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 online annually and is available in electronic format by visiting www.healthplanofnevada.com/Provider. Additionally, important information is communicated between the annual guides by periodic updates on the HPN website, correspondence and faxes to all affected providers.

HPN Website

Another valuable tool available to providers and their office staff is the HPN website located at www.healthplanofnevada.com/Provider. The HPN website 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 the online provider center
- 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

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
- Submit a claim appeal

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 the online provider center (www.myaysonline.com). 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 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 the online provider center 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 24.3 in Section 24 and fax it back to HPN at (702) 242-7853 or email NVSierraCred@sierrahealth.com

For all other additions, changes, or provider terminations, please fax notification on your company letterhead to HPN at (702) 266-8809.

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:

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

Specialist Physician Access Standards:

Specialist Consultation (Outpatient)

STAT:	Appointment is available within 24 hours.
Expedited:	Appointment is available within 72 hours.
At Risk:	Appointment is available within 14 days.
Routine:	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.healthplanofnevada.com to find the most current directory of our network physicians and health care professionals.

Please see Section 8.13 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 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.

4.5 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.

4.6 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.

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) 266-8782

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