CHF) with EF 41% or greater

- Chest X-ray
- Lab work: CMP w/EGFR (#6200) BNP within past 30 days
- EKG
- Echocardiogram within past 6 months

New onset CHF patients without history of left ventricular dysfunction should be sent to UC/ER

Arrhythmia (Tachycardia / Bradycardia / Afib/ Aflutter)

- Documentation of arrhythmia-ECG, Holter, Event Monitor, or telemetry showing arrhythmia or previous Cardiologist Office Note documenting arrhythmia, etc.
- Lab work: CBC, Chemistry Panel, Lipid and Thyroid Panel
- Echocardiogram within past year
- Holter Monitor/Event Recorder-if not previously done (included in requested documentation)

Heart Block (same as above)

- Medication List
- Lab work: CBC, Chemistry Panel, Lipid and Thyroid Panel
- EKG
- Echocardiogram
- Holter Monitor

If high degree heart block and patient is symptomatic, send to emergency room.

Evaluation of Coronary Artery Disease Guidelines

Identification of patients with Coronary Artery Disease. The initial screening and diagnostic work-up of patients suspected of having Coronary Artery Disease is to be performed by the Primary Care Physician (PCP). Cardiology consultation is to be obtained only after the screening and therapeutic measures below have been accomplished. (Telephone consultation is appropriate at any time with on-call cardiologist)

Evaluation for Cardiac Risk Factors without Established Disease

- ♦ Individual screening of patients by PCP for initial complete history and physical examination.
- ♦ Initial evaluation consists of ruling in or out the factors listed below:
 - Smoking
 - Hypertension
 - Diabetes mellitus
 - HDL <35mg/dl
 - LDL >130mg/dl
 - Family history: Male, **first-degree relative**, MI at age <55 years
Female, **first-degree relative**, MI at age <65 years
First degree relative = Birth Father or Mother, and siblings
 - Presence of atherosclerosis elsewhere (PVD)
- ♦ Diagnostic evaluations to include:
 - Yearly lipid panel evaluation
 - Referral for stress testing if indicated.
- ♦ Therapy:
 - Treatment of the positive treatable risk factors.

- Cardiology referral is appropriate if the stress test is positive for ischemia or the patient's history is strongly suggestive of angina in the presence of a negative stress test.

Evaluation of Episodic Chest pain (not ongoing):

Initial history and physical examination to be performed by PCP. Evaluation to include the following:

- ♦ High risk chest pain (classic symptoms, risk factors, etc.) should be managed in UC or ER.
- ♦ Evaluation of precipitating and relieving factors, presence or absence of aggravation by breathing or motion of ribs and/or shoulders.
- ♦ Evaluation of cardiac risk factors
- ♦ Presence or absence of atherosclerosis by history and physical exam.

Diagnostic evaluations to include (conducted and treated by PCP):

- ♦ Laboratory evaluation to include CBC, Renal Panel, TSH, Lipid Panel, Hemoglobin
- ♦ Current EKG
- ♦ Referral for non-invasive testing, if indicated, to include:
 - Appropriate stress testing modality
 - Echocardiography, if murmur or left ventricular dysfunction suspected

Therapy:

- ♦ Treatment with Aspirin, beta-blockers, nitrates and ACE Inhibitors as indicated.
- ♦ Cardiology referral is appropriate at this point if the stress test is positive for ischemia.
- ♦ Referral **must** include copies of above-generated data, *except data previously generated by outside Cardiology group.*

Evaluation of Known Atherosclerosis:

- ♦ Routine follow up of patients with previous CABG, MI or PTCA or Stent >6 months old, if stable, is to be conducted by the PCP.
- ♦ PCP evaluation consists of:
 - Referral for appropriate stress test when indicated.
 - Yearly lipid panel.
- ♦ Therapy:
 - Treatment with Aspirin, beta-blockers, ACE-Inhibitors, nitrates and calcium channel blockers (patient's intolerant to beta-blockade) as indicated.
 - Treatment of lipids according to ACC/AHA guidelines (LDL <100mg/dl).
 - Treatment of hypertension according to JNC-8 guidelines (BP<140/90).
 - Cardiology referral is appropriate if clinical status changes.

Evaluation of Active Chest Pain:

Evaluation conducted by PCP reveals current symptoms with or without EKG changes (this is not an appropriate office-to-office outpatient referral).

- ◆ Diagnostic Evaluation
- ◆ Current EKG
- ◆ Therapy
 - Chest Pain (ongoing or resolved) with EKG changes
 - Arrange EMS transfer to Emergency Room.
 - Arrange for evaluation by HPN Hospitalist and/or covering cardiologist.
 - Protocol for starting medical regimen pending cardiology consultation to consist of Aspirin, Heparin, IV nitroglycerin, SL NTG, beta blocker as indicated. IIb/IIIa antagonists, clopidogrel or similar, and/or thrombolytics at discretion of consulting cardiologist.
 - CPK/MB every eight (8) hours, three (3) times, or Troponin I every eight (8) hours, three (3) times.
 - Appropriate Stress Testing if first two (2) CPK/B or Troponin I determinations are normal and chest pain has resolved or is considered low risk.
 - TIMI Risk stratification by SMA or Network Hospitalists according to established protocol is to be conducted. Patients TIMI Risk Scored ≤ 2 may be discharged for 24 to 48 hour outpatient stress testing per established guidelines. TIMI Risk Score > 2 should be admitted.
 - Cardiology referral is appropriate for cardiac evaluation.
 - Cardiac Catheterization if high risk features (dynamic ECG changes, positive biomarkers, high risk non-invasive study).
 - Chest pain (stable) with no EKG changes
 - Referral to Urgent Care (and/or ER) for work up and observation
 - Repeat EKG
 - Chest x-ray
 - CPK/MB or Troponin I every eight (8) hours, three (3) times.
 - If Bio Markers abnormal – arrange for admit to hospital – admit to HPN internist.
 - TIMI Risk stratification by SMA or Network Hospitalists according to established protocol is to be conducted. Patients TIMI Risk Scored ≤ 2 may be discharged for 24 to 48 hour outpatient stress testing per established guidelines. TIMI Risk Score > 2 should be admitted.
 - Therapeutic trial to include Aspirin, SL NTG, beta-blocker, ACE-Inhibitors and calcium channel blockers (patient's intolerant to beta-blockade) and/or nitrates as indicated.

Evaluation of Congestive Heart Failure Guidelines

Identification of patients with Congestive Heart Failure: the initial screening and diagnostic work up of patients suspected of having the syndrome of Congestive Heart Failure is to be performed by the patient's primary care physician (PCP). Cardiology consultation is to be obtained only after the screening and therapeutic measures below have been accomplished, if the diagnosis of Congestive Heart Failure is substantiated. (Telephone consultation is appropriate at any time with on-call Cardiologist.)

Evaluation for Congestive Heart Failure

Patients presenting to PCP with signs and symptoms of new onset CHF without prior history should be transferred via EMS for inpatient work-up.

Patients with history of congestive heart failure with suspected exacerbation should undergo initial screening by PCP as follows:

Individual screening of patients by PCP for initial history and physical examination, including: neck veins, carotids, lungs, heart with specific note of presence or absence of S3 or S4 gallops and murmurs, abdominal organ size and tenderness, check pulses all extremities, presence or absence of peripheral edema. Document physical examination at every visit.

Diagnostic evaluation to include:

- ◆ EKG
- ◆ Referral for Echocardiography (to evaluate segmental wall motion abnormality, left ventricular dysfunction and/or valvular heart disease).
- ◆ Chest x-ray.
- ◆ Laboratory testing: T4, TSH, CBC, Chemistry Panel and Urinalysis. Digoxin level if indicated and BNP.
- ◆ Referral for Holter monitor if indicated.
- ◆ Referral for stress testing if indicated (ischemia suspected).
- ◆ Therapy
 - In patients with acute CHF exacerbation, stop all unnecessary medications and negative inotropes; i.e., diltiazem, verapamil.
 - Control blood pressure aggressively. ACE-Inhibitors and ARBs are first line therapy.
 - - ACE inhibitors to be titrated to highest dose tolerable for cardiac afterload reduction.
 - Diuretics to be utilized to control fluid overload ONLY. Carefully evaluate electrolyte renal function and hydralazine levels. Note fluid depletion, as ACE inhibitors decrease need for diuresis.
 - Long acting nitrates if needed to further reduce afterload and preload.

NOTE: Laboratory evaluations to be obtained at least every six (6) months to include: Electrolytes, Renal Panel (BUN, Creatinine), obtained one (1) week and one (1) month after change in chronic dose of diuretic.

- Potassium supplements replacement therapy as indicated.
- Ensure that all patients have anatomic diagnosis for their congestive heart failure.
- Patient educational program to include dietary, exercise, risk factor modification, heart failure management and monitoring techniques to be done by PCP or referral to appropriate specialist, i.e., Dietician).
- ♦ Referral Guideline (to Cardiology)
 - Referral to SMA cardiology for patients with CHF exacerbation is appropriate if patient's symptoms are stable and oxygenation is appropriate.
 - Patients with left ventricular dysfunction once evaluation has been completed as above and therapy with ACE inhibitors (if not contraindicated) is instituted. (Referral must include copies of all pertinent, generated data.)
 - Patients with rest symptoms that may need immediate hospitalization and stabilization should be seen at Urgent Care Observation Unit or transferred to hospital via EMS.
 - Referral of patients with normal left ventricular systolic function but abnormal diastolic function and hypertension and documented CHF is appropriate.
 - Referral of patients without rest symptoms without work up as defined above is not appropriate.
 - Referral of patients without documented CHF by methods above, normal left ventricular function and COPD is not appropriate.

Evaluation of Cardiac Dysrhythmias Guidelines

Identification of patients with Cardiac Arrhythmias: The initial screening and diagnostic work up of patients suspected of having the syndrome of Cardiac Arrhythmias is to be performed by the patient's primary care physician (PCP). Cardiology consultation is to be obtained only after the screening and therapeutic measures below have been accomplished, if the diagnosis of cardiac arrhythmias is substantiated. (Telephone consultation is appropriate at any time.)

Evaluation for Palpitations

- ♦ Individual screening of patients for initial complete history and physical to be completed by PCP.
 - Near syncope episodes
 - Syncope episodes
 - Arrhythmia

Diagnostic evaluation to include:

- Medication review (AV nodal blocking agents, Beta agonists/sympathomimetics)
- Lifestyle Review (activity level, hydration status, caffeine intake, tobacco use, illicit drug use, stimulant or diet medication use, etc.)

- EKG
- Holter Monitor/Event Recorder
- CBC, Thyroid panel, Chemistry panel, Toxicology screen if suspected drug use
- Echocardiogram if EKG abnormal and/or murmurs heard
- Treadmill stress test if history of atherosclerosis.
- ♦ Therapy
 - Treatment of the positive treatable risk factors and/or symptomatology.
 - Cardiology referral is appropriate for malignant arrhythmias only. Referral is not warranted for benign arrhythmias or palpitations unassociated with symptomatology.
- ♦ Referral guideline (to Cardiology)
 - Patient with palpitation associated with syncopal episode and/or malignant arrhythmias is appropriate.
 - APCs do not warrant treatment or referral.
 - PVCs, whether unifocal or multifocal, couplets regardless of frequency in patients without atherosclerosis or left ventricular dysfunction (as defined by history, treadmill and/or echocardiography) are not generally treated and do not warrant referral.
 - If no arrhythmias are seen, referral is not warranted, nor is treatment.

Evaluation for Atrial Fibrillation

- ♦ Individual screening of patients for initial complete history and physical to be conducted by PCP.
- ♦ Diagnostic evaluation to include:
 - Chest x-ray
 - EKG
 - Echocardiogram
 - Thyroid Panel, Chemistry Panel
- ♦ Therapy
 - Treatment of contributable underlying disease states
 - Initiation of Beta-blocker or Channel Blocker to control rate.
 - Initiation of anticoagulation based on **CHA₂DS₂-VASc score**
 - No risk factors – Aspirin 81 to 325 mg daily
 - One risk factor – Aspirin 81 to 325 mg daily, warfarin (INR 2.0 to 3.0, target 2.5) or NOAC. If no contraindication exists.

- More than 1 risk factor – warfarin (INR 2.0 to 3.0, target 2.5, but if mechanical valve target INR greater than 2.5 is goal) or NOAC
- Cardiology referral is appropriate once evaluation has been completed as above and therapy initiated.
- Referral **must** include copies of all pertinent, generated data at the time of referral.

Evaluation for Paroxysmal Supraventricular Tachycardia (SVT)

- ♦ Individual screening of patients for initial complete history and physical to be conducted by PCP.
- ♦ Diagnostic evaluation to include:
 - EKG and/or Holter monitor/Event Recorder with documented arrhythmia
 - Echocardiogram
 - Thyroid Panel, Chemistry Panel, Medication/Supplement review
 - Referral for treadmill stress test if coronary risk factors present, or if patient complains of exercise-induced arrhythmias.
- ♦ Therapy
 - Treatment of contributable underlying disease states.
 - Initiation of calcium channel blockers (Verapamil or Diltiazem) or beta-blockers.
 - Cardiology referral is appropriate once evaluation has been completed as above and therapy initiated.
 - Referral **must** include copies of all pertinent, generated data at the time of referral. Referral Guidelines (to Cardiology)
 - Cardiology referral is appropriate when:
 - Recurrent episodes occur after treatment
 - Pre-excitation is present on EKG (refer prior to initiation of therapy).
 - Left ventricular dysfunction is present.

Referral **must** include copies of all pertinent, generated data at the time of referral.

Evaluation for Atrial Flutter

- ♦ Individual screening of patients for initial complete history and physical to be conducted by PCP.
- ♦ Diagnostic evaluation to include:
 - Chest x -ray
 - EKG and/or Holter monitor/Event Recorder documenting pre-excitation or arrhythmia
 - Echocardiogram

- Thyroid Panel, Chemistry Panel
- ♦ Therapy
 - Treatment of contributable underlying disease states.
 - Initiation of Beta-Blockers or Ca 2+ Channel Blockers to Control Rate (refer pre-excitation to cardiology prior to initiating therapy if symptoms are minor)
 - Cardiology referral is appropriate once evaluation has been completed as above and therapy initiated.
 - Referral **must** include copies of all pertinent, generated data at the time of referral.

Evaluation for Ventricular Tachycardia

- ♦ Patients found in Ventricular Tachycardia need Hospitalization and cardiology consultation as inpatients.
- ♦ Individual screening of patients for initial complete history and physical to be conducted by ER physician once patient stabilized.
- ♦ Diagnostic evaluation to include:
 - EKG
 - Echocardiogram
 - Thyroid Panel, Chemistry Panel
 - Appropriate stress testing or angiography depending on presentation.
- ♦ Therapy
 - Treatment of contributable underlying disease states (revascularization if ischemic, correction of metabolic derangements, etc.)
 - Outpatient referral (after inpatient treatment and stabilization) must include copies of all pertinent, generated data at the time of referral.

Evaluation for Heart Block

- ♦ Individual screening of patients for initial complete history and physical to be conducted by PCP.
- ♦ Diagnostic evaluation to include:
 - EKG and/or Holter/Event Recorder monitor documenting arrhythmia
 - Medication list
 - Referral for Echocardiogram.
 - Thyroid Panel, Chemistry Panel.
- ♦ Therapy

- First (1st) Degree Heart Block
 - Asymptomatic 1st degree block does not require treatment or consultation.
- Second (2nd) Degree Heart Block
 - Discontinue contributing medications if possible: Digoxin, verapamil, diltiazem, nifedipine, beta-blockers.
 - Cardiology referral is appropriate if discontinuation of contributing medication does not correct problem.
- ♦ Referral **must** include copies of pertinent, generated data relevant to evaluation.
- ♦ Third (3rd) Degree Heart Block Referral
 - Discontinue contributing medications if possible: Digoxin, verapamil, diltiazem, nifedipine, beta-blockers.
 - If patient is symptomatic (syncope, lightheadedness, low blood pressure) immediate EMS transfer to the ER is appropriate.
 - Arrange admit to hospital.
 - Arrange for evaluation by covering cardiologist.
 - Permanent pacemaker insertion.
 - Cardiology referral for follow-up is appropriate.

Evaluation for Right Bundle Branch Block (Complete)

- ♦ Individual screening of patients for initial complete history and physical to be conducted by Primary Care Physician (PCP). Initial evaluation consists of the following:
 - Evaluation of coronary risk factors
 - History of pulmonary disease
 - History of congenital heart disease
 - Examination of neck veins, lungs, cardiac examination to include presence or absence of murmurs.
 - Abdominal examination including liver size.
 - Evaluation of extremities including pedal pulses and presence or absence of edema.
- ♦ Diagnostic evaluation to include:
 - EKG
 - Chest x-ray
 - Referral for Echocardiogram
 - Referral for treadmill stress test if ischemia is suspected
- ♦ Referral Guidelines

- ♦ Cardiology referral warranted if atrial septal defect or positive treadmill for ischemia found.
- ♦ Referral **must** include copies of all pertinent, generated data with referral, *except data previously generated by CCN.*

Evaluation of Left Bundle Branch Block

- ♦ Individual screening of patients for initial complete history and physical to be conducted by PCP. Initial evaluation consists of the following:
 - Evaluation of coronary risk factors.
 - History of pulmonary disease.
 - History of congenital heart disease
 - Examination of neck veins, lungs, cardiac examination to include presence or absence of murmurs.
 - Abdominal examination including liver size.
 - Evaluation of extremities including pedal pulses and presence or absence of edema.
- ♦ Diagnostic evaluation to include:
 - EKG
 - Chest x-ray
 - Referral for Echocardiogram
 - Referral for Persantine Cardiolite if ischemia is suspected.
- ♦ Referral guidelines (Cardiology)
 - Cardiology referral warranted if left ventricular ejection fraction <45% or if ischemia diagnosed by non-invasive testing.
 - Referral **must** include copies of all pertinent, generated data with referral. .
 - **Patients presenting with chest pain and new LBBB should be treated as acute MI until proven otherwise. Transfer of patients with ongoing chest pain and new LBBB via EMS to ER is appropriate.**



12.3 CARDIOVASCULAR/THORACIC SURGERY REFERRAL GUIDELINES

Contracted Group: Cardiovascular Surgery of Southern Nevada

For Appointments:

Location	Numbers
5320 S Rainbow Blvd, #282 Las Vegas, NV 89118	Phone: (702) 737-3808 Fax: (702) 737-7364

All referrals and patient medical records (pertaining to the specified condition) are to be faxed or attached to online referral. Physician notes are required for any diagnosis indicated on the referral.

Patients are to bring required films and other diagnostic test reporting (if applicable) to their appointments.

The following diagnostics are needed prior to cardiovascular consultations:

Abdominal Aortic Aneurysm:

- CT Angiogram of the abdomen/pelvis (report & films required) showing aneurysm 5 cm or larger. (4.5 cm if referred by Cardiologist)

CAD/Valve Disease:

*** Must be referred by Cardiology.

- Cardiac Cath (report & films required)
- Echocardiogram/Stress Test (report required)
- PFT Screening (report required) if done
- Carotid Ultrasound (report required) if done

Carotid Stenosis:

- CT Angiogram of neck (report & films required)
OR
- Carotid Angiogram (report & films required)

*If ultrasound shows stenosis >65% obtain angiogram; if stenosis is <65% refer to Neurology.
Asymptomatic: If ultrasound shows stenosis >70% obtain angiogram; if stenosis is <65% ultrasound every year.

Chronic Venous Insufficiency:

***Refer to Las Vegas Surgical Associates

Must have documentation of failure of conservative therapy (i.e., compression stockings, elevation, diuretics) or actual beginning of ulceration formation.

- Lower extremity Doppler/flow studies

Esophageal Cancer/Stricture:

***Must be referred by GI

- Endoscopy (EGD) (report required)
- CT Scan of the chest/abdomen/ (report & films required)
- Esophageal ultrasound is suggested
- Pathology report (report required)
- PET scan (report & films required) if done

Heller Myopathy:

***Must be referred by GI

- CT scan chest/abdomen/pelvis (report & films required)
- Pathology report (report required)

Hyperhidrosis:

- Chest x-ray (report & films required)

Lung Cancer/Mass/Nodule:

- CT scan of the chest (report & films required)
- Pathology report if needle biopsy (FNA) or bronchoscopy has been done (report required)
- PFT/DLCO full set with room air ABG's (reports required)
- PET Scan (report & films required) if done

Peripheral Vascular Disease:

- Arterial ultrasound (report & films required) & ABI's

Renal Artery Stenosis:

***Must be referred by Nephrologist

- Aortogram with bilateral renal angiogram (report & films required)

Thoracic Aortic Aneurysm:

Ascending Thoracic Aortic Aneurysm:

- Echocardiogram and CTA chest which must measure > 5cm (films required) size could be less if referred by Cardiologist

Descending Thoracic Aortic Aneurysm:

- CTA chest, abdomen, and pelvis which must measure > 5.5cm (films required) size could be less if referred by Cardiologist

Varicose Veins:

- Venous reflux ultrasound (required prior to scheduling consult) must be done standing.



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12.4 DERMATOLOGY REFERRAL GUIDELINES

Contracted Group: See below

Group Name	Addresses/Phone Numbers		
Couture Dermatology	2615 Box Canyon Dr. Las Vegas, NV 89128 (702) 998-9001		
Las Vegas Skin & Cancer Clinic Centralized Appts: (702) 933-0225	2650 N Tenaya Way, #208 Las Vegas, NV 89128 (702) 360-2100	630 S Rancho Dr., #E Las Vegas, NV 89106 (702) 258-1001	4488 S. Pecos Rd Las Vegas, NV 89121 (702) 436-1001
	8205 W. Warm Springs Rd., #190 Las Vegas, NV 89113 (702) 588-6730	880 Seven Hills Dr., #260 Henderson, NV 89052 (702) 990-4800	
	1250 S Buffalo Dr., #170 Las Vegas, NV 89117 (702) 255-7924	6850 N Durango Dr., #100 Las Vegas, NV 89149 (702) 589-3100	
Surgical Dermatology & Laser Center	6460 Medical Center St., #350 Las Vegas, NV 89148 (702) 255-6647		

The specialists will keep the PCP fully informed of their patients' progress with notes, letters, and phone consultations as needed. All recommendations of treatment will be coordinated with the PCP, so their continuing care of the patient will progress as smoothly and effectively as possible. The PCP is encouraged to call the consultant about any questions they have regarding the recommendations of the specialist for their patient.

In cases of melanoma or other more aggressive malignancies requiring referral to other specialists (ie. surgeon, oncologist, radiation oncologist), HPN/Senior Dimensions will provide a case manager to coordinate and facilitate care in order to assure expeditious patient care and follow up.

Dermatology Services Do Not Require Prior Authorization
Suggested PCP Guidelines are general suggestions only and may be modified based on physician judgment in individual cases.

Inappropriate referrals include:

- Referred for general skin exam of non-specific nature.
- Removal of benign lesions such as skin tags, benign moles, seborrheic keratosis, cysts and lipomas.
- Patients who have "seen the dermatologist before", and request a referral, either by phone or in person, to have a skin check without prior evaluation by PCP to evaluate necessity.

- Referrals in which patient is told the dermatologist will “check all your skin problems and treat them”, without prior evaluation of conditions by the PCP. PCPs should never discuss what the dermatologist/dermatology physician assistant will treat. Referrals are for evaluation and consideration of any possible necessary treatment. PCPs should never state that a specific lesion should or will be removed by dermatology.
- Referral of any skin tumors over 2 cm. in size. Lesions over 2 cm. are referred to general or plastic surgery.

Referral guidelines for the following diagnoses are:

Routine exam of skin in patients without skin cancer risks

PCP: Initial exam includes evaluation of shape, size, and color of skin lesions and decision if any abnormality exists. Documentation of a suspicious lesion should be noted in chart.

Referral warranted: Patient should be referred if abnormal lesions are noted. The referral form must include location and suspected diagnosis of suspicious lesion.

Referral not warranted: Removal of benign moles, lipomas, skin tags, epidermal cysts, pilar cysts or seborrheic keratosis. If the patient desires removal of these lesions, then the PCP should advise the patient that this is not covered under his/her insurance. Since this is not a covered benefit, the PCP may choose to remove these lesions themselves. Patient needs to be informed that removal of these lesions by dermatology are at the patient's expense to be paid at the time of service.

Evaluation of patients with precancerous and cancerous lesions and past history of non-melanoma skin cancer

PCP: As a general rule, PCP should screen patients with a complete skin exam every six months or annual exams if patient has been free of new lesions for two years. The PCP may modify these recommendations on frequency of their skin checks as they deem appropriate in individual cases. The PCP should educate patient about sun protection, self-examination of the skin, and the importance of regular skin examinations. Therapy of minor actinic lesions may be treated by PCP with a variety of recognized methods as deemed appropriate.

Referral warranted: Patients with lesions that are suspicious for non-melanoma skin cancer should be referred to dermatology for evaluation prior to having a biopsy by the PCP. The referral form must note the location and suspected diagnosis of the lesion. If a biopsy has been done, patient must bring the pathology report with his referral. If a melanoma is highly suspected, referral to dermatology is indicated.

Routine exam of patients with history of melanoma or a family history of melanoma

PCP: Patient should be examined every three months for the first year after melanoma diagnosis, and every six months afterward for five years, and then annual exams are recommended.

The exam includes:

- Checking the melanoma surgery site
- General examination of the skin for new or changing lesions
- Palpation of regional lymph nodes
- Follow-up by an oncologist may be needed if melanoma is advanced or greater than 0.75 mm. Breslow depth.

Referral warranted: Any lesions suspicious for melanoma should be referred to dermatology for biopsy. The location of the lesion must be noted on the referral note.

Psoriasis

PCP: Perform the initial history and physical and in mild and moderate cases, the PCP may institute therapy which may include appropriate topical monotherapy or combination topical therapy.

- CBC & Chemistry profile performed prior to referral to dermatology

Referral warranted: Dermatology referral is indicated for patients who do not respond to three months of therapy or patients with severe disease or erythroderma. The referral form should detail past treatment attempts, and patient must bring lab work with them.

Common warts

PCP: Initiate therapy with a variety of topical or physical modality options based on the comfort level of the PCP.

Referral warranted: Dermatology referral is appropriate if patient has failed three months of conservative therapy or up to three episodes of cryosurgery. Referral note must include delineation of failed therapy.

Acne vulgaris

PCP: Treat Grade I-III for three months with a variety of topical therapeutic options and oral antibiotics if warranted.

Referral warranted: Dermatology referral is indicated if patient has inadequate response to combination treatment after three months of therapy. Therapy must be documented on referral form.
Grade IV (Severe cystic acne) – PCP will evaluate patient, and initiate referral to dermatology.

Eczema, Itching skin and Urticaria

PCP: Evaluate the patient with a complete history and physical. In mild to moderate cases, appropriate therapy may be initiated by the PCP.

Referral Warranted: For patients who do not respond to one month of therapy or patients with severe disease or erythroderma. The referral form must detail previous treatment attempts, and patient must bring any performed lab work with them.



12.5 EAR NOSE AND THROAT REFERRAL GUIDELINES
Contracted Group: Ear Nose and Throat Consultants (ENTC)

For Appointments:

Telephone Number: (702) 792-6700

Fax: (702) 792-7198

Locations:

3195 St. Rose Parkway, Suite 210
Henderson, NV 89052

7040 Smoke Ranch Road
Las Vegas, NV 89128

8840 W. Sunset Road, Suite A
Las Vegas, NV 89148

Important Note:

Please have Patients bring their films to their appointments as indicated below. In order for patients to be seen at the time of their appointment we will need requested documentation.

THROAT		
PLEASE send documentation for recurrent episodes		
DIAGNOSIS	EVALUATION	CONDITIONS FOR REFERRAL
PHARYNGEAL AND TONSILLOADENOID PROBLEMS Streptococcal Pharyngitis	1. Throat pain & odynophagia 2. Constitutional symptoms 3. Cervical Lymphadenopathy 4. Pharyngeal petechia 5. Throat culture	Seven or more episodes of streptococcal pharyngitis in a twelve-month period.
Acute Tonsillitis	Throat pain & odynophagia with <u>any</u> of the following Findings: 1. Fever 2. Tonsillar exudate 3. Lymphadenopathy 4. Positive Strep Test	Documented episodes: 7 or more in previous 12 Months, treated with antibiotics. 5 per year in 2 preceding years, treated with antibiotics - Persistent streptococcal carrier state with or without acute tonsillitis. - Peritonsillar Abscess (Acute)

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DIAGNOSIS	EVALUATION	CONDITIONS FOR REFERRAL
Chronic Tonsillitis	Frequent or chronic throat pain and odynophagia; may have any of the following findings: - intermittent exudates - adenopathy - improves with antibiotic	ENT referral is indicated if problem recurs following adequate response to therapy As for recurrent acute tonsillitis, 3 infections, treated with antibiotics, for 3 or more consecutive years.
Mononucleosis	Throat pain & odynophagia with: - fatigue - posterior cervical adenopathy - CBC, mono test (Required for referral)	Airway obstruction <u>Needs ER referral.</u> CBC MONO TEST
Adenoiditis	1. Purulent rhinorrhea 2. Nasal obstruction 3. Cough 4. May be associated with otitis media	1. As for tonsillitis 2. Persisting symptoms and findings after two courses of antibiotics
UPPER AIRWAY OBSTRUCTION: Tonsillar and/or adenoid hyperplasia	1. Mouth breathing 2. Nasal obstruction 3. Dysphonia 4. Severe Snoring with or without apnea 5. Daytime fatigue 6. Dysphagia 7. Weight and/or height below normal for age 8. Dental arch maldevelopment: narrow arched palate, cross bite deformity 9. Adenoid facies 10. Cor pulmonale 11. Polysomnogram	ENT referral indicated with significant symptoms of upper airway obstruction, Polysomnogram Results <u>If Acute ER Referral Should be Made</u>
Tonsillar Hemorrhage	Spontaneous bleeding from a tonsil	ENT/ER referral is indicated
Neoplasm	Progressive unilateral tonsil enlargement	ENT referral is indicated
Hoarseness, Associated with respiratory obstruction	Stridor	IMMEDIATE <u>ER</u> REFERRAL IS INDICATED IN ALL CASES
Hoarseness without associated symptoms or obvious etiology	1. History of tobacco and/or alcohol use 2. Evaluation, when indicated, for: - Hypothyroidism - Diabetes mellitus - Gastro-esophageal reflux - Rheumatoid disease - Lung neoplasm - Esophageal or pharyngeal neoplasm	ENT referral is indicated if hoarseness persists more than <u>two weeks</u> despite medical therapy

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DIAGNOSIS	EVALUATION	CONDITONS FOR REFERRAL
DYSPHAGIA	GI Consultation Barrium Swallow (General Dysphagia referral go to GI)	ENT referral indicated for: 1. Foreign body suspected in the pharynx/larynx (esophageal foreign bodies NOT for ENT) 2. Dysphagia in children 3. Dysphagia assoc. with hoarseness 4. Barrium Swallow Results for Adults without hoarseness.
NECK MASS • Inflammatory	1. Head and Neck examination- Dental source? 2. CT NECK with contrast and Fine Needle Aspirate with/without Ultrasound guidance (needed for referral) 3. CBC 4. Cultures if indicated 5. TB test 6. Inquire about possible cat scratch 7. HIV testing if indicated 8. Toxoplasmosis titre if indicated	ENT referral is indicated if: Mass persists for 2 weeks without improvement after medical management (PCP treatments) URGENT referral if painless progressive enlargement URGENT referral if suspicion of metastatic carcinoma (PT MUST BRING CT FILMS and FNA RESULTS TO BE SEEN)
NECK MASS • Non-inflammatory	Complete head and neck examination indicated If lower neck, thyroid evaluation may include: • Thyroid function studies • Thyroid ultrasound • Thyroid uptake and scan • Needle aspiration biopsy <u>Open biopsy of neck mass is contra indicated in all cases</u> CT Neck with contrast Fine Needle Aspirate with or without Ultrasound guidance	ENT referral is indicated other than for THYROID or PARATHYROID disorders PT MUST BRING CT FILMS and FNA Results TO BE SEEN

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DIAGNOSIS	EVALUATION	CONDITONS FOR REFERRAL
SALIVARY GLAND DISORDERS Parotiditis	1. Assess hydration of patient 2. Palpate for stones in floor of mouth 3. Observe for purulent discharge from salivary ducts when palpating involved gland 4. Evaluate mass for swelling, tenderness, inflammation 5. CT of Neck with contrast.	ENT referral indicated : 1. Poor antibiotic response within one week of diagnosis 2. Calculi or mass suspected on exam and CT (Pt MUST BRING CT FILMS <u>TO BE SEEN</u>) 3. Abscess formation-immediate referral
Salivary gland mass	1. Complete head and neck examination 2. Evaluate facial nerve function 3. MRI scan may be considered or Ct with contrast <u>Open biopsy of salivary mass is contra-indicated in all cases</u> 4. CT Neck with Contrast 5. Fine Needle Aspirate with or without Ultrasound Guidance.	<u>ENT referral is indicated in all cases of salivary gland neck masses</u> PT MUST BRING CT FILMS AND FNA RESULTS <u>TO BE SEEN</u>.
SLEEP APNEA & SNORING	Symptoms of obstructive sleep apnea may include: 1. Disturbed sleep 2. Documented apnea during sleep 3. Fatigue on waking 4. Headache on waking 5. Daytime fatigue 6. Sleep Medicine Eval Evaluation may include: • Obesity • Hypothyroidism • Hypertension • Cardiac disturbances • Polysomnography	ENT referral indicated after 1 month CPAP home trial 1. Evaluation of upper airway and nasal obstruction 2. Abnormal Polysonogram and considering surgical options AFTER CPAP trial and Sleep Medicine Eval 3. Elective management of snoring in absence of sleep apnea (Pt. <u>needs to bring copy of studies</u>)

NASAL AND SINUS PROBLEMS, ADULT

Caveats:

ENTC does not have access to SMA radiology or labs

Definitive sinus diagnosis requires CT scan; **CT must be done at least 2 weeks after acute episode** (CT sinus without contrast) Please have patient bring films (not just reports) or **patient cannot be seen**

DIAGNOSIS	EVALUATION	CONDITONS FOR REFERRAL
EPISTAXIS (NOSEBLEED); PERSISTING OR RECURRENT	Determine whether: Bleeding is unilateral or bilateral Bleeding is anterior or posterior Any bleeding diathesis or hypertension Coagulation studies	1. Bleeding is posterior 2. Bleeding persists (Despite PCP Treatment) 3. Bleeding recurs 4. Discontinue anticoagulants prior to referral for packing removal
Chronic sinusitis/polyps	Symptoms: persisting or recurrent Nasal congestion (unilateral or bilateral) Post-nasal discharge Epistaxis Recurrent acute sinusitis Anterior facial pain/ headache (SINUS HEADACHE) CT scan of Sinus shows abnormal findings. <u>CT Scan normal, must f/u with PCP</u>	<u>*CT to BE DONE after treatment attempts*</u> 1. Recurrent three episodes per year, failing 3 antibiotic trials, one at least 14 days 2. Failure of medical management including use of oral and/or topical steroids, saline irrigations, decongestants, treatment of allergic rhinitis and antibiotics as above. 3. CT Scan Sinuses without contrast after failing medical management as above. (PATIENT MUST BRING FILMS). CT results must indicate more than minimal or mild mucosal disease or small cyst polyp.
Deviated Septum	Symptoms: Nasal congestion (unilateral or bilateral) Post-nasal discharge Epistaxis Recurrent sinusitis Anterior facial pain headache. Physical Examination Confirm w/ CT Sinus and r/o associated sinus pathology	ENT referral if medical allergy management failure and exam shows deviated septum.

DIAGNOSIS	EVALUATION	CONDITONS FOR REFERRAL
Allergic Rhinitis/Post Nasal Drip	Symptoms: Seasonal or perennial; congestion Watery discharge Sneezing fits Watery eyes Itchy eyes/throat. <u>Physical Examination:</u> boggy swollen bluish turbinates Allergic "shiners" "Allergic salute."	Refer to ALLERGIST <u><i>If suspicious of Sinusitis, see above.</i></u>
Acute nasal fracture	1. Immediate changes: edema, Ecchymosis, epistaxis. 2. Evaluate for associated nasal congestion, septal fracture of septal hematoma. 3. Nasal bone X-rays usually positive.	1. Immediate referral if possible septal hematoma (significant airway obstruction). 2. ENT referral in approximately 7-10 days if external nasal deformity, septal deformity, or breathing problem. <u>(ENT DOES NOT CONTRACT FOR FACIAL BONE FRACTURES EXCEPT FOR NASAL BONES)</u>

EAR PROBLEMS, CHILDHOOD

Caveats:

The so called "light reflex" is not a valid indicator of ear health

Absence of the so-called "light-reflex" is not a valid indicator of ear disease

In a crying child, one may see uniform injection of tympanic membrane without infection

Otoscopic examination is NOT capable of evaluating middle ear negative pressure

Otoscopic examination is often NOT adequate for identifying non-infected middle ear effusion

Otoscopic examination is often NOT adequate for identifying tympanic membrane retraction

Pneumo-Otoscopic examination improves reliability for identifying middle ear effusion/pressure/retraction

Tympanometry provides high reliability for identifying middle ear effusion/pressure (though it is not infallible)

DIAGNOSIS	EVALUATION	CONDITONS FOR REFERRAL
ACUTE OTITIS MEDIA "Ear infection"	1) Symptoms: ear pain, decreased hearing, ear drainage, fever 2) <u>Physical Examination:</u> Inflamed tympanic membrane TM, desquamated epithelium on TM, bulging TM, middle ear effusion 3) <u>Audio</u> (not required if A & B are present) tympanogram may show positive or negative pressure 4) <u>Caveat:</u> Tender, swollen ear canal usually indicated external otitis rather than otitis media	Chronic otitis media criteria 1) Secondary antibiotic treatment fails 2) Complications are noted mastoiditis, facial weakness, dizziness, meningitis

2018 HPN Provider Summary Guide

DIAGNOSIS	EVALUATION	CONDITONS FOR REFERRAL
CHRONIC OTITIS MEDIA i.e., persistent effusion or negative middle ear pressure, with or without recurrent acute otitis media	MAY HAVE NO SYMPTOMS: pneumotoscopy and/or tympanogram are crucial 1) <u>Symptoms</u> : ear pain, decreased hearing, ear drainage 2) <u>Physical Examination</u> : (may include) TM discolored thinned, or retracted; bubbles behind TM, Pneumo-otoscopy reveals sluggish or retracted TM. 3) <u>Audio</u> : tympanogram may show effusion (type B) or negative pressure (type C)	1) Recurring otalgia or hearing loss (3 episodes in 6 months) 2) Effusion, TM retraction, perforation, or negative pressure persist > 3 months 3) Ear discharge (persisting or recurrent) 4) Abnormal tympanogram and/or audiogram after 3 months
ACUTE EXTERNAL OTITIS "Swimmers Ear"	1) <u>Symptoms</u> : ear pain, significant EAR TENDERNESS, swollen external canal, hearing may or may not be diminished 2) <u>Physical Examination</u> : Ear canal always tender, usually swollen, may be inflamed. Often unable to visualize TM because of debris or canal edema 3) <u>Caveat</u> : Occasional cases have a large fungal pad indicating fungal external otitis-often spores visible	1) Canal is swollen shut and wick cannot be inserted 2) Cerumen impaction compounding external otitis 3) Unresponsive to initial course of wick and anti-bacterial drops <u>Avoid Cortisporin Otic due to high allergy rate.</u>
HEARING LOSS BILATERAL, SYMMETRICAL, ADULTS (FOR CHILDREN, SEE ABOVE)	<u>Symptoms</u> : diminished hearing 1) Cerumen blockage 2) Middle ear effusion 3) Normal findings	1) Cerumen, or hearing loss persistent after treatment by PCP 2) Effusion persists more than 8 weeks
UNILATERAL HEARING LOSS	1) <u>Symptoms</u> : difficulty hearing, or difficulty localizing sound, or problems hearing only in a crowded environment 2) <u>Physical Examination</u> : may be normal or may have cerumen or tympanic membrane abnormality	Referral for OTO-HNS evaluation is indicated in all cases of unilateral hearing loss, after vascular etiology ruled out, unless the problem resolves with elimination of cerumen

2018 HPN Provider Summary Guide

DIAGNOSIS	EVALUATION	CONDITIONS FOR REFERRAL
<u>Sudden Hearing Loss</u>	<u>Loss of hearing with or without vertigo</u>	<u>Urgent referral to ENT</u> if not resolved with cerumen removal See above for Effusion
TINNITUS 1)Chronic bilateral 2)Unilateral or recent onset 3)Pulsatile	1) Normal tympanic membranes or cerumen 2) Normal tympanic membranes or cerumen 3) Mass behind tympanic membrane? If positive, need CT temporal bones w/o contrast	1) No referral indicated unless associated hearing loss, dizzy or unilateral Tinnitus. 2) If persists more than 8 weeks, Oto-HNS referral and hearing evaluation indicated
DIAGNOSIS	EVALUATION	CONDITIONS FOR REFERRAL
DIZZINESS 1)Orthostatic 2)Vestibular neuronitis 3)Chronic or episode	1) <u>Symptoms</u> mild brief, only standing up (usually A.M.) 2) Associated with URI; may be positional or persisting 3) Significant imbalance and/or vertigo; may have associated hearing loss, tinnitus, ear pressure, nausea 4) If no hearing loss, <u>pt must be referred for Balance Eval, get VNG and Neurology Eval.</u> if there is hearing loss, follow hearing loss guidelines	1) ENT referral for vertigo (<u>sensation of spinning</u>) General dizziness needs work up with neurologist, cardiologist or PCP. 2) Associated hearing loss, vertigo increased severity or persistence > 6 weeks 3) <u>Bring Balance Center Results, VNG Results and Neurology Evaluation Results</u>

Skin Lesions of Head/Neck: Dermal lesions are not contracted with ENT

Thyroid Mass: Refer after ultrasound guided FNA results and endocrine evaluation completed.



12.6 ENDOCRINOLOGY REFERRAL GUIDELINES
Contracted Group: Southwest Medical Associates

Southwest Medical Associates Endocrinology Department provides consultation and treatment for diabetes, thyroid conditions, glandular diseases and other endocrine disorders in adults. Our team includes Physicians, Nurse Practitioners, Certified Diabetes Educators and Registered Dietitians.

**4750 W. Oakey Blvd
Las Vegas, NV 89102**

Department Contact Information: Phone (702) 877- 5306 fax (702) 560-2020

Referrals Information: Phone (702) 877-5074 fax (702) 667-4600

Hours: 8 a.m. - 5 p.m., Monday through Friday. Closed daily 12 p.m. - 1 p.m.

Appointments are by referral only. Please allow 5-7 business days for your referral to be processed.

Expedited referrals require a physician to physician consult. 702-560-2020

All referrals should include a specific question to be answered by the Endocrinology Department, recent labs related to the diagnosis and information on any prior treatment attempts.

Examples of Appropriate Referrals to Endocrinology:

- Diabetes with HbA1C greater than 9% or HbA1C between 7%-9% despite the best efforts of the PCP at controlling the blood sugars
- Diabetes requiring complex insulin regimens
- Diabetes with uncontrolled hypoglycemia or pregnancy
- Gestational Diabetes requiring management of blood sugars and insulin regimens throughout pregnancy **(Please refer member to High Risk Pregnancy Center)**
- Gestational Diabetes Education (Patients should be educated on monitoring their blood sugars and be set up with meters and supplies prior to appointment). **(Please refer member to High Risk Pregnancy Center)**
- Hyperparathyroidism (with lab work performed without patient being on a calcium supplement or thiazide diuretic)
- Hyperthyroidism with TSH and Free T4 (all labs to be completed within the month prior to submitting the referral)

- Hypogonadism (Male) with Testosterone and Free Testosterone completed by Equilibrium Dialysis (morning fasting), LH, Prolactin, TSH and Free T4 (all labs to be completed within the month prior to submitting the referral)
- Pituitary Disease
- Pituitary Related Amenorrhea with fasting Prolactin Level, Estradiol, FHS, TSH, Free T4, fasting blood sugar and serum pregnancy test (all completed within the last month prior to submitting the referral)
- Thyroid Cancer follow up with TSH, Free T4, Thyroglobulin and Anti-Thyroglobulin (all labs completed within the 3 months prior to submitting the referral)
- Thyroid Cancer (new diagnosis) with thyroid biopsy completed prior to submitting referral
- Thyroid Nodules with thyroid ultrasound and FNA under ultrasound guidance completed prior to submitting referral

Patients with diabetes will be returned to Primary Care for glycemic management once HbA1C is at goal (<7%) or the Endocrinology provider feels that patient has achieved the best control he/she can achieve.

Diabetes education is only offered to patients whose condition is being managed by an SMA Endocrinology provider. Endocrinology can not accept referrals for education only (with the exception of gestational diabetes).



12.7 GASTROENTEROLOGY REFERRAL GUIDELINES

Contracted Group: SMA Gastroenterology Clinic

For Appointments:

4750 W. Oakey Blvd., Suite 3B
Las Vegas, NV 89102
Phone: (702) 877-5199
Fax: (702) 304-7426
Referrals: (702) 877-5024 or (702) 877-5022
Hours: 8 a.m. - 5 p.m., Monday through Friday.

The goal of the Gastroenterology Clinic is to address the needs of the patients who are referred to the clinic by their Primary Care Physicians. The patient will be cared for in an organized systematic manner to promote a positive health outcome through diagnostics and treatment of their gastrointestinal symptoms. The Southwest Medical Gastroenterology Clinic is eager to assist in the care of your patients.

Appointments are by referral only. Please allow 5-7 business days for your referral to be processed. Expedited referrals require a physician to physician consult.

All referrals should include: a specific question to be answered by the Gastroenterology Department, recent labs related to the diagnosis, and information on any prior treatment attempts.

- All **Screening Colonoscopy** referrals must include documentation of cardiac & lung exam appropriate for H&P needed for surgery center.
- All testing must be ordered or completed prior to sending a referral to the Gastroenterology Department.
- Indicate in the note section of the referral the acuity status of the referral, i.e. **EXPEDITED, AT RISK or ROUTINE**. If other than ROUTINE, indicate the reason for the acuity.
- **Expedited referrals must be discussed provider to provider. Please call (702)-877-8314, state you have an EXPEDITED referral and ask to speak to a provider.**
- After approval of Expedited Referrals, patient will be contacted to schedule an appointment.
- Any patient receiving an **AT RISK or ROUTINE** referral should contact: (702) 877-5199 to schedule an appointment

Appropriate Referrals to Gastroenterology should include the following and/or answer the following questions:

Elevated Liver Enzymes/Hepatitis

- Viral Hepatitis Panel (355) completed within last 12 months
- Hep C dx requires a Heptimax or HCV-RNA
- RUQ Abdominal ultrasound is encouraged
- Is the patient jaundice?

Anemia- Chronic

- The following labs completed within the last 6 months to be attached with referral: CBC, Iron Profile, Folate, B12, Serum Ferritin

Anemia-Iron Deficiency

- The following labs are completed: CBC, Iron Profile

Abnormal Weight Loss

- Must specify amount of weight loss over a defined time period

Routine Colorectal Screening - Do Not use this Template if patient has any GI Symptoms (example: no blood in stool, no GERD)

- Does patient have hx of colon polyps?
- Is pt 50 years of age or older? If not, does pt have a family member with cancer at an early age?
- Does pt. have family history of colon cancer?
- Does pt. have any other GI issues?
- Does pt. have sleep apnea?
- Does Pt. have any cardio-pulmonary issues?

Dysphagia

- Does patient have food catching retrosternally?
- For oropharyngeal dysphagia/aspiration issues include a documented barium swallow and speech evaluation prior to referral

GI Dyspepsia/GERD

- Are patient's symptoms refractory to H-2 blockers or PPI?
- Does patient require long term (>2 months) with H2 blockers or PPI?
- For GERD – a documented trial of PPI x 6weeks is required.

Persistent Nausea/ Vomiting

- Negative pregnancy test for reproductive age females unless post menopausal x 2 years or documented hysterectomy
- Duration of symptoms - must be greater than 2 weeks

Abdominal Pain

- CBC, Chem Panel, Liver Profile, Lipase within last 90 days be attached
- Specify whether rectal exam has been performed.

GI Bleed/ Hemoccult Positive Stool / Blood in Stool

- CBC **within past 30 days-if HGB is equal to or <8, refer to Urgent Care**
- Indicate if pt. has melena, bright red blood rectally, hematemesis, hematochezia, heme + stools

Constipation

- Indicate if rectal exam performed
- Indicate which laxatives tried-none, bulk, softeners, non-stimulants, other

Chronic Diarrhea

- MUST have diarrhea for > 2 weeks duration



12.8 GASTROENTEROLOGY- PEDIATRIC REFERRAL GUIDELINES
Contracted Group: Pediatric Gastroenterology and Nutrition Associates (PGNA)

For Appointments:

Phone: (702) 791-0477

Fax: (702) 791-6831

Locations:

3196 S Maryland Pkwy, #309
Las Vegas, NV 89109

653 N. Town Center Dr., #412
Las Vegas, NV 89144

The goal of PGNA is to address the needs of patients referred by their primary care physicians. Appointments are by referral only, whereby the insurance plan mandates this, and even in cases in which the insurer is not required to give prior authorization, patients are encouraged to seek a referral from their primary care physician rather than self-referring.

Please allow 7 days for your referral to be processed. Expedited or STAT referrals must include a **physician to physician** call or contact, and must include on the referral the reason for the expedited or emergent need.

All referrals should include the specific reason for referral or question to be answered, any records addressing the particular question or diagnosis from the primary care office or from other specialists also involved in the patient's care, and all laboratory and imaging results, as well as prior treatment attempts and their outcomes.

Patients will be contacted by the office once a completed referral has been received, but patients should be encouraged to contact the office to schedule routine appointments.

Patients referred for growth or nutritional concerns must have a growth chart completed and submitted with the referral (attached to online referral or fax directly to PGNA).

Patients referred because of abnormal blood or laboratory results of any kind must have the results in question submitted with the referral.

Many times, it is appropriate for the primary care physician to begin the evaluation before the patient is seen in our clinic. For specific guidance as to what testing may be appropriate prior to referral, the primary care or referring physician is encouraged to contact one of our physicians directly. This will expedite patient care and avoid unnecessary testing or repetition of testing. In small children, efficiency is critical when ordering blood draws and exposing them to radiation, thus a coordinated effort needs to be made between referring physicians and our physicians.

**12.9 GENERAL SURGERY REFERRAL GUIDELINES****Contracted Groups: See below****Appointments:**

Group Name/Phone Number	Addresses		
Desert West Surgery (702) 383-4040	1111 Shadow Ln. Las Vegas, NV 89102	5375 S. Fort Apache Rd. Las Vegas, NV 89148	7200 Cathedral Rock Dr., #250 Las Vegas, NV 89128
General Surgery Associates (702) 382-8222	700 Shadow Ln, #370 Las Vegas, NV 89106		5380 S. Rainbow Blvd, #210 Las Vegas, NV 89118
Las Vegas Surgical Associates, LLP (702) 258-7788	10105 Banbury Cross Dr., #130 Las Vegas, NV 89144		2637 W Horizon Ridge Pkwy., #110 Henderson, NV 89502
	8930 W. Sunset Rd., #300 Las Vegas, NV 89148		1250 S Eastern Ave. Las Vegas, NV 89104
Southern Nevada Surgery Specialist (702) 914-2420	8285 W. Arby Ave., #225 Las Vegas, NV 89113	10001 S. Eastern Ave., #200 Henderson, NV 89052	999 Adams Blvd., #104 Boulder City, NV 89005

The following information based on diagnosis should be forwarded with a completed Universal Prior Authorization/Referral form:

<u>Diagnosis</u>	<u>Information Necessary/Testing Requirements</u>
Adrenal Glands	Pertinent office records, endocrine work up, CT scan
Breast	Mammogram, Ultrasound, spot view mammogram if indicated, is mass palpable? OR A referral from the Breast Care Program.
Colons	Colonoscopy, Barium Enema (optional), Biopsy with tattoo, precise location, measurement (this is to include rectal masses as well), pertinent office records, Flex Sigmoid. (No flex sigmoid without Barium Enema)
Cyst and Abscess	Size, location and duration, previous treatment. Size must be greater than 3 cm. Pertinent office records

Diagnosis	Information Necessary/Testing Requirements
Diverticulitis	CT, Colonoscopy, Barium Enema, labs, and pertinent office records.
Fissure	Physical exam, pain or bleeding, Colonoscopy, pertinent office records.
Fistulas	Location and pertinent office records.
Gallbladder	Ultrasound or hidascan and labs, LFT's, pertinent office records. CT scan acceptable if it shows gallstones.
Gynecomastia	Up to 18 years of age. Clinically significant functional impairment (ex. Chronic skin irritation, pain, related psychological disorder requiring therapy) Patients older than 18 years of age: 1. Gynecomastia does not recess after cessation of medications known to cause the condition. 2. Results of labs (serum creatinine, liver enzymes, thyroid function test, hormone evaluation). 3. Mammography or needle biopsy have ruled out breast cancer.
Hemorrhoids	Examination is required to confirm presence of hemorrhoids. If thrombosed no work up necessary. Colonoscopy is required if patient is over 40 years of age or if rectal bleeding is present. Please include pertinent office records and any previous treatment.
Hernia	Appropriate clinical exam necessary including co-morbidities. Pertinent office records.
Hiatal Hernia/Gerd	EGD, Esophageal manometry, 24 hr/48 hr Bravo PH study, full GI work up, pertinent office records.
Incisional Hernia	Operative report from initial surgery if it has been within the last five (5) years, possible CT scan, pertinent office records.
Lipoma	Accurate size and location, has it increased in size? Must be greater than 3 cm in size and <u>accurately</u> measured. Pertinent office records.
Livers	Pertinent office records, ultrasound of liver, labs, triple contrast CT scan, biopsy of liver with tumor markers

<u>Diagnosis</u>	<u>Information Necessary/Testing Requirements</u>
Pancreas	Pertinent office records, ultrasound of abdomen, labs, CT scan, GI test with tumor markers, pancreatic protocol (+/- endoscopic ultrasound)
Pilonidal Cyst	Appropriate clinical exam and pertinent office records.
Rectal Cancer	Full GI work up with tattoo and measurements, colonoscopy and biopsy results, CT scan, pertinent office records.
Spleen	CT scans, labs, hematology/oncology evaluation, possible BMA, pertinent office records.
Thyroid	Thyroid scan and ultrasound of neck, possible CT scan, Endocrine work up required, FNA thyroid nodules, pertinent office records.

Please also include:**Summary of previous treatments and consultations.****List of current and past medications.****All pertinent co-morbidities should be thoroughly documented.****Full History and Physical.****Indications for surgery.**



12.10 NEPHROLOGY REFERRAL GUIDELINES

Contracted Group: Kantor Nephrology Consultants, Ltd.

For Appointments:

Central Office:

1750 East Desert Inn Road, Suite 200
Vegas, Nevada 89169
Phone: (702) 732-2438
Fax: (702) 737-5043

Northwest Office:

2420 Professional Ct, #150 Las
Las Vegas, NV 89128
Phone: 702-853-0090
Fax: 702-853-0096

Southeast Office:

2850 W. Horizon Ridge Pkwy, #100
Henderson, NV 89052
Phone: 702-726-6344
Fax: 702-726-5828

Northeast Office:

2425 N. Lamb Blvd, #120
Las Vegas, NV 89115
Phone: 702-851-7766
Fax: 702-851-7760

Southwest Office:

6970 W. Patrick Lane, #140
Las Vegas, NV 89113
Phone: 702-588-7077
Fax: 702-588-7079

The following diagnostics are needed prior to nephrology referral and consultations

Proteinuria

- Evaluation with renal panel, complete urinalysis, a urine spot for protein and Cr clearance, and protein electrophoresis.
- Significant proteinuria with a 24-hour protein of >500 mg (without hematuria) should be referred for a nephrologic evaluation.
- Proteinuria of >300 mg associated with gross or microscopic hematuria should be referred for a nephrologic evaluation.

Hematuria

- Gross and microscopic hematuria should be initially referred for urologic evaluation.
- Hematuria should be referred for a nephrologic evaluation after completion of a urologic evaluation, if deemed necessary by a urologist.
- Obtain a renal ultrasound and /or CAT scan of the abdomen and pelvis.
- Evaluation with a renal panel and complete urinalysis.

Renal Failure

- Cr clearance/estimated GFR of equal or <60 ml/min and/or Cr >1.8 mg/dl.
- Evaluation with a renal panel, CBC, complete urinalysis, urine spot protein/cr, microalbumin, protein electrophoresis, and PSA (males only).
- Obtain a renal ultrasound.

- Diabetic nephropathy should be treated with ACE or ARB medications and aggressive blood pressure and glycemic control. Patients with frank proteinuria with a 24 hour protein >500 mg may be referred for a nephrologic evaluation.
- Provide most recent Hemoglobin A1C level.

Nephrolithiasis

- Obtain a renal ultrasound and /or CAT scan of the abdomen and pelvis.
- Evaluation with panel, complete urinalysis, uric acid, PTH, 24-hour protein >500 mg may be referred for a nephrologic evaluation.
- Complicated stone with hydronephrosis and /or hydroureter should be immediately referred for a urologic evaluation.

Nephrotic Syndromes with proteinuria, hyperlipidemia and hypoproteinemia require timely nephrology referral.

- Evaluation with renal panel, liver panel, lipid panel, urine spot for Cr clearance and protein, microalbumin, protein electrophoresis.
- Obtain a renal ultrasound.

Polycystic Kidney Disease (PKCD) and any genetic kidney disease should be referred for a nephrologic evaluation.

- Evaluation with a renal panel, urinalysis.
- Obtain a renal ultrasound and /or CAT scan of the abdomen and pelvis.

Hypertension, moderate to severe, requiring multiple medications should be referred for a nephrologic evaluation.

- Evaluation with a renal panel, urinalysis, spot urine for Cr and microalbumin.

The following situations do not normally require nephrology consultations

- **Acute Renal Failure** – particularly with oliguria, anuria or hyperkalemia-requires urgent evaluation in an acute care facility and is not appropriate for outpatient consultation.
- **Renal masses or complex renal cysts** worrisome for malignancy should be referred to a urologist for possible resection.
- **Simple renal cysts** are present in 20% of the population and do not require nephrology evaluation.
- **Hydronephrosis** implies post-renal obstruction and almost always requires urologic consultation to address the underlying anatomic pathology.
- **Mild hyponatremia and hypokalemia** are generally related to diuretic therapy. A patient on diuretic therapy with a serum Na>126 meq/L and a serum k>3.1 meq/L do not generally require a nephrologic evaluation.



12.11 NEUROLOGY REFERRAL GUIDELINES
Contracted Group: SMA Department of Neurology

For Appointments:

4475 S. Eastern Ave.
Las Vegas, NV 89119
Phone: (702) 669-5944
Fax: (702) 727-0327
Referral Fax: (702) 737-0237

For prompt processing of both consultation and neurological testing requests, please provide the following:

- Reason for referral
- Tentative diagnosis
- Specific service requested
- Legible problem related history & physical. (Please add any other patient records containing relevant patient information pertaining to current neurological problems.)

For patients previously treated by another neurologist, records of such treatment should accompany the new referral.

All requests for consultations relating to patients with chronic headaches need to contain the following information:

- Information concerning the headache (how often, how long it lasts, lateralization, how many years it has been occurring, etc.)
- History of previous investigation and treatment
- Family history of headache
- Social history including: Sleep patterns, work, family, and social stress
- History of behavioral illness, if any

PLEASE NOTE:

One of the following acuity statuses must be documented in the note section of the referral:

- Expedited (3 days) – *requires a doctor-to-doctor phone call to the clinic.*
 - At Risk (14 days)
 - Routine (30 days)
- (Also, indicate the reason for the acuity if other than Routine)

During normal business hours Monday-Friday, 8:00 am – 5:00 pm, please call (702) 650-2443 and request to speak to a Neurologist regarding an expedited referral. These referrals are handled differently from other referrals.

Please call the Neurology Department with any questions you may have at (702) 699-5944



12.12 OPHTHALMOLOGY REFERRAL GUIDELINES

Contracted Group: Center for Sight

For Appointments:

Telephone Number: (702) 724-2020

Locations:

5871 W. Craig Road Las Vegas, NV 89130	10521 Jeffreys St., Ste.100 Henderson, NV 89052
4475 S. Eastern Ave. Las Vegas, NV 89119	330 S. Rampart Blvd., #360 Las Vegas, NV 89145

Center for Sight is HPN's designated provider for Ophthalmology services, specializing in the treatment of disorders of the eye.

Diabetic eye exams do not require a referral.

Center for Sight performs a variety of medically necessary surgical eye procedures including but not limited to:

1. Cataract surgery - Medicare guidelines outline best-corrected visual acuity of 20/40 or worse in the preoperative eye is necessary for cataract surgery to be covered. Visual acuity is best evaluated by patients utilizing their vision benefits through optometrists.
 - Has the member had an eye exam in the last 6 months? If no, please refer member to optometry for evaluation before referring to Center for Sight.
2. Secondary Intra-ocular lens implants (if indicated)
3. Glaucoma procedures
4. Cornea transplant
5. Strabismus surgery
6. Oculoplastic procedures (medically necessary) – Aesthetic procedures not covered
7. A variety of minor surgical procedures (medically necessary)
8. Laser procedures, in-office (medically necessary)
9. Medical Eye Exams, including annual diabetic eye exams
10. Pediatric services
11. Dry eye - evaluation and treatment
12. Eye floater - evaluation and treatment
13. LASIK/PRK (All Custom)
14. Presbyopia – KAMRA Inlay/Raindrop Inlay



12.13 ORTHOPEDIC REFERRAL GUIDELINES

Contracted Group: Nevada Orthopedic and Spine Center

Appointments: (702) 258-3773

All Other Inquiries: (702) 878-0393

Fax: (702) 258-3777

NORTHWEST LOCATION:

7455 W Washington Ave Ste 160
Las Vegas, NV 89128

SOUTHEAST LOCATION:

1505 Wigwam Pkwy Ste 330
Henderson, NV 89074

All referrals and patient medical records (pertaining to the specified condition) are to be faxed or attached to online referral.

The patient's telephone number must be on the referral.

If the patient has a fracture, **call Nevada Orthopedic & Spine Center while the patient is still in the office to schedule an appointment.**

Patients are **required to bring appropriate x-rays and other diagnostic test reporting** (if applicable) to their appointments.

Patients experiencing **numbness and tingling in the upper extremities or possible diagnosis of carpal tunnel syndrome** must have EMG testing before seeing an orthopedic surgeon.

ACUTE INJURIES - IMMEDIATE (AT RISK OR EXPEDITED) REFERRAL

Fractures

Sprains

Cauda equina (loss of bowel & bladder) symptoms

Acute neurological deficits

Acute sudden onset of pain

NON-ACUTE PAIN AND CHRONIC CONDITIONS –ROUTINE REFERRAL

Patient must be experiencing pain in excess of six weeks

Referrals require documented conservative treatment:

NSAID's (non steroid anti inflammatory drugs)

Physical Therapy applies to:

*Knee pain up to age 57 will need Physical Therapy before orthopedic referral

*Shoulder pain for all ages will need Physical Therapy before orthopedic referral

*Elbow pain age 18-60 will need Physical Therapy before orthopedic referral

*Spine/Back pain for all ages will need Physical Therapy before orthopedic referral

NON-ORTHOPEDIC BODY PARTS: (Should not be referred to Orthopedics)

Head, Facial Bones, Ribs

Podiatry issues such as bunions, hammertoes, metatarsal fractures, bone spurs, etc. Please refer these issues to SMA Podiatry.

X-RAYS NEEDED FOR CONSULTATIONS

SPINE

- Cervical: Standing A/P, Lateral, Odontoid
- Thoracic: Standing A/P, Lateral, Swimmer's view
- Lumbar: Standing A/P, Lateral, spot lateral

SHOULDER

- A/P, Internal & External
- Y view
- Axillary view

ELBOW

- A/P, Lateral
- External oblique
- For masses, consider MRI

HIP

- A/P, Lateral to include proximal ½ femur
- A/P, Pelvis

KNEE

- Standing A/P views bilateral
- Lateral skyline or sunrise view of affected side

FOOT

- A/P, Lateral and Oblique

WRIST

- PA, Lateral, Oblique, Scaphoid

HAND

- PA, Fan Lateral and Oblique

FINGER

- PA, Lateral and Oblique



12.14 PAIN MANAGEMENT REFERRAL GUIDELINES
Contracted Group: SMA Pain Management Center

PAIN MANAGEMENT REFERRAL GUIDELINES

For Appointments:

4750 W Oakey, Suite 3A
Las Vegas, NV 89102
Phone: (702) 877-5370
Fax: (702) 366-9064

New appointments:

Phone (702) 877-5370 –follow the prompts

THE FOLLOWING INFORMATION SHOULD BE FORWARDED:

- Reason for consultation
- Specific requests (i.e. interventional procedure)
- History and physical exam
- Available diagnostics (x-ray, MRI, laboratory tests)
- Summary of previous evaluations and treatments
- Current and previous medications

IN GENERAL, A PAIN MANAGEMENT REFERRAL SHOULD BE MADE WHEN:

- Pain has lasted greater than 6 months despite conservative therapy, or
- Pain is from an acute event than may benefit from early intervention (i.e. acute disc herniation)
- Provider feels there is SPECIFIC intervention (i.e. interventional procedure, pharmacotherapy) that Pain Management Center can offer in the acute or chronic setting
- Pre-surgical diagnostics (i.e. diagnostic nerve blocks)
- Surgery is contemplated or eliminated as option by appropriate specialist
- Recommendations sought for medication management (please note: prescriptions for opiates and other medications will not automatically be resumed by Pain Management Center. Please do not plan for this or indicate to patients that prescriptions will be transitioned or provided on day of consultation)



12.15 PLASTIC SURGERY REFERRAL GUIDELINES

Contracted Group: Nevada Plastics

For Appointments:

Centralized Appointment Number: (702) 476-3011

Locations:

Nevada Plastics at Reynolds Plastic Surgery

Brandon Reynolds, MD

5550 Painted Mirage Rd., #217

Las Vegas, NV 89149

Phone: (702) 476-3011

Fax (702) 476-5022

Nevada Plastics at Couture Dermatology and Plastic Surgery

Marvin Spann, MD

2615 Box Canyon Dr.

Las Vegas, NV 89128

Phone: (702) 476-3011

Fax (702) 476-5022

Plastic Surgery phone consultations are available at the above phone numbers.

The physicians at Nevada Plastics will keep the PCP fully informed of their patients' progress with notes, letters, and phone consultations as needed. All recommendations of treatment will be coordinated with the PCP, so their continuing care of the patient will progress as smoothly and effectively as possible. The PCP is encouraged to call the consultant about any questions they have regarding the recommendations of the specialist for their patient.

Plastic Surgery Services Do Not Require Prior Authorization

Inappropriate referrals include:

- Scar revisions where the scar does not pose a limitation of function
- Treatment of keloid scars, cysts, skin tags, lipomas, and verrucous lesions. If the cyst or lipomas has become infected, is increasing in size rapidly in the last few months or causing pain not controlled with OTC medications, the mass can then be removed by the plastic surgeon. (Supporting documentation and office notes will be required for review by the plastic surgeon.)
- Emergency treatment of lacerations
- Treatment of burns, acute or chronic
- Treatment of facial fractures
- Treatment of excess skin obstructing visual fields

- Treatment of excess skin resulting from massive weight loss surgery unless it causes panniculitis resistant to conservative medical management
- Treatment of complications related to previous cosmetic breast augmentation. **If the patient has had silicone implants and an MRI confirms evidence of silicone extravasation outside of the capsule, the carrier will permit the plastic surgeon to remove the implant material only.**
- Treatment of pigmented lesions with no malignancy
- Treatment of acne scars
- Lesions of the genitalia
- Treatment of gynecomastia
- Treatment of torn ear lobes
- Complications from cosmetic enhancements to the body and or face. (I.e., tattoos and body piercing.)

Referral guidelines for the following diagnoses are:

Reconstruction of the breast after mastectomy

- Initial exam includes evaluation and referral to general surgeon for biopsy. If patient is deemed appropriate candidate for reconstruction by the general surgeon it can be referred to a plastic surgeon for evaluation.
- Reconstruction, whether immediate or delayed, is to be determined between the plastic surgeon and the general surgeon.
- For the purposes of this section, "**reconstructive surgery**" means *a surgical procedure performed following a mastectomy on one breast or both breasts to reestablish symmetry between the two breasts. The term includes, but is not limited to, augmentation mammoplasty, reduction mammoplasty and mastopexy. The surgical procedure on the non-involved side to achieve symmetry to be determined by the plastic surgeon after the involved side is reconstructed and in consultation with the patient.*

Breast Reduction

Reduction mammoplasty for symptomatic macromastia as medically necessary when ALL of the following criteria have been met:

- The patient is at least 18 years of age or breast growth is complete
- The patient must be nicotine free for 6 weeks prior to scheduling a consultation
- The patient must have a documented BMI below 35 prior to scheduling a consultation

Macromastia is causing at least ONE of the following conditions/symptoms with documented failure of at least one continuous three-month trial of appropriate medical management:

- shoulder, upper back/ neck pain, and/or ulnar nerve palsy for which no other etiology has been found on appropriate evaluation,
- intertrigo, dermatitis, eczema, or
- hidradenitis at the inframammary fold

Pre-operative photographs confirm the presence of BOTH of the following:

- significant breast hypertrophy and shoulder grooving from bra straps and/or
- intertrigo if stated to be present

Average weight of tissue planned to be removed in each breast, is above the 22nd percentile on the Schnur Sliding Scale based on the patient's body surface area (BSA)

Grams of tissue to be removed per breast

1.40 – 1.50	218 – 260
1.51 – 1.60	261 - 310
1.61 – 1.70	311 - 370
1.71 – 1.80	371 - 441
1.81 – 1.90	442 - 527
1.91 – 2.00	528 - 628
2.01 – 2.10	629 - 750
2.11 – 2.20	751 - 895
2.21 – 2.30	896 - 1068
2.31 – 2.40	1069 - 1275

Gynecomastia

PCP: Patients should be examined and referred for evaluation for a potential malignancy of the breast. If lesion is suspicious then excision is warranted. Excision to be referred to a general surgeon. If no suspicion of malignancy, then the condition is considered cosmetic in nature and not a covered benefit.

Mastectomy for benign disease

Mastectomies for benign disease are to be performed by general surgery and if indicated, then referred to plastic surgery for evaluation for reconstruction.

Hidradenitis

PCP to evaluate the patient and treat conservatively with antibiotics, oral or IV and local wound care if required. If symptoms are recurrent with episodes requiring more than 3 courses of treatments with antibiotics and local wound care in one year, then referral to plastic surgery for excision is indicated.

Excess skin after massive weight loss

On the occurrence of excess skin developing after massive weight loss, if there is a scenario of panniculitis that is not responsive to conservative wound care, then removal of the offending pannus can be referred to a plastic surgeon for the removal of the offending skin and only the offending skin. Any other procedure will be considered cosmetic in nature and not a covered benefit.

- The patient must be nicotine free for 6 weeks prior to scheduling a consultation



12.16 PODIATRY REFERRAL GUIDELINES

Contracted Group: SMA Department of Podiatry

For Appointments:

**4750 W Oakey, Suite 1A
Las Vegas, NV, 89102**

Department Phone 702-877-8625 or 725-600-8630

Appointments 702-877-5199

Referral Issues 702-877-5193

Doctor to Doctor Line for Expedited Referrals 702-877-8623

- All referrals submitted to the Podiatry Department will be reviewed to determine priority and completeness. Referrals that do not include a specific diagnosis indicating the reason for intervention by a Podiatrist will be returned.
- All referrals must encompass areas below the Knee.
- Expedited referrals require a doctor-to-doctor call if anything other than a fracture, acute trauma or dislocation.
- Patients of any age will be seen in Podiatry.

Fracture

Any referral for a fracture requires an accompanying x-ray. If the written x-ray report clearly identifies a fracture, the patient will be scheduled as an "At Risk or Expedited appointment based on podiatrist review.

Ingrown Toenail

Please indicate if the toe is infected and if patient is diabetic.

Trauma

If trauma to the foot or ankle has broken the skin or caused a recent sprain of the ankle, this should be indicated within the referral. If the trauma involves a recent sprain but the location of the sprain is not specified, the referral will be sent back to referring provider for additional details. Toe sprains are almost always considered routine referrals.

Ulceration/Infection

The Podiatrists will review all referrals for ulceration and infection to make a determination on priority

The following diagnoses are usually processed according to the priority level indicated here.

Expedited

Current ankle or foot fracture
Ankle Sprain
Cellulitis
Charcot
Osteomyelitis

At Risk

Avulsed Nail
Blisters
Foreign body
Ingrown Toenail with infection and on antibiotics
Sprain of mid foot or metatarsal

Routine

Achilles Tendonitis
Arthritis 2nd to Previous Fracture
Bone Spur
Bunion
Calcaneal Apophysitis
Calluses/corns
Cysts
Dermatophytosis
Flat foot
Genu Valgum
Gout
Hallux Valgus
Hammertoe
Heel Spur
Neuroma
Onychomycosis
Pain in limb
Diabetic Peripheral Neuropathy
Pes Planus
Plantar Fasciitis
Plantar Warts
Rash
Tinea Pedis
Toe Sprain



12.17 RHEUMATOLOGY REFERRAL GUIDELINES
Contracted Group: SMA Department of Rheumatology

For Appointments:

4750 W. Oakey Blvd
Las Vegas, NV 89102
Tel.# (702) 251-3670
Fax# (702) 252-4906

History

- Characteristics, duration, and extent to the present pain complaint
- Past history of pain or similar problems
- Sleep and fatigue
- Other areas of pain other than the one of chief complaint

Physical

- The most important part of the assessment
- Palpation of joints: spongy/rubbery suggests inflammation, hard/bony swelling suggests degenerative.
- Rheumatoid/inflammatory arthritis should be diagnosed BEFORE deformities are present, since these days deformities are largely preventable with early treatment
- Neurologic exam when appropriate

Laboratory

- Back pain, bursitis, tendonitis, etc.: no labs are needed (RF, ANA are not of any clinical use in the evaluation of back pain)
- Current prescription of NSAIDS/COX-2: CBC, creatinine, and liver enzymes within the last year, or sooner if any reason to suspect change
- Suspected inflammatory arthritis: CBC, creatinine, liver enzymes, ESR, CRP, RF, ANA WITH PATTERN, uric acid, anti CCP
- High suspicion for systemic illness (such as lupus or vasculitis): add U/A, C3 and D4 complement, auto-immune profile, ANCA
- Gout: recheck and include results of uric acid AFTER the acute attack (uric acid is often falsely low during the attack)
- Elevated liver enzymes (even mild): consider hepatitis C (can also cause +RF)
- In most circumstances, it is not useful to "follow" or repeat RF/ANA in patients with established diagnoses of RA or Lupus. These tests are for diagnosis, and do not indicate disease activity
- The vast majority of people with +RF or +ANA do NOT have RA or lupus
- ANA titers of 1:80 are almost never significant

X-ray

- Please obtain an x-ray if:
 - If a fracture is suspected
 - In the case of progressive back pain, or if there are other suggestions of metastatic disease
 - If suspect spurring/degenerative changes may be the cause of radicular pain
- X-ray is unnecessary if:
 - It is a routine assessment of joint pain – they are not helpful
 - In some cases of neck and back pain, especially at the initial visit
 - No dramatic change in clinical situation since the patient had previous x-rays

When to refer to the rheumatologist

- Please refer all patients suspected or known to have auto-immune diseases such as RA, lupus, psoriatic arthritis, etc
- These diseases are very treatable and treatment is best begun as soon as possible
- Refer all patients in whom there is diagnostic uncertainty
- Refer patients with osteoarthritis and other musculoskeletal pain syndromes when they are refractory to attempts to treat
- Please ensure that all lab and x-ray results are faxed in advance or available online

Follow-up

- Follow-up care will be arranged by rheumatology indefinitely for all patients with auto-immune disease
- Rheumatology will be responsible for toxicity monitoring of all medications for these disorders
- Follow-up care will also be arranged for those still with diagnostic uncertainty or pending issues



12.18 UROLOGY REFERRAL GUIDELINES - Adult

Contracted Group: Urology Specialists of Nevada

For Appointments:

Telephone Number: (702) 877-0814

Fax: (702) 877-3238

Locations:

58 N. Pecos Road
Las Vegas, NV 89074

2010 Wellness Way, Suite 200
Las Vegas, NV 89106

3150 N Tenaya Way, Suite 165
Las Vegas, NV 89128

Note: All patients require standard referral form along with results of all required testing before a consult appointment will be made. For all diagnoses or chief complaints which require a Urine C&S, an appointment date will be made even though the culture result may still be pending, provided that the **Quest Lab Accession Number** on the culture is written on the consult request form.

Diagnosis/ Chief Complaint	Required Testing	Diagnosis/ Chief Complaint	Required Testing
Balanitis/Balanoposthitis	Urinalysis w/ reflex C&S.	Congenital Abnormalities of Urachus	CT Abd-Pelvis, Cystogram
Bladder Cancer	Pathology report, Urinalysis w/ reflex C&S, Urine Cytology.	Cystitis	Urinalysis w/ C&S.
Bladder Infection / Cystitis	Urinalysis with C&S.	Cystocele	Needs to be referred to Geoff Hsieh, MD: Urogynecology.
Bladder Mass / Lesion	CT-Urogram or IVP, Urinalysis w/ reflex C&S, Urine Cytology.	Delayed Ejaculation	None
Bladder Outlet Obstruction	PSA, urinalysis w/ reflex C&S.	Dysparuenia (pain w/ intercourse)	Urinalysis w/ reflex C&S
Bladder Spasms/Over-active	Urinalysis w/ reflex C&S.	Dysuria- Burning w/ urination	Urinalysis w/ C&S.
Blood in semen	PSA, Urinalysis with C&S.	Enuresis (Bedwetting)	Urinalysis w/ reflex C&S
BPH	PSA, urinalysis w/ reflex C&S.	Epididymitis	Urinalysis w/ C&S, Testicular/Scrotal Ultrasound.

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Diagnosis/ Chief Complaint	Required Testing	Diagnosis/ Chief Complaint	Required Testing
Concealed Penis	None	Epididymal Cyst	Testicular/Scrotal Ultrasound.
Condyloma (Genital-warts)	None	Erythema Penis Glands	Urinalysis w/Reflex, UCX, Scrotal Ultrasound
Fused Kidney	CT Abd-Pelvis with or without Contract/Creatinine	Kidney Cyst	Renal Ultrasound, Urinalysis w/ reflex C&S.
Genital Warts	None	Kidney Mass	CT Abd-Pelvis w/contrast, Urinalysis w/ reflex C&S, Renal Panel.
Groin Pain	Urinalysis w/ reflex C&S, Testicular/Scrotal Ultrasound.	Nephrolithiasis (Kidney Stones)	CT-KUB (NC Spiral CT abd-pelvis+KUB), Urinalysis w/ reflex C&S.
Hematospermia	PSA, Urinalysis with C&S.	Neurogenic Bladder	Renal Ultrasound, Urinalysis w/ Reflex C&S, Renal Panel
Hematuria	CT-Urogram, Urinalysis w/reflex C&S,	Nocturia	Urinalysis w/ Reflex C&S, (Plus PSA if Male)
Horseshoe Kidney	Urinalysis w/Reflex, CT Abd-Pelvis	Nocturnal Enuresis (Bedwetting)	Urinalysis w/ Reflex C&S.
Hydrocele	Testicular/Scrotal Ultrasound.	Oligospermia (low sperm Count)	Quant. Semen analysis, LH, FSH, Free and Total Testosterone
Hydronephrosis	CT-Urogram or IVP, Urinalysis w/ reflex C&S, Renal Panel	Orchitis	Testicular/Scrotal Ultrasound, Urinalysis w/ C&S
Hypogonadism (low Testosterone)	Free and Total Testosterone, Prolactin, LH, and PSA level.	Penile Adhesions	None
Hypospadias	None	Penile Mass	Referral Only
Impotence (ED-Erectile Dysfunction)	Free and Total Testosterone, Prolactin, LH, and PSA level.	Peyronies Disease	None
Incontinence	Urinalysis w/ reflex C&S.	Premature Ejaculation	None
Infertility	Quant. Semen analysis, Free and Total Testosterone, LH,FSH.	Prolapsed Bladder	Needs to be referred to Geoff Hsieh, MD: Urogynecology.

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Diagnosis/ Chief Complaint	Required Testing	Diagnosis/ Chief Complaint	Required Testing
Interstitial Cystitis	Urinalysis w/ C&S.	Prostate Cancer	PSA, Urinalysis w/ Reflex C&S, Chem-20 panel
Prostate Enlargement (BPH)	PSA, Serum creatinine, Urinalysis W/ Reflex C&S	Undescended Testis	Inguinal/Scrotal Ultrasound.
Prostate Nodule	PSA, Urinalysis w/ C&S	Urethral Caruncle or Prolapse	Urinalysis w/ Reflex C&S.
Prostatitis (acute or chronic)	PSA, Urinalysis w/ Reflex C&S	Urethral Mass	Urinalysis w/ Reflex C&S.
PSA Elevation	PSA, Urinalysis w/ Reflex C&S	Urethral Stricture	Urinalysis w/ Reflex C&S.
Pyelonephritis	Urinalysis w/ C&S, Renal Ultrasound, Renal Panel.	Urethritis	Urinalysis w/ C&S, Chlamydial and GC Urine Antigen, HIV, RPR.
Renal Cyst	Renal Ultrasound, Urinalysis w/ Reflex C&S, Renal Panel.	Urinary Frequency/OAB (Female)	Urinalysis w/ reflex C&S.
Renal Failure/Insufficiency	Renal Ultrasound, Urinalysis w/ Reflex C&S, Renal Panel.	Urinary Frequency/OAB (Male)	Urinalysis w/ reflex C&S, PSA.
Renal Mass/Neoplasm/RCCA	CT Abd-Pelvis with contrast, Chem-20, Urinalysis w/Reflex C&S.	Urinary Retention (Male)	Urinalysis w/ Reflex C&S, PSA, Renal Panel, Renal Ultrasound.
Scrotal Mass or Cyst	Scrotal/Testicular Ultrasound.	Urinary Retention (Female)	Urinalysis w/ Reflex C&S, Renal Ultrasound, Renal Panel.
Sexually Transmitted Disease (STD)	Urinalysis w/ C&S, Urine Chlamydial and GC antigen, HIV, RPR.	UTI	Urinalysis w/ C&S, Renal Ultrasound, Renal Panel.
Spermatocele	Scrotal/Testicular Ultrasound.	Varicocele	Doppler Scrotal Ultrasound, Urinalysis w/ Reflex C&S.
Testicular Mass	Scrotal/Testicular Ultrasound, AFP, B-HCG.	Vasectomy	None
Testicular Torsion	Surgical Emergency Refer to Emergency Room.	Vesico-ureteral Reflux	Voiding Cystourethrogram, Renal Ultrasound, Serum Creatinine, Urinalysis w/ Reflex C&S.

ABBREVIATION	DEFINITIONS
CT-KUB	Non-contrast CT Scan of the Abd-Pelvis + Flat plate KUB xray
CT-Urogram	CT Scan Abd-Pelvis w/wo IV contrast and Post-scan KUB (equivalent to a limited post-scan IVP)
VCUG	Voiding Cystourethrogram
IVP	Intravenous Pyelogram
Quant. Semen analysis	Quantitative Semen analysis for infertility evaluation (as opposed to a qualitative semen analysis post vasectomy check)
AFP	Alpha Feto-Protein Tumor Marker
B-HCG	Beta-Human Chorionic Gonadotropin Tumor Marker
PSA	Prostate Specific Antigen
LH	Leutinizing Hormone
FSH	Follicle Stimulating Hormone
Renal Panel (Chem-7)	Serum Na, k, Cl, CO ₂ , BUN, creatinine, glucose, and Ca levels
Chem 20	Complete Chemistry Panel

CONSULT NOTES: General Guidelines regarding PSA, ED, MH, and BPH referrals.

1. PSA Screening should be performed judiciously in asymptomatic male patients. PSA's should not be obtained routinely in men over age 75 with no history of prostate cancer. A patient found to have an elevated PSA should receive some initial counseling from the PCP that a Urology referral will most likely result in a recommendation for Prostate Needle Biopsy.
2. The definition of clinically significant microhematuria is > 3RBC's/HPF on formal urinalysis. Dipstick positive hematuria does not constitute enough evidence for clinically significant microhematuria.
3. Patients with the diagnosis of Erectile Dysfunction should have been tried on and essentially failed medical therapy with 5-phosphodiesterase inhibitors (Viagra, Levitra, or Cialis) if there are no medical contra-indications to this therapy before referral to Urology.
4. Patients with the diagnosis of BPH should ideally have been tried on alpha blocker therapy (if no medical contra-indication) and failing prior to referral.

Note: Simple UTI's are to be treated and followed by the Primary Care Physician. Appropriate Urology referrals are for patients with chronic problems, chronic complex UTI's with previous bladder or prostate surgery, stone, infected stone, obstructions, BPH or congenital abnormalities.



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12.19 UROLOGY REFERRAL GUIDELINES - Pediatric

Contracted Groups: See below

For Appointments:

Group Name/Phone Number	Address	
Children's Urology Associates (702) 369-4999	3196 S. Maryland Pkwy., #202 Las Vegas, NV 89109	2637 W. Horizon Ridge Pkwy, # 140 Henderson, NV 89052
	6670 S. Tenaya Way, #160-180 Las Vegas, NV 89113	
Clare Close, MD (702) 220-4006	2653 W. Horizon Ridge Pkwy., #100 Henderson, NV 89052	3150 N. Tenaya Way, #530 Las Vegas, NV 89128
Las Vegas Pediatric Urology (702) 728-5686	653 N. Town Center Dr., #407 Las Vegas, NV 89144	
Pediatric Urology of Las Vegas (702) 916-1996	3131 LaCanada St., #205 Las Vegas, NV 89169	

Labs and Tests that need to be done prior to patient's appointment are listed below by Diagnosis

All imaging studies, where requested, are good if done within 12 months of the referral.

Diagnosis		Labs-Test Required PRIOR to Appointment for Peds.
Ambiguous Gentilia (Underdetermined Sex)		Karyotype, Prior Studies, and Records
Dysuria (Burning w/ Urination)		UA reflex to culture
Enuresis (Bed Wetting)		UA reflex to culture
Flank Pain		UA, reflex to culture, Renal Bladder U/S, KUB

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Diagnosis	Labs-Test Required PRIOR to Appointment for Peds.
Gross Hematuria	Renal Bladder U/S, CBC, PT/PTT, UA, with reflex to culture
Microscopic Hematuria	Renal bladder U/S, UA, reflex to culture, urine calcium creantine ratio
Hydrocele	Referral Only
Hydronephrosis	Renal Bladder U/S, VCUG
Incontinence	Renal Bladder U/S, UA, reflex to culture
Meatal Stenosis	Referral Only
Nuerogenic Bladder	Renal Bladder U/S, VCUG, Chem Profile
Pelvic Pressure	UA, reflex to culture, Renal Bladder U/S, KUB
Posterior Urthelial Valves	Renal Bladder U/S, VCUG, Chem Profile, CBC
Prenatal Hydronephrosis	Renal Bladder U/S, VCUG
Renal Mass/Bladder Mass	All X-ray reports, UA, UCX, Urine Cytology, All old records
Retention MALE	Renal Bladder U/S, VCUG, Chem Profile
Retention FEMALE	Renal Bladder U/S, VCUG, Chem Profile
Stones	CT/KUB or Renal U/S, UA, reflex to culture, Random Urine Creantine and Calcium, Chem Profile
Testicular Mass	Scrotal US w/ Doppler
Testicular Pain, Swelling	Testicular US, UA, reflex to culture
Ureterocele Ureteral Duplication, Ureteric Obstruction	ALL Prior Records, Renal Bladder U/S, VCUG
UTI/ Pyelonephritis	UA, reflex to culture, Renal US, VCUG
Varicocele	Scrotal US
Vesicoureteral Reflux	Renal Bladder U/S, VCUG, ALL old records, UA, UCX

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SECTION 13

SUPPORT SERVICES

13 – Support Services

13.1 Radiology

Southwest Medical Associates (SMA) provides radiology services at multiple locations. The facility located at 888 S. Rancho Drive offers extended hours for urgent situations. SMA offers additional facilities, which operate during normal business hours (please call the individual facility for office hours).

Special radiology studies such as CT, Ultrasound, Fluoroscopy, and IVP's require appointments. Appointments can be made by contacting the scheduling department at **(702) 877-5390**. Plain film studies do not require a referral or an appointment; however, they do require an order signed by a physician. Contact the Radiology Department at **(702) 877-5125** option 5 with any questions.

NAME/LOCATION	PHONE	HOURS	PROCEDURES
Rancho/Charleston 888 S. Rancho Dr.	(702) 877-5125	S-S 24 hours	Scheduled procedures 24 hours for emergencies STAT, Expedited Ultrasounds, CT Scans Diagnostic Mammography DEXA Scans
N. Tenaya Satellite 2704 N. Tenaya Way	(702) 243-8500	S-S 7 a.m. - 7 p.m.	Plain film studies Screening Mammography Routine Ultrasounds Routine CT Scans
S. Eastern Satellite 4475 S. Eastern Ave.	(702) 737-1880	S-S 7 a.m. - 8 p.m.	Plain film studies Screening Mammography DEXA Scans Routine Ultrasounds STAT, Expedited, Routine CT Scans
Siena Heights Satellite 2845 Siena Heights	(702) 617-1227	S-S 8 a.m. - 8 p.m.	Plain film studies Screening Mammography Routine Ultrasounds
Montecito Satellite 7061 Grand Montecito Pkwy	(702) 750-7424	S-S 8 a.m. - 8 p.m.	Plain Film Studies Routine Ultrasounds
Sunrise Satellite 540 N. Nellis Blvd	(702) 459-7424	M-F 8 a.m. - 5 p.m.	Plain film studies Screening Mammography
W. Tropicana Satellite 4835 S. Durango	(702) 984-5200	M-F 8 a.m. - 5 p.m.	Plain film studies Screening Mammography
Pahrump Satellite 2210 E. Calvada	(775) 727-6400	M,W,Th 8 a.m. - 5 p.m.	Plain film studies
Lake Mead Satellite 270 W. Lake Mead	(702) 677-3720	M, T, F 8 a.m. - 5 p.m.	Plain film studies
Summerlin Satellite 10105 Banbury Cross Drive	(702) 877-5199	M-F 8a.m.-5 p.m.	Plain film studies Screening Mammography Routine Ultrasound

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W. Oakey Satellite 4750 W. Oakey Blvd	(702) 877-5199	M-F 7 a.m.-5 p.m.	Plain film studies Screening Mammography Routine Ultrasound
Green Valley 3175 St. Rose Parkway #200	Scheduled to open tentatively 12/28/17		Diagnostic Mammography

For radiology providers not listed, please refer to the HPN Provider Directory, the HPN web site www.myhpnprovider.com or contact Provider Services at (702) 242-7088 or (800) 745-7065.

Southwest Medical Associates Mammography Guidelines

Screening Mammography

Screening mammogram for female patients ages **35 or older**:

- Must have an order (patients can self-refer if they are over 40+)
 - General breast pain or tenderness
 - Fibrocystic breasts
 - Yellow, green, white or milky discharge

Screening mammogram for female patients age **34 or younger**:

- Must have an order (no self-referrals)
 - Typically done for pre-augmentation purposes
 - Genetic testing and/or a strong family history of breast cancer (first degree relative)

Diagnostic Mammography

Female patients ages **35 or older** must have a diagnostic mammogram FIRST:

- Must have a diagnostic order/referral
 - New mass or lump
 - Rule out breast implant rupture (patient can be ANY age)-NO BCP VISIT, IMAGING ONLY
 - New onset nipple retraction, skin puckering or thickening
 - Bloody, black or clear discharge
 - First mammogram after being diagnosed with breast cancer (if the patient had a mastectomy unaffected breast can resume screening mammogram)
 - EXCEPTION: if a patient had a mammogram within the last 6 months and presents with a new lump, nipple retraction, skin puckering or discharge, a breast ultrasound should be completed first

Female patients ages **34 or younger** must have a *breast ultrasound* FIRST:

- Must have a diagnostic order/referral
 - New mass or lump
 - New onset nipple retraction, skin puckering or thickening
 - Bloody, black or clear discharge
 - Focal breast pain ONLY (please provide location)

Male patients:

- Must have a diagnostic order/referral
 - All males 18 and over require a diagnostic mammogram first, unless they are of pediatric age (please see pediatric patient guidelines)

Pediatric patients 17 years and under:

- Must have a breast ultrasound order/referral
 - All males 17 years of age and younger-NO BCP VISIT, IMAGING ONLY

******PLEASE NOTE:**

- If a patient presents with an issue that has already been imaged within the last 12 months with normal results and there are no **NEW** changes, referral may be declined.
- Breast Ultrasound referrals for dense breast will be declined.

Radiology reports are available in 24-48 hours and are faxed to the requesting physician's office. Finalized reports can be mailed to a physician's office if requested by the physician or designated staff. Access to dictated reports is available on a 24-hour basis through the PowerScribe dictating system and 24-hour access to completed reports is available through the Imagecast Radiology Information System. Arrangements for access may be made by telephoning **(702) 877-5125 (option # 5)**. All reports are confidential and released only to the physician/provider or designated staff.

Imaging Expectation Sheets and Member Instruction Sheets – Please see Section 25.9 thru 25.23 for copies of these frequently used forms

Timelines for diagnostic tests performed in the SMA Radiology department are as follows:

- ♦ Expedited requests – studies done in 72 hours
- ♦ At Risk requests – studies done in 14 days
- ♦ Routine requests – studies done in 30 days
- ♦ STAT Referrals will be handled according to the below process.

Important Note:

Because of department limitations all requests for STAT examinations must be done between the hours of 8:00am and 5:00pm at the Rancho location.

Providers ordering a STAT study need to furnish the scheduling department with a contact number for direct telephonic result notification, an ETA of the patient arrival, a referral with appropriate clinical information and all necessary lab results.

If the patient needs I.V contrast and is 75 years of age or older, diabetic, or has a history of renal disease, please provide current (within 30 days) BUN and Creatinine levels. If lab tests have not been completed, please order them stat.

Please instruct Patients to arrive by 5:00pm. If Imaging is unable to contact the requesting Provider with results, the patient will be directed to check in through the Urgent Care for Evaluation & Treatment.

Please share this information with your applicable staff. If you have any questions about the above timeframes or require additional information, please contact the SMA Scheduling department at 877-5390, Fax 877-5157.

13.2 Laboratory

Quest Diagnostics Laboratory is the HPN designated provider for all outpatient laboratory services in Nevada, including clinical laboratory testing, surgical pathology, fine needle aspirations (FNA), cytology (GYN and non-GYN) and bone marrow aspirations.

Quest Diagnostics maintains drawing stations at 7 Southwest Medical Associates' locations and at 26 additional Quest locations throughout the state. The Quest Diagnostics main laboratory is located at 4230 Burnham Avenue and offers 24-hour stat service, extended patient hours and access to specialized testing. For exact facility locations and hours, please visit Quest Diagnostics online at www.questdiagnostics.com or call (866) MYQUEST or (866) 697-8378.

Quest Diagnostics offers a comprehensive test directory, which includes complete instructions for accessing its services and preparing patients for certain, specialized testing. Quest Diagnostics also offers complete courier services, provides laboratory supplies and arranges for prompt result reporting. For more information visit Quest Diagnostics online at www.questdiagnostics.com or phone (866)MYQUEST or (866)697-8378.

13.3 Speech Therapy

Speech Therapy Center of Excellence is HPN's designated provider for all speech therapy services. Their telephone number is (702) 641-8255.

Referral Process:

- New referrals for HPN, POS and Senior Dimensions members should be sent to Speech Therapy Center of Excellence via @YourService.
- If needed, supporting clinical information may be faxed to Speech Therapy Center of Excellence at (702) 399-8255.
- After 5 business days, members may contact Speech Therapy Center of Excellence directly to schedule an appointment.

For HPN Medicaid and Nevada Check Up, please refer to the Provider Directory for additional speech therapy providers.

13.4 Physical Therapy/Occupational Therapy

Desert Valley Therapy is Health Plan of Nevada's (HPN) designated provider for therapy services. Staff includes physical therapists, occupational therapists, certified hand therapists, exercise specialists, athletic trainer, therapy assistants and therapy technicians.

For HPN-Medicaid and Nevada Check Up, please refer to the Provider Directory for additional physical therapy and occupational therapy providers

Referral Process

- Provide the patient with a written referral and have the patient contact the Desert Valley Therapy site of their choice for an appointment:

Address	Phone Number
1950 E. Desert Inn Rd. Las Vegas, NV 89169	(702) 735-1501
7455 W. Washington Ste. 100 Las Vegas, NV 89128	(702) 655-9456
6830 W. Oquendo Rd. #101 Las Vegas, NV 89118	(702) 258-3066
1701 N. Green Valley Pkwy #8B Henderson, NV 89074	(702) 998-3333

- For Pahrump Members, provide the patient with a written referral and have member contact Affiliated Physical Therapy at **(775)-727-3838**.
- Routine referrals are seen within 30 days. Patients may be seen sooner as needed.
- A telephone call in conjunction with the written referral can expedite the referral process in surgical and other more urgent cases.

For more information visit www.desertvalleytherapy.com

13.5 Optometry

EyeMed is HPN's designated provider for quality comprehensive eye care. **Please confirm member's vision coverage prior to referring patients.** Fee-for-service patients and most insurance plans are also accepted.

LensCrafters provides comprehensive visual examinations that include:

- * automatic perimetry
- * subjective refraction
- * binocularity testing
- * biomicroscopy
- * dilated ophthalmoscopy
- * tonometry
- * fundus photography (if needed)

Full-service contact lenses are also provided which includes hard gas permeable, soft daily wear, soft disposable daily and extended wear, tinted soft contacts and a wide range of special design contact lenses for hard-to-fit patients.

LensCrafters carries a wide variety of frames from inexpensive to high-end designer lines. The optical lab can manufacture any type of spectacle lens including progressive addition, and no-line bifocals.

Please visit www.lenscrafters.com for locations/hours or to schedule an appointment.

13.6 Home Health Care

Southwest Medical Home Health (SMA Home Health) a full-service Medicare-certified home health agency licensed by the State of Nevada.

SMA Home Health offers comprehensive care in the least restrictive environment to promote independence and wellness. Together with a physician, our team members develop a plan of care that best suits the needs of each client.

Who is Eligible for Home Health Services?

SMA Home Health maintains written guidelines and criteria for admission, they are as follows:

- The patient must be confined to his/her home.
- The patient must need Skilled Nursing care on an intermittent basis, Physical Therapy, Speech-Language Pathology Services, or has continued need for Occupational Therapy.

- The patient must be able to have his/her needs met by the agency's stated scope of service.
- The patient must be under the care of a primary care physician, licensed to practice medicine or osteopathy in the state of Nevada, who will order and approve the provision of services. Referral for service will also be accepted from dentists and oral surgeons.
- The patient must be located within the geographic area served by SMA Home Health. Direct services are available in the metropolitan Las Vegas area. Those patients outside of the service area will be served through contractual arrangements. In some areas outside of the metropolitan Las Vegas area, services may be limited. Depending on the need of the patient and the availability of services, the patient may need to stay within the Las Vegas area until independent with care.
- The home environment must be safe and able to meet the patient's physical needs and ensure safety of all staff.
- Services and care must conform to current standards of practice for the respective discipline.
- The clinical condition of the patient must be within the feasibility of the agency's services, time, cost, personnel and skills.
- Acceptance for home care services is realistically based on the patient's willingness and ability to function in a non-institutional environment. The primary focus of home care is to teach the patient and/or care giver self-care in the home environment
- Eligibility for participation is not based on the patient's race, creed, color, religion, ancestry or national origin, gender, sexual preference, age, handicap or veteran status.
- Patients who cannot be cared for by the agency will be appropriately referred to other resources.
- If the patient does not meet admission criteria, the referring physician will be promptly notified.

What Services are available under Home Health?

- Skilled nursing services
- Wound care and enterostomal therapy
- Medication teaching and monitoring
- Infusion therapies (i.e. antibiotics, hydration, pain management, TPN, etc.)
- Enteral nutrition
- Chronic Disease management
- Rehabilitation Services
 - Physical therapy
 - Occupational therapy
 - Speech therapy
- Dietary evaluation and education
- Social work services
- Home health aide

Who Provides the Home Care Services?

An interdisciplinary team of professional staff including registered nurses, therapists, medical social workers, dietitians and home health aides. Individualized care is available on an intermittent basis 24-hours-a-day, 7-days-a-week.

How Do I Initiate a Referral?

Call the Referral Department at **(702) 383-0887**, 8 a.m. - 5 p.m. during weekdays, 8 a.m. to 5 p.m. Saturday and Sunday. After-hours, call **(702) 383-0887** for the on-call nurse for SMA Home Health.

How Do I Receive Feedback?

Interaction with the physician will occur as frequently as necessary based on the complexity and urgency of the plan of care, but at least every 60 days.

Telephone and written communication will take place as needed. A formal written plan of care will be sent to the physician every 60 days.

What Is the Criteria for Discharge from Home Health Services?

Patients are discharged from home health service upon achievement of goals as noted in the interdisciplinary plan of care, once they no longer meet the eligibility requirements or when services can no longer be provided safely and effectively in the patient's home or upon order by the attending physician. When the physician discharges a patient from home health service, all pertinent information regarding the condition of the patient will be documented in the patient's medical record. Services may be discontinued at any time, for any reason, by the patient or the patient's family.

Who Can I Call for Questions and Concerns about the Agency?

If you have questions or concerns regarding home health services, contact the SMA Home Health Professional Services Director at (702) 383-0887.

13.7 Hospice

Southwest Medical Hospice Care (SMA Hospice) is a Medicare/Medicaid certified hospice agency, licensed by the State of Nevada.

The mission of Southwest Medical Hospice is to compassionately meet the needs of individuals living with a life limiting condition or terminal condition, their families and loved ones, by providing comprehensive patient centered care. Our families will be supported with quality medical care in a professional and ethical manner, while we strive to support the patient and families emotionally and spiritually.

Hospice care for terminally ill patients can be provided in the home, in a custodial residence, or in our contracted inpatient facilities depending on the needs of the patient.

Who Is Eligible for Hospice Services?

SMA Hospice provides hospice care for any HPN insured as well as Medicare, Medicaid, private insurance and private-pay patients.

When should hospice be considered?

Patients are eligible for hospice care when the attending physician and hospice medical director make a clinical determination that life expectancy is six months or less, if the disease follows its usual course.

Examples include:

- Any terminal cancer diagnosis
- End-stage chronic obstructive pulmonary disease (COPD)
- End-stage cardiomyopathy
- End-stage renal failure (dialysis has been stopped)
- End-stage congestive heart failure (CHF)
- Amyotrophic lateral sclerosis (ALS)
- End stage peripheral vascular disease (PVD)
- HIV/AIDS
- End stage dementia

- Stroke
- Parkinsons

These indicators can suggest eligibility but do not replace professional judgment, CMS regulations or local coverage determinations (LCDs).

What Is the Admission Criteria?

- The patient has been informed by their physician that they have a terminal diagnosis with a prognosis of six months or less.
- The patient has elected no additional curative treatment for their terminal disease and all intervention will be directed toward the provision of comfort.
- The patient resides in the Las Vegas metropolitan area and can be safely serviced by SMA Hospice staff.

Note: Referrals may come from the physician, patient, family, friends, social workers or clergy.

Services may include:

- Skilled nursing services
- Occupational therapy
- Personal care services
- Pastoral/spiritual counselors
- Bereavement services
- Nutritional therapy
- Physical therapy
- Speech therapy
- Medical social service
- Trained Volunteers
- Respiratory therapy
- Clinical pharmacy services
- Medical supplies coverage
- Inpatient care for symptom control
- Durable Medical Equipment
- Medications for symptoms related to the terminal diagnosis

SMA Hospice patients will receive care and services consistent with the needs identified in the continuing evaluation process and consistent with their benefit plan description.

Who Provides the Hospice Services?

An interdisciplinary team with shared responsibility for cases. The patient's physician and the SMA Hospice Medical Director, registered nurses, social workers, therapists, home care aides, pastoral counselors and trained volunteers work together to provide physical, emotional and spiritual support to the patient and family.

How Do I Initiate a Referral?

Call Southwest Medical Hospice Care at **(702) 671-1111**. Individualized care is available 24-hours-a-day, 7-days-a-week.

For more information about Southwest Medical Hospice Care, please call **(702) 671-1111**.

13.8 Durable Medical Equipment (DME): Specialty Rehabilitation and Home Infusion Services

Southwest Medical Pharmacy & Home Medical Equipment is dedicated to delivering quality patient care in the home. Southwest Medical Pharmacy & Home Medical Equipment is Health Plan of Nevada's contracted full-service durable medical equipment, specialty rehabilitation, and home infusion pharmacy company that offers a comprehensive range of health care services and products including:

Home Infusion Therapy	Durable Medical Equipment	Rehab and Specialty Products
• IV Antibiotics • Total Parenteral Nutrition • Chemotherapy • Hydration • Immunotherapy • Enteral Nutrition and Pumps	• Walkers • Wheelchairs • Crutches • Canes • Commodes • Bili Lights • Diabetic supplies • Insulin Pumps • Ostomy Supplies • Urological Supplies • Breast pumps	• Customized wheelchairs • Cushions • Power wheelchairs and scooters • Standing frames
All clinical services are overseen by a Registered Pharmacist	Respiratory Therapists on staff and available 24/7	Licensed ATP on staff

Southwest Medical Pharmacy & Home Medical Equipment provides products and equipment to rent and purchase. We are committed to providing customized home health care to each patient. Our team of professionals includes doctors of pharmacy, registered pharmacists, respiratory therapists, licensed technicians and patient intake specialists. Our customer service staff is available 24 hours a day, 7 days a week to assist providers, patients and their caregivers with questions or concerns regarding our products and services.

Location: 6720 Placid Street, Las Vegas, NV 89119

Phone: (702) 796-1016

DME Fax: (702) 242-7703

Pharmacy Fax: (702) 796-0818

13.9 Durable Medical Equipment (DME): Large DME and Respiratory Equipment

Preferred Home Care is Health Plan of Nevada's designated DME provider for large DME and Respiratory Equipment. For the DME listed below, contact Preferred Home Care directly at (702) 951-6900 or (888) 520-1212 or fax to (702) 951-6904.

- Alternating pressure pad and pump

- Apnea monitor
- CPAP, BiPAP, BiPAP ST
- Knee CPM
- Lightweight wheelchairs
- Low Air-Loss Mattress
- Oxygen systems
- Patient lift/hoyer
- Semi-electric beds
- Standard wheelchairs
- Tens units
- Trach supplies
- Volume ventilators

For all custom DME or DME purchases above \$200, call HPN for Prior Authorization at (702) 242-7330.

13.10 Transitional Care Unit (TCU) Admissions (Subacute and SNF)

A transitional level of care is available in the following types of settings

Medical/Subacute Level of Care:

Definition of patient types:

A **subacute patient** is a medically complex patient who qualifies for acute hospitalization, but does not require the high technology of the acute hospital. Subacute care requires the coordinated services of an interdisciplinary team including physicians, nurses and other relevant professional disciplines.

An **acute rehabilitation** patient is one who requires the care of a physiatrist, an interdisciplinary team, has a good rehabilitation potential and can tolerate four to six hours of therapy a day.

Admission criteria to the medical/subacute unit:

- Patient has a subacute/medical need or short-term rehabilitation need.
- Services needed cannot be performed in a less intensive setting, e.g., home health or outpatient setting.
- Patient may have failed in his/her home environment with alternative, less intensive services.
- Subacute setting can meet patient's needs. The Harmon Hospital (HH), admissions service can provide you with specific admission criteria by calling the admission service at (702) 794-0100, extension 4012.
- Admissions can occur as a transfer from an acute or skilled/custodial facility, an emergency room, urgent care or to a surgery center. Admission services case managers will assist with referral to HH.
- The patient must be evaluated by a physician prior to a direct admission.

All admissions require:

- Physician orders and transfer summary completed by the transferring physician (ER/UC/PCP)
- Chest x-ray or orders for a portable x-ray on admission.

Patients that are in the medical subacute level of care are to be seen by the attending physician daily.

Skilled Care/Skilled Rehabilitation Level of Care:

Definition of patient types:

A **skilled rehabilitation** patient is a patient who requires at least one therapy a day to increase his/her level of functioning, is alert and able to follow instructions.

A **skilled nursing** patient is patient, who regardless of age, meets Medicare Part A skilled criteria and cannot be maintained at home.

Admission to the **skilled care or skilled rehabilitation** is coordinated through HH admissions service. These criteria are in accordance with Medicare definition of skilled care and skilled rehabilitation.

Admissions to the skilled units are generally arranged during normal working hours unless there is need for special arrangements. Patients admitted to a skilled/skilled rehabilitation should be seen by the attending physician bi-weekly or as needed.

Custodial Level of Care:

Definition of patient types:

A **group care** patient is one who is independently mobile but cannot be at home due to inability to provide own meals, handle medications or finances.

An **intermediate nursing facility** patient is one who is unable to be maintained at home; requires assistance with ADLS (bathing, dressing, transferring, ambulating), as well as with IADLs (shopping, homemaking, etc.); and does not meet any skilled Medicare criteria.

Admission to the **custodial level** of care can be made by contacting the nursing facility directly. The facility will then notify HPN of the admission.

13.11 Breast Care Program

The Southwest Medical Breast Care Program is dedicated to promoting breast health, breast cancer education, and early detection of breast cancer. The program has three APRN's to perform clinical breast exams prior to any diagnostic exam of the breast. Patients receive preliminary results of their diagnostic mammogram and/or breast ultrasound prior to leaving the department. If a biopsy/procedure is recommended, patients are informed by the APRN, instructions are provided and patients have the opportunity to have all their questions answered. The Breast Care Department staff assists patients with scheduling their biopsy/procedure while they are still in the department. If additional testing is required, the Breast Care staff will obtain prior authorization and submit referrals for any other post visit procedures that are ordered.

The program consists of a team of qualified professionals ready to provide medical and emotional support. The following are the major goals and services of the Breast Care Program:

- Review, process and prioritize all referrals to the Breast Care Program to expedite evaluation and diagnosis.
- Educate and heighten the awareness of breast health and early detection of breast cancer.

RN Navigator

The Breast Care Nurse Navigator is specially trained registered nurse who functions as the primary contact and support person throughout diagnosis, treatment, and recovery of the patients' breast cancer journey. The RN Navigator assists with the coordination and expediting of patient care. Information and education are given to newly diagnosed breast cancer patients in order for them to informed decision regarding treatment options. The RN Navigator also provides breast health education in the community.

For more information about the Breast Care Program please **call (702) 877-5253**.

13.12 Wound Care

Southwest Medical Associates Wound Care Center was designed to provide medical treatment to non homebound patients with chronic wounds. Set in a caring environment, the Clinic offers direct supervision by an onsite physician with a wound care background. The primary job of the Wound Care Clinic is the treatment of "Chronic Wounds". This includes many conditions related to vascular disease and diabetes, lower extremities chronic wounds. We also offer transcutaneous pulse oximetry testing for hyperbaric treatments.

Locations:

Wound Care
4750 W Oakey Blvd, 1st floor
725-600-8630

Hours of Operation for Wound Care:

Monday and Friday (Wounds below knee to toe only)
7:00am - 12:00pm & 1:00pm – 4:00pm

Tuesday, Wednesday, and Thursday (Wounds from head to toe)
7:00am-12:00pm

****All services are by appointment only****

Appointment procedure:

- Patients must have a referral form completed by Primary Care Provider, Specialist, or Urgent Care Provider.
- Referral must be faxed to 702-266-8774 or submitted electronically via At Your Service.
- A Wound Care assistant will contact patient and schedule an appointment

Services provided:

Wound Care

- Evaluation for Hyperbaric oxygen therapy (HBO) is available on referral. TCOM (TcPO2) studies will be done to determine if HBO treatment will be effective.
- Chronic Wound Care
- Consultation for negative pressure therapy (wound vacuum) is available
- ABI evaluation for PAD screening and diagnosing
- No "STAT" or "Expedited" wound care referrals. Patients needing higher level care of care for their wounds may need to go to Urgent Care or Emergency Room to be evaluated.

Podiatry Wound Care:

- Wounds below the knee
- Any wounds of the lower extremity (below the knee)

13.13 Closed Observation Unit

Southwest Medical Associates Closed Observation Unit (COU) consist of five beds intended to meet the needs of Health Plan members requiring additional services and/or care that can be reasonably provided on a strictly outpatient basis. Health Plan patients can be admitted to the Observation Unit when it is decided additional monitoring and/or care is necessary and can safely and appropriately be provided within 23 hours of disposition.

The Closed Observation Unit is located at:

**888 S. Rancho Dr.
Phone (702) 877- 5335**

The Chest Pain Center is an important component of the unit.

All admissions to the Observation Unit must be screened by Care Management to establish eligibility. **Only Urgent Care providers can admit to this unit.**

Providers: If you are considering admitting a patient for admission to COU, you can contact the provider on duty at the Rancho Urgent Care for consultation.

Appropriate admissions include but are not limited to:

- Patients with an episode of chest pain who are now pain free with no significant EKG changes requiring ongoing monitoring and serial cardiac enzymes
- Blood transfusions
- Rehydration
- Adult Asthmatic patients needing serial SVN treatments
- CHF patients requiring diuresing.

13.14 Disease Management Program

HPN 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 Health Plan of Nevada's current Disease Management Program.

Evidence-Based Clinical Practice Guidelines

HPN 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 HPN website at:

www.myHPNprovider.com, "I need help with", select "Clinical Guidelines". For a hardcopy of a guideline, please 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. HPN 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 HPN Works with Members in Disease Management Program

Members identified for the Disease Management Program receive mailings from HPN 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

HPN issues member-specific "Gaps in Care" reports to primary physicians on a quarterly basis. Members in the HPN 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 myHPNOnline.com and sign in to the online provider center (@ your service).

Primary Components of HPN'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 HPN 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 HPN 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 HPN'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.

13.15 Complex Case Management Program

Health Plan of Nevada 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 Program 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.

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- Members diagnosed with cancer. 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, including AIDS.
- 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 other high risk diagnoses).
- 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 Complex Case Management Program, please contact the CCM Department at: (702) 797-2100 or (877) 692-2058.

**HEALTH PLAN OF NEVADA
PROVIDER SUMMARY
GUIDE**

SECTION 14

CLAIMS

14 - Claims

For several years, Health Plan of Nevada (HPN) 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. HPN's claims processing time frames have been defined based upon Nevada State Statutes and Federal Regulations.

14.1 Claims Adjudication and Payment

For levels of care and up-to-date procedural coding, HPN 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 HPN 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, HPN **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.

HPN 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

Health Plan of Nevada (HPN) applies the following guidelines for 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.

14.2 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 Health Plan of Nevada (HPN) 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 HPN 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 HPN 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 HPN any compensation for which they are entitled from the third party. This will allow HPN to seek reimbursement from the third party for claims it paid on behalf of the member.

Please follow these simple steps when billing HPN:

- 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 7.4)*
- Interactive Voice Response HPN **(702) 242-7724** or **(800) 768-2808**
 - *(For more information about IVR, please refer to section 7.3)*
- Check the back of the member's ID card for claim and billing information.
- Note the member number listed on the HPN 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 claims(s) to:

Health Plan of Nevada, Inc.
Attention: Claims
P. O. Box 15645
Las Vegas, NV 89114-5645

14.3 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:

Health Plan of Nevada, Inc.
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/Prior Authorization ☐ ERSDOT/TIME 90%									
2. Predetermination/Prior Authorization Number									
POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #6)									
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code									
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION									
3. Company/Plan Name, Address, City, State, Zip Code									
13. Date of Birth (MM/DD/YYYY) 14. Gender ☐ M ☐ F 15. Policyholder/Subscriber ID (SSN or ID#)									
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)									
5. 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									
16. Plan/Group Number 17. Employer Name									
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 Dental)									
RECORD OF SERVICES PROVIDED									
24. Procedure Date (MM/DD/YYYY)	25. Area of Oral Care	26. Teeth System	27. Teeth Number(s) (1-16)	28. Teeth Surface	29. Procedure Code	30a. Orig. Provider	30b. City	30. Description	31. Fee
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
33. Missing Teeth Information (Place an "X" on each missing tooth):					34. Diagnosis Code List Qualifier ☐ (ICD-9 = B; ICD-10 = AS)		31a. Other Fee(s)		
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
41	42	43	44	45	46	47	48	49	50
51	52	53	54	55	56	57	58	59	60
61	62	63	64	65	66	67	68	69	70
71	72	73	74	75	76	77	78	79	80
81	82	83	84	85	86	87	88	89	90
91	92	93	94	95	96	97	98	99	00
35. Remarks									
AUTHORIZATIONS									
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.									
X Patient/Guardian Signature _____ Date _____									
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.									
X Subscriber Signature _____ Date _____									
ANCILLARY CLAIM/TREATMENT INFORMATION									
38. Place of Treatment (e.g. 11=office; 12=Outpatient) 39. Enclosures (Y or N) (Use "Place of Service Codes for Professional Claims")									
40. Is Treatment for Orthodontics? ☐ No (Skip 41-43) ☐ Yes (Complete 41-43)									
41. Date Appliance Placed (MM/DD/YYYY)									
42. Months of Treatment 43. Replacement of Prosthetics Remaining ☐ No ☐ Yes (Complete 44)									
44. Date of Prior Placement (MM/DD/YYYY)									
45. Treatment Resulting from ☐ Occupational (Work Injury) ☐ Auto accident ☐ Other accident									
46. 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.)									
48. Name, Address, City, State, Zip Code									
49. NPI 50. License Number 51. SSN or TIN									
52. Phone Number () - 53a. Additional Provider ID									
54. NPI 55. License Number 56. Provider Specialty Code									
57. Address, City, State, Zip Code									
58. Phone Number () - 59. Additional Provider ID									
©2012 American Dental Association (A30) (Same as ADA Dental Claim Form - A301, A302, A303, A304, A300)									
To reorder call 800.647.4746 or go online at adacatalog.org									

14.4 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/>

14.5 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. Medicaid claims must be submitted within 180 calendar days from the date of service. If a Medicaid claim is submitted more than 180 calendar days after the date of service, the claim will be considered stale dated. Claims not submitted within these timely filing periods 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. Reconsiderations or resubmissions submitted after one year may not be considered.

Submit claims(s) to:

Health Plan of Nevada, Inc.
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 HPN Medical Director and/or the peer review committee.

14.6 Coordination of Benefits

When HPN 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.

14.7 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, please 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 HPN to provide our customers with superior service.

14.8 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 Health Plan of Nevada to follow industry standard guidelines with regard to altered claim images and ensures that HPN maintains compliance with Federal Regulations.

14.9 Electronic Claims Submission

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.

Health Plan of Nevada has chosen to use intermediaries for the receipt of electronic claims data. Health Plan of Nevada has completed compliance 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's:

Claims – Payor ID 76342
Encounter Data – Payor ID 76343

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

HPN will continue to receive paper claims. 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 contact us to discuss options for submitting attachments with your electronic claims.

14.10 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 7.4.

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.

14.11 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.

14.12 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 HPN 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.

14.13 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.

Health Plan of Nevada has developed a Quick Reference Guide for our Providers to assist you in the reconsideration process. Please visit our website at www.myhpnprovider.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.myhpnprovider.com, "I need help with" then "Frequently Used Forms" or in the Frequently Used Forms, Section 25.7, of this summary guide.



Telephone: You can call Member Services to request an adjustment for a claim that does not require written documentation. For HPN members please call **(800) 962-8074**.



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 also available for download on www.myhpnprovider.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.

14.14 Filing a Provider Dispute for a Medicaid and Nevada CheckUp Claim

Filing a Provider Claim Reconsideration

A provider has the right to file a reconsideration when a disagreement occurs regarding the claims adjudication process. Additionally, appeal rights are offered after the provider has completed two (2) claim reconsideration processes. If the second claim reconsideration process is not favorable, the provider is provided with their appeal rights and an appeal may be followed as outlined in the section **Filing a Provider Appeal for a Claim**.

An easy way to remember the claim reconsideration process is the "3 Step Rule". The following is an example of a claim denial that demonstrates the claims reconsideration.

1. Claim submission and claim denied for payment (Step 1 of 3)
2. Provider must submit a second Claim Reconsideration including EOP with an explanation for the dispute (Step 2 of 3). . Provider is notified of decision by EOP. Please see Section 14.13 for the claim reconsideration process.
3. Provider submits Claim Reconsideration requesting further review and includes any additional information and/or reiterates their reasons for dispute. Decision remains unchanged. Provider is informed of their appeal rights via EOP (Step 3 of 3)

After completing the claims reconsideration process above if the provider is not satisfied with the outcome of the claims reconsideration process an appeal may be filed. **See Filing a Provider Appeal for a Claim below for the appeal process.**

For claim reconsiderations, please submit your EOP with an explanation for the dispute and any supporting documentation to:

HPN
ATTN: Claim Reconsiderations
P.O. Box 15645
Las Vegas, Nevada 89114-5645

Filing a Provider Appeal for a Claim

Providers may file a claims appeal after following the process outlined above for claim reconsiderations. Claim-related appeals should be submitted to the HPN Customer Response and Resolution (CR&R) Department listed below. An appeal can be filed by sending a copy of the Explanation of Payment (EOP) along with the reason the claim is being appealed. The process is outlined below:

1. Provider submits appeal to the address listed below
2. The Health Plan acknowledges appeal request in writing
3. The Health Plan renders decision on appeal and notifies provider in writing of decision. If the decision is unfavorable, the correspondence provides the rationale and the right to a State Fair Hearing. **Please see the Fair Hearings section below for detailed information.**

For appeals, please submit your written request explaining your reasons for dispute and any supporting documentation to:

HPN
ATTN: CR&R/Appeals
P.O. Box 14865
Las Vegas, Nevada 89114

If you have any questions regarding claims payment, please contact the Member Services department at **(800) 962-8074**.

State Fair Hearings

A provider may request a State Fair Hearing when he has exhausted HPN's dispute resolution process. HPN will participate in the State Fair Hearing process. HPN is bound by the decision of the Fair Hearing Officer.

A State Fair Hearing may be requested by contacting the Nevada Medicaid Hearings Unit at 1-800-992-0900, extension 43602 or 1100 East William Street, Suite 204, Carson City, NV 89701. This hearing may be requested within 90 days of receiving the final dispute resolution decision from HPN. A State Fair Hearing may also be requested if HPN fails to make our decision in a timely manner. That is, within the 30-day time frame.

If information or help is needed, call the State Medicaid Office at:

Las Vegas: (702) 486-3000, extension, 43602 or
1-800-992-0900, extension 43602
Carson City: 1-800-992-0900, extension 43602

HPN will help providers through the Dispute Resolution process. If a provider needs information or help, contact HPN at:

Phone	(702) 242-7317
Toll free	(800) 962-8074
TTY/TDD	(702) 242-9214
TTY/TTD	(800) 349-3538

Business Hours: Monday – Friday, 8:00 a.m. – 5:00 p.m. Pacific Standard Time

A member has the right to review the case file, including medical records and any other documents and records used during the appeal process.

14.15 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)

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SECTION 15

QUALITY ASSURANCE/RISK MANAGEMENT

15 - Quality Assurance/Risk Management

HPN'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.

15.1 Quality Review Structure

HPN 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.

15.2 Quality of Care Reviews

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

Identification

HPN 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 HPN participating provider while providing care to a HPN member. If the findings of an investigation indicate that a participating provider has provided substandard or inappropriate care, or has exhibited inappropriate professional conduct, HPN 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.

15.3 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, HPN 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 HPN network.)

Coordination with Credentialing

To promote coordination with the HPN 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 16

QUALITY IMPROVEMENT PROGRAM

16 - Quality Improvement Program

Health Plan of Nevada (HPN) 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, HPN 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 HPN Provider Web site (www.myhpnprovider.com) or for a hardcopy, call (702) 242-7735.

16.1 HPN's NCQA Accreditation

HPN is accredited by the National Committee for Quality Assurance (NCQA), an independent, not-for-profit organization dedicated to measuring the quality of America's healthcare. Accreditation is for the commercial Health Maintenance Organization (HMO), commercial Point of Service (POS), commercial Marketplace, Medicaid and Medicare HMO product lines in Nevada.

NCQA accreditation surveys include rigorous on-site and off-site evaluations of over 80 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 has awarded a "Commendable" accreditation status for service and clinical quality that meet NCQA's rigorous requirements for consumer protection and quality improvement for the Medicare HMO product line.

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).

16.2 QI Program Structure

The HPN 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, HPN 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. HPN 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.

16.3 QI Initiatives

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

16.4 Member and Practitioner Satisfaction Surveys

Member and practitioner satisfaction surveys provide important feedback on performance in a number of areas. HPN 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 HPN members who access primary and specialty care. In addition, HPN conducts annual satisfaction surveys of its provider network. Data collected from these surveys are analyzed by HPN and opportunities for improvement are identified. The member and practitioner satisfaction surveys frequently result in the creation and implementation of focused quality improvement activities.

16.5 HEDIS Measures

Annually, HPN 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 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.

HPN 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. HPN looks to the network of providers to share health care data with HPN in order to generate accurate reports. As part of this annual data collection, the HPN's Quality Improvement Department may request access to medical records and charts to abstract specific HEDIS® information. Providers agree to participate in these mandatory quality activities when they contract with managed care plans who maintain state and federal government contracts.

16.6 Quality and Patient Safety Reminders

Maintaining high quality and promoting optimal patient safety are critical goals for the entire health care system. HPN 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 preventive 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 <http://www.justice.gov/crt/about/cor/Pubs/ISpeakCards.pdf>
- 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 (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.

2018 HPN Provider Summary Guide

HPN 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 the communication process, please contact the HPN Quality Improvement Department at: (702) 242-7735.

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SECTION 17

MEDICAL DIRECTOR

17- Medical Director

As an integral part of its medical management services, HPN offers a knowledgeable Medical Director who is available 24-hours-a-day, 365-days-a-year for physician to physician communication. The HPN 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 HPN Medical Director.

17.1 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 HPN'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.

Health Plan of Nevada

<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 18

MENTAL HEALTH

18 - Mental Health/Substance Abuse

Mental Health/Substance Abuse Utilization Management

Behavioral Healthcare Options (BHO) provides Mental Health and Substance Abuse services to Health Plan of Nevada (HPN) 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

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 cases 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/Insureds 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**.

18.1 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 or 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 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 medical necessary admission.

18.2 Concurrent Review

To provide a member with continued quality care, an assigned Senior Care Advocate will monitor the case throughout the course of treatment. Through discussion with the provider and/or review of daily records, the Senior 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.

18.3 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 Senior Care Advocate. A retrospective review may include onsite visits or a thorough review of clinical records.

18.4 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.

18.5 Non-Authorization and Appeal Procedure

Notification of Non-Authorization:

1. If the case is an outpatient case:
 - The Senior Care Advocate will complete the data entry, print information as needed, and close the case. Notification will be mailed to the provider, patient and facility as appropriate.
 - BHO will provide the specific administrative or clinical rationale and the review criteria used for the non-authorization decision.
2. If the case is an inpatient case:
 - The Senior Care Advocate will complete the data entry, fax a copy of the non-authorization letter to the facility business office, mail hard copy of the non-authorization letter to the facility, attending provider, and patient.
 - The Senior 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 and case will be closed.

- Non-authorization notification will include the specific 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.

Behavioral Healthcare Options (BHO) Physician/Peer Advisors and Medical Directors are available to discuss problems with non-authorizations during each working day.

Appeal

When a patient or an assigned agent of their choice with written assignment 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) 242-7300 or (800) 777-1840. In a consult capacity for the Health Plan, 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 19

HEALTH EDUCATION & WELLNESS

19 - Health Education and Wellness

19.1 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 myHPNOnline.com and sign in to the online provider center (@ your service).

- 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.

19.2 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 myHPNonline and sign in to the online provider center (@ your service)

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.

19.3 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.

19.4 Online Learning

HEW offers MyHEWOnline.com, 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.com and they can access the Health Risk Assessment (MyHRA), online learning modules, and various videos and health education tools.

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SECTION 20

NEW MEDICAL TECHNOLOGY

20 - New Medical Technology

To keep pace with developments in new medical technology and to ensure that members receive safe and effective care, Health Plan of Nevada (HPN) has a formal process to assess emerging medical discoveries and new uses for existing technologies before they can be offered as a benefit to HPN members. This process includes the review of medical procedures, drugs, devices, diagnostic tests and new applications for existing technologies. In addition, HPN adopts (and notifies members of) the Centers for Medicare & Medicaid Services' notice of a national coverage decision regarding new medical technology.

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. HPN 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, HPN 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 Relations for provider requests or have the member contact Member Services for member requests.

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SECTION 21

PHARMACY SERVICES

21 - Pharmacy Services

The role of Health Plan of Nevada's (HPN) 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 HPN'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

21.1 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 HPN 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 HPN's protocols. The prior authorization process for our Commercial and Medicaid lines of businesses is handled locally by the HPN Pharmacy Services Department. For Senior Dimensions, prior authorization services are provided by OptumRx.

21.2 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 SECTION 25.8** and must be completely filled out.

Exception and Prior Authorization Requests for Senior Dimension Members

An exception request allows members to ask for coverage a non-formulary drug, coverage of a non-preferred drug at a preferred cost, or to waive step therapy requirements or quantity limit restrictions. A provider must submit a statement supporting an exception request; this supporting statement should be submitted with the exception request either using the Exception Request Form or a separate request in the event the patient asked for the exception. To request an exception, use the Exception Request Form. Please make sure to complete all requested information and submit the form as outlined below.

To submit an *exception request by fax*, fax to (800) 527-0531. Hours of operation are 5 a.m. - 7 p.m., Monday through Friday and 6 a.m. - 3 p.m. on Saturday.

To submit a *prior authorization request by phone*, call (800) 711-4555. Hours of operation are 5 a.m. – 7 p.m., Monday through Friday and 6 a.m. – 3 p.m. on Saturday.

To submit an *exception request by mail*, mail to OptumRx, 3515 Harbor Blvd, Costa Mesa, CA 92626.

Exception and Prior Authorization Requests for Commercial and Medicaid Members

To submit a *prior authorization request by phone*, call (702) 242-7050 or (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 ((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 HPN - Pharmacy Services, Attn: Medical Necessity, P.O. Box 15645, Las Vegas, NV 89114-5645.

If you have questions on Commercial or Medicaid 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 (800) 443-8197, 8:00 a.m. – 5:00 p.m. Monday through Friday.

21.3 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.

21.4 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.

Senior Dimensions

Appeals must be submitted within 60 calendar days from the date of the coverage determination notice.

Medicaid Members

Appeals must be submitted within 90 calendar days from the date of the coverage determination. Extensions may be provided for good cause.

Commercial Members

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)
Senior Dimensions	(702) 242-7301 / (800) 650-6232	(702) 242-7655
Medicaid	(702) 242-7317 / (800) 962-8074	(702) 242-9431
Commercial	(702) 242-7300 / (800) 777-1840	(702) 242-9431

21.5 Pharmacy Services Call Center

Available for Commercial and Medicaid lines of business only. Medicare lines of business utilize the Pharmacy Help Desk provided by OptumRx. They can be reached 24 hours a day and 7 days a week at (800) 711-4555.

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

21.6 After Hours Call Center (for Commercial and Medicaid lines of business only)

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 HPN/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.

21.7 Pharmacy and Therapeutics Committee

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

Please note: The Senior Dimensions Medicare formulary is maintained by UnitedHealthcare's Medicare division.

21.8 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.

21.9 Published Preferred Drug List

The HPN Preferred Drug List is updated regularly and is available on our web site at www.myhpnonline.com/provider/Pharmacy-Benefits, click on **Prescription Drug Lists** and at www.seniordimensions.com under the **Drug List** tab. Preferred Drug List updates are sent via fax as needed throughout the year. Practitioners are encouraged to use the HPN 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.

21.10 Moratorium

HPN 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.

21.11 Incentives

HPN **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. HPN may institute quantity limits on medications if there is no data to support the continued high usage of the quantity/dosage being prescribed.

21.12 Senior Dimensions

The HPN Senior Dimensions Medicare Advantage plan provides prescription and medical coverage for patients. It provides pharmaceutical coverage that Medicare alone does not cover with variable co-payments to the members that are based upon the type of drug (generic/brand name) and whether or not it is included on the Senior Dimensions formulary. Rules and limitations of coverage are based upon Centers for Medicare and Medicaid Services regulations.

21.13 Generic Substitution for Commercial Plans

HPN 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.

21.14 Direct Member Reimbursement of Prescription Drugs

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

Senior Dimensions

The member can call (702) 242-7301 or (800) 650-6232 and request a Direct Member Reimbursement Form or go online to www.seniordimensions.com and click on **I need help with** then click on **Direct Member Reimbursement Form** to print out form. Once the form has been filled out, please mail the form to OptumRx, P.O. Box 29045, Hot Springs, AR 71903.

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

HPN (Medicaid)

The member can call (702) 242-7317 or (800) 962-8074 and request a Direct Member Reimbursement Form.

Once the form has been filled out, please mail the form to: **Claims Department, P.O. Box 15645, Las Vegas, NV 89114.**

HPN (Commercial)

The member can call (702) 242-7300 or 1-800-777-1840 and request a Direct Member Reimbursement Form or go online to www.myhpnonline.com/Member then click on **I need help with**, 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.**

21.15 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

HPN 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 HPN 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.

21.16 Medication Therapeutic Management Program

For our qualified and interested Medicare members, the health plan offers a Medication Therapeutic Management program. This program periodically screens the members' medication profile and looks for ways to reduce medication costs, as well as the amount of prescriptions that the patient is taking for a specific disease state. Qualifying members are then given an opportunity to join the program. Those that choose to join either receive educational materials in the mail or have the opportunity to meet with a clinical pharmacist to review their medications and discuss any problems they may be having. Enrollment is completely optional and enrolled members are encouraged to discuss all issues with their providers.

21.17 Frequently Used Forms

- Medical Necessity Request Form (HPN Commercial and Medicaid)
- Senior Dimensions Coverage Determination 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

Prior Authorization Request Form

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information (required)					
Medication Name:			Strength:	Dosage Form:	
Is This Medication a New Start? ☐ Yes ☐ No			Directions for Use:		
Clinical Information (required)					
What is the patient's diagnosis?					
ICD-9/10 Code(s):					
What medication(s) has the patient tried and failed?					
Are there any supporting labs or test results? (Please specify)					

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
 If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
 For urgent or expedited requests please call 1-800-711-4555.
 This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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SECTION 22

ADVANCED DIRECTIVES

22 – 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 22.1 NV and 22.2 AZ)

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 cannot 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

22.1 Advanced Directives 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.

22.2 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: _____