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 that are not eligible for enrollment into our Managed Care Medicaid program. For purposes of this manual section, all programs are referred to as Medicaid, unless discrepancies are noted.

8.2 Member Enrollment

Medicaid members are requested to select a managed care plan during their 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, collectively referred to as Nevada Medicaid. An open enrollment period occurs annually, at the discretion of DHCFP.

A member who is enrolled in HPN may switch to a different health plan within 90 days of their initial enrollment. After their initial 90 days of enrollment, members are "locked in" to the plan they have chosen. However, members may request to change their health plan due to good cause, which generally includes:

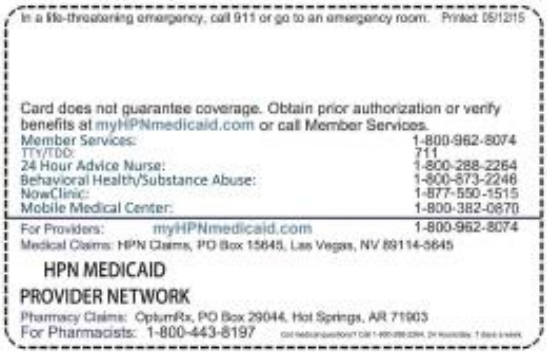
a. The member moves out of the service area.
b. The plan does not, because of moral or religious objections, cover the service the recipient seeks.
c. The recipient needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the recipient's primary care provider or another provider determines that receiving the services separately would subject the recipient to unnecessary risk.
d. Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, lack of access to providers experienced in dealing with the recipient's health care needs.

8.3 ID Cards

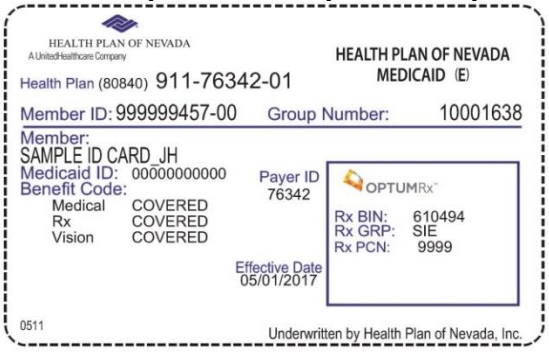
Health Plan of Nevada issues ID Cards for HPN Medicaid members. Members should take their health plan ID card along with their or their child's State Medicaid ID card to all of their appointments and to fill prescriptions. They should also have it available when contacting Member Services. Sample ID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

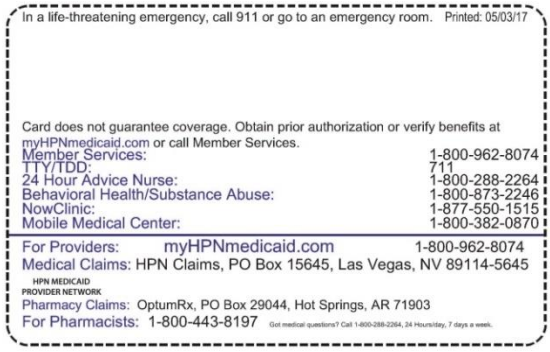
Medicaid sample health plan ID card

Nevada Check Up sample health plan ID card

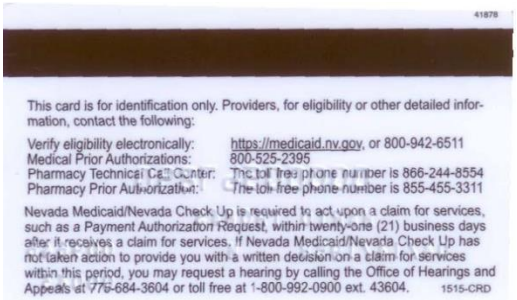


Nevada Expansion sample health plan ID card





Sample State ID card



8.4 PCP Assignment

All Medicaid members are requested 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. Members are not allowed to be assigned at the clinic level.

Members may change their PCP at any time. Pregnant members may choose an OB physician or health care provider as their PCP during the duration of the pregnancy and up to six weeks post-partum. Members with disabilities, chronic conditions, or complex conditions shall be allowed to select a specialist as their PCP. Members who have lost their eligibility and have become eligible again will be reassigned to the previous PCP unless the member requests a different PCP at the time of re-enrollment.

8.5 PCP Reassignment (Divorce of 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

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

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

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

A copy of the Divorce of Patient Care letter should be emailed to your provider advocate, or mailed to the Provider Services Department at:

HPN Provider Services
Attention: Provider Services Advocate
P.O. Box 15645
Las Vegas, NV 89114-5645

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

8.6 Pharmacy Lock-Ins

The health plan may restrict members to a specific pharmacy from which to get their medications. This program is called the Lock-In Program and "locks" members to a pharmacy if their medication utilization meets certain criteria.

Pharmacy and medical claims are reviewed for opioid use and pain related services. Members with multiple opioid prescriptions from multiple providers being filled at multiple pharmacies will be reviewed for inclusion in the Lock-In Program. Medical claims associated with pain diagnoses at the hospital, ER, or clinics will be reviewed. Other potentially harmful regimens such as the "Holy Trinity" (carisoprodol, hydrocodone, alprazolam) may be part of the review for Lock-In.

Information received from other entities such as CMS or the State of Nevada will be considered as well for inclusion in the Lock-In Program. Members who transition to the Health Plan of Nevada Medicaid plan and were in the Fee For Service or other MCO Lock-In Program will be included in the HPN Lock-In Program.

Members are notified via letter of their inclusion in the program, their locked pharmacy, their ability to request or change their pharmacy, and about the availability of an appeal. Members in the program are periodically reviewed for continued inclusion in the program.

8.7 HPN Medicaid Members' Rights and Responsibilities

Medicaid members have the following rights and responsibilities, which agree with federal and state regulations and the National Committee for Quality Assurance Accreditation standards.

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.

8.8 Member Grievances

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.

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. 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 of the investigation. 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.

8.9 Referrals, Prior Authorizations and Utilization Management

Please refer to Section 9 for specific Prior Authorization and Utilization Management information and Section 11 for Referrals to Specialists information. HPN responds to routine requests with an approved or denied status within 14 calendar days upon receipt of the request, and 30 days for post-service decisions. Urgent service requests will be approved or denied within 72 hours upon receipt of the request.

The following services 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

Medical director decision notification is sent to the requesting care provider and the member. The decision is faxed and mailed to the care provider. The denial notification letter contains information on the member's appeal and grievance rights, continuation of benefits and the fair hearing process.

8.10 Member Appeals

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.

HPN will provide a letter called 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.

Handling of an Appeal

A member or provider on behalf of a member has the right to file an **appeal** within 60 calendar days of the date on the notice of action 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, or a provider on behalf of 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 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

State Fair Hearings

Members, or a provider on behalf of a member, may access the State Fair Hearing process only after they have exhausted the HPN internal appeal process. Members are notified of the Fair Hearing process with the Notice of Action and the Appeal Decision letter. Grievances are not eligible for referral to the State Fair Hearing process.

Members may request a Fair Hearing by contacting the Nevada Medicaid Hearings Unit within 120 days of the denial per the notification of Fair Hearing Rights. HPN participates in the State Fair Hearing process and is bound by the decision of the Fair Hearing Officer. If HPN or the Fair Hearing Officer reverses an action to deny, limit, or delay services that were not furnished while the appeal was pending, HPN authorizes or provides the disputed services promptly and as expeditiously as the member's health condition requires.

Expedited State Fair Hearing

Members, or a provider on behalf of a member, may file for an Expedited Fair Hearing (via DHCFP) if the clinical documentation shows that the time permitted for a Standard Fair Hearing could jeopardize the individual's life, health or ability to attain, maintain or regain maximum function.

The granting of an expedited State Fair Hearing is at the discretion of DHCFP. If DHCFP grants the member an expedited State Fair Hearing, the health plan will follow procedures and processes as requested by the DHCFP. All Expedited Fair Hearings are held telephonically due to time constraints.

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.

Continuation of Benefits While Appeals and State Fair Hearings Are Pending

The member's benefits must be continued if the member requests that 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 a State Fair Hearing 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.

8.11 Provider Responsibilities and Network Information

Eligibility Verification

Care providers who furnish services to Medicaid members agree to comply with all federal and state laws and regulations relevant to the provision of medical services, including but not limited to: Title XIX of the Social Security Act, the Medicare and Medicaid Anti-Fraud Act, the Health

Insurance Portability and Accountability Act (HIPAA), and the state Medicaid Fraud Act. You also agree to conform to MAD policies and instructions as specified in this manual and its appendices, as updated.

It is important that a provider office verify which Managed Care Plan a member is enrolled in by using one of Nevada Medicaid's eligibility verification tools. 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 Nevada Medicaid at 1-800-942-6511 or access their website at http://www.medicaid.nv.gov. 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, Monday through Friday, 8:00 a.m. – 5:00 p.m. PT at the following numbers:

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

Demographic Updates

HPN is committed to providing our members with the most accurate and up-to-date information about our network. Care providers must furnish HPN with complete information on changes to their address, license, certification, board specialties, corporate name or corporate ownership.

HPN must receive this information at least 60 days prior to the change. Any payment made by HPN based upon erroneous or outdated information is subject to recoupment. A care provider who notifies HPN of a change in status, location, licensure or certification must also update their status with Nevada Medicaid.

PCP Responsibilities and Expectations

Primary Care Physicians (PCP) 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. In addition to the requirements applicable to all care providers, the responsibilities of the PCP include:

- Provision of age appropriate preventive care, including but not limited to: immunizations, history and physical assessments, examinations, disease-risk assessments and well woman and well child examinations.
- Provision of EPSDT services for members under age 21, as described further in this Chapter.
- Member education, including but not limited to, examination findings, symptoms or side effects of treatments or medications, medically necessary treatment options, health maintenance, disease prevention counseling and education on the difference between urgent conditions and emergent conditions and what to do in those situations.

- PCPs and obstetricians must be available to members by telephone 24 hours a day, seven days a week, or have arrangements for telephone coverage by another HPN participating PCP or obstetrician.
- Maintain continuity of care by reducing duplication of diagnostic procedures. PCPs should provide all medical records to the member and forward these to the specialist.
- Communicate with the member's specialist care providers regarding drug therapy, laboratory and radiology results, medical consultations, and sentinel events, such as hospitalization and emergencies. Delivery of covered medically necessary, primary care services and preventive services, including EPSDT screening services and Well Baby/Child Services;
- Referrals for specialty care and other covered medically necessary services in the managed care benefit package;
- Maintenance of a current medical record for the enrolled recipient, including documentation of all services provided by the PCP, and specialty or referral services, or out-of-network services such as family planning and emergency services.

Specialist Responsibilities

In addition to the requirements applicable to all care providers, the responsibilities of specialist physicians include:

- responding to a PCP referral for specialist intervention and reporting results to the PCP in a timely manner.
- member education and training, 24-hour availability coverage and proper eligibility verification, authorization, and claims submission for services.
- assurance that a written report of the outcome of any referral, containing sufficient information to coordinate the member's care, is forwarded to the PCP within seven calendar days after the screening and evaluation visit, unless the member does not agree to release this information.

Advance Directives

Members have the right to make health care decisions for themselves, including the right to accept or refuse treatment and to execute a medical or psychiatric advance directive.
An advance directive is a written instruction, such as a living will or a durable power of attorney for health care that is recognized under state law and relates to the provision of health care when an individual is incapacitated. There may be several types of advance directives available to a member. Care providers must comply with state law requirements regarding advance directives.

PCPs must inform members of their right to determine their end of life care through education on advance directives. During the initial visit or PCP visit, PCPs must explain, in layman's terms, the meaning of: Cardiopulmonary Resuscitation (CPR), artificial hydration and nutrition, intubation, and comfort measures. Documentation supporting the member education must be recorded in the member's medical records. Signed copies of advance directives should be kept in the member's medical records and accompany the member when transferring care.

Members are not required to have an advance directive and a care provider cannot condition the provision of care or otherwise discriminate against a member based on whether or not the member has executed an advance directive. Care providers should document in a member's medical record whether the member has executed an advance directive. If a member does have an advance directive, a copy of it should be maintained in the member's medical record. The member (or the member's designee) should keep the original.

Changing the Advance Directives

Care providers must inform a member that he/she has a right to reaffirm an advance directive or change an advance directive at any time and in any manner, including oral statements. Care providers must also educate staff on issues concerning advance directives, including notification of direct care providers of services, such as home health care and personal care of any advance directives executed by members to whom they are assigned to provide services.

Members receive information on advance directives through the Member Handbook.

8.12 Medical Records

Medical records must be maintained in an organized and confidential manner. Providers are responsible for ensuring mechanisms are 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:

- 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;
- 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;
- 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;
- Advance Directive
- 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

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.

8.13 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

- Medically Necessary, PCP appointments are available within two (2) calendar days
- Urgent care PCP appointments are available in the Same Day
- 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.

8.14 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.

8.15 Cultural Competency

HPN recognizes cultural competency as a necessary component of member rights. It is our desire to integrate cultural competency into all systems of HPN, including quality improvement efforts.

Physicians and health care providers should be culturally sensitive to the diverse populations they serve. All services should be conducted in accordance with Title VI of the Civil Rights Act of 1964 and should be provided in a manner that respects the member's cultural heritage and appropriately uses natural supports in the member's community.

Some cultural preferences to remember include:

- Ask what language the member prefers to help eliminate communication barriers and, when necessary, use the available interpretation services.
- Understand the member's religious and health care beliefs.
- Understand the role of the member's family and their decision-making process.
- Don't assume the diets of similar countries are the same.

8.16 HPN Medicaid Network and Provider Advocates

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

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. 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.

8.17 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
- ✓ An unclothed physical exam
- ✓ Immunizations
- ✓ Laboratory tests
- ✓ Health education
- ✓ Vision services
- ✓ Hearing services
- ✓ Other medical needed 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
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 apply:

- Comprehensive health and developmental assessment and history
- Unclothed physical exam
- Immunizations (use all visits, preventive and sick, if medically appropriate)
- Laboratory tests, as appropriate for the age of the child
- Health education and age-appropriate anticipatory guidance
- A vision examination
- A hearing examination
- A dental examination
- And many other medically-needed services.

Allowable Sick Visits When Billing with a Wellness Visit Allowable Sick Visit CPT Codes with Required Modifier
99201, 99202, 99203, **99204*, 99205***, 99211, 99212, 99213, **99214*, 99215***

*****If using these billing codes, HPN requires a copy of the chart/progress note to accompany the billing.

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 99391-99395) using one of the appropriate sick visit Evaluation and Management (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 documented 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 HPN's online provider center, 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.

8.18 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 additional information about this program, please contact the Nevada State Immunization Program at **775-684-5900**.

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.

8.19 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. To enroll in this program please contact the registry coordinator at **775-684-4032**.

8.20 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.

8.21 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 24.6.

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 the online provider center 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 the online provider center, you may contact HPN's Provider Services department at 702-242-7088.

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.

8.22 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 denied.
- 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

Before any claims can be paid, the provider must be enrolled with Nevada Medicaid. To register with DHCFP, 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.

8.23 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.

8.24 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.

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.

8.25 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.healthplanofnevada.com/Provider) or for a hardcopy, call (702) 242-7735.

Please see Section 15 for detailed information about the Quality Improvement Program.