4 - Provider Administrative Requirements, Rights 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 HPN Provider Summary Guide is published online annually and is available by visiting www.healthplanofnevada.com/Provider. Additionally, important information is communicated by periodic updates on the HPN website and correspondence by fax and/or email to all affected providers.

For copies of provider updates please contact your Provider Advocate at **(702) 242-7088** or **(800) 745-7065** or visit our website www.healthplanofnevada.com/Provider.

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 will 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
- View and print member ID card
- 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 reconsideration

- Provider Demographic Attestation
- View empanelment and HEDIS reports (when applicable)

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 Use Acknowledgement Form** (section 24). 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** (section 24).

If your office does not currently have an account administrator, you may request an account online through the Online Provider Center. 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.

4.2 Provider Demographic Updates, 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 demographic 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. This attestation must occur on the Online Provider Center, failure to do so will result in your group/facility and providers being removed from our provider directories until the attestation has been completed. If upon review, you cannot attest to the information because it is inaccurate, you must promptly make the appropriate changes using the edit feature in the portal, or by reaching out to your provider advocate directly or email us at ProviderAdvocateTe@uhc.com.

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 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,
- 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.
- Whether the participating provider offers telehealth services

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.

The health plan may administratively terminate a provider contract 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 the provider addition request form at healthplanofnevada.com/Provider/Join-Our-Network.

For all other additions, changes, or provider terminations, please fax notification on your company letterhead to contracting at (702) 266-8809 or email ProviderAdvocateTe@uhc.com.

4.3 Access Standards

HPN establishes standards for appointment access and after-hours care to ensure timely access for our members. Performances against these established standards are 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

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 require that you and your practice have a mechanism in place for after-hours access to ensure 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 expect that you advise callers who are unable to wait until the next business day to do at least one of the following:
- Go to an in-network urgent care center,
- Call the nurse line on the back of their member ID card for assistance,
- Stay on the line to be connected to the physician on call,
- Call an alternative phone number to contact you or the physician on call, or
- Leave a name and number with your answering service or on a voicemail for a physician or qualified health care professional to call back within (at least) 2 hours.

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 for Medicaid Access Standards

4.4 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

4.5 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.

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, emailed, 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
ProviderAdvocateTe@uhc.com

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

4.8 Provider Grievance

As a provider for HPN members, there may be occasions in which you or your staff might wish to file a grievance. A grievance is defined as an expression of dissatisfaction with any aspect of the Health Plan's operations, activities or behavior, regardless of whether the communication requests any remedial actions. A grievance is a statement of dissatisfaction that does not include a request for benefits to be provided or altered, nor is a grievance a request for reimbursement or payment of claims. Submit the **Provider Grievance Form** (section 24) in writing to: ProviderAdvocateTe@uhc.com, or by phone at (702) 242-7088 (option 2 then 5).

4.9 Government Mandated Price Transparency and Disclosure

Government Mandated Price Transparency and Disclosure

This guidance is being issued to clarify and document that all agreements between Health Plan of Nevada (HPN) and health care physicians, health care professionals, medical groups, facilities and ancillary providers will be interpreted consistently with government mandated price transparency and disclosure, including each of the requirements set forth below.

Your agreement with HPN may include a confidentiality provision that lists types of information that neither party may disclose to a customer, health care provider, or other third party, except as required by an agency of the government. Each of the recently enacted requirements set forth below constitute such a requirement by an agency of the government, and nothing in your agreement with HPN will be interpreted to supersede or conflict with the requirements set forth below:

Consolidated Appropriations Act, 2021

The Consolidated Appropriations Act, 2021 ("CAA"), enacted December 27, 2020, states that a group health plan or health insurance issuer offering group health insurance coverage may not enter into an agreement with a health care provider, network or association of providers, third-party administrators, or other service provider offering access to a network of providers that would directly or indirectly restrict a group health plan or health insurance issuer offering such coverage from:

1. providing provider-specific cost or quality of care information or data, through a consumer engagement tool or any other means, to referring providers, the plan sponsor, enrollees, participants or beneficiaries, or individuals eligible to become enrollees, participants, or beneficiaries of the plan of coverage.

2. electronically accessing de-identified claims and encounter information or data for each enrollee, participant or beneficiary in the plan or coverage, upon request and consistent with the privacy regulations pursuant to section 264(c) of the Health Insurance Portability and Accountability Act (HIPAA), the amendments made by the Genetic Information Nondiscrimination Act of 2008, and American with Disabilities Act of 1990, including, on a per claim basis:
    a. financial information, such as the allowed amount, or any other claim-related financial obligations included in the provider contract.
    b. provider information, including name and clinical designation.
    c. service codes.
    d. any other data element included in claim or encounter transactions.
3. sharing information or data described in subparagraph (1) or (2) above, or directing that such data be shared, with a business associate as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations), consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990.

The CAA further states that a health insurance issuer offering individual health insurance coverage (including on exchanges) may not enter into an agreement with a health care provider, network or association of providers, or other service provider offering access to a network of providers that would directly or indirectly restrict the health insurance issuer from:

1) providing provider-specific price or quality of care information, through a consumer engagement tool or any other means, to referring providers, enrollees, or individuals eligible to become enrollees of the plan or coverage; or
2) sharing, for plan design, plan administration, and plan, financial, legal, and quality improvement activities, data described in subparagraph (1) with a business associate as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations), consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990.

CMS Hospital Price Transparency Rule

The CMS Hospital Price Transparency Rule, effective January 1, 2021, requires that hospitals publicly disclose the rates they negotiate with payers for all items and services, along with other pricing information, in a machine-readable file format. Separately, hospitals must create a consumer-friendly online display of charges for a set of “shoppable” services.

Tri-Agency Health Plan Transparency in Coverage Rule

The Departments of Health and Human Services, Labor and Treasury finalized the Tri-Agency Health Plan Transparency in Coverage Rule that will require health plans and health insurance issuers in the group and individual market (including exchanges) to publicly disclose in-network negotiated rates, along with historical payments to and billed charges from out-of-network providers, along with other detailed pricing information, in a machine readable file format. Separately, these health plans will be required to provide a consumer tool with personalized, real-time cost share estimates for all covered items and services, including prescription drugs. This regulation will become effective in phases beginning on January 1, 2022, January 1, 2023, and January 1, 2024.

4.10 Sign Language Interpretation Services

In support of your HPN patients, Health Plan of Nevada will provide access to our contracted sign language vendor for your interpretation needs. To access this free service, please contact the Member Services Department (phone numbers listed in **section 3 – Frequently Called Numbers**) who will confirm your patient's eligibility and connect you to the appropriate interpreter.