8 – Medicaid and Nevada Check Up

8.1 Medicaid Overview

Health Plan of Nevada Medicaid (HPN Medicaid) has been providing managed care Medicaid services in Nevada since 1997. Starting in 2026, HPN will only provide managed care services in Urban Clark County. HPN Medicaid 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 Nevada Medicaid. 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 Nevada Medicaid 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.

In order to participate in Health Plan of Nevada Medicaid, providers must be enrolled with Nevada Medicaid. If a provider is not enrolled, they will be referred to the State's fiscal agent for Medicaid provider enrollment to ensure that all Network Providers meet the provider disclosure, screening, and enrollment requirements set by the State. Providers must be enrolled with Medicaid and Nevada Check Up for all provider types and specialties under which they intend to bill for rendered services. In addition to provider enrollment, all providers must go through credentialing via Nevada Medicaid's centralized credentialing vendor.

8.2 Member Enrollment

Medicaid members may be 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 Nevada Medicaid in conjunction with Gainwell, Nevada Medicaid administrator, collectively referred to as Nevada Medicaid. An open enrollment period occurs annually, at the discretion of Nevada Medicaid.

Once enrolled in an MCO, a member 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 includes:

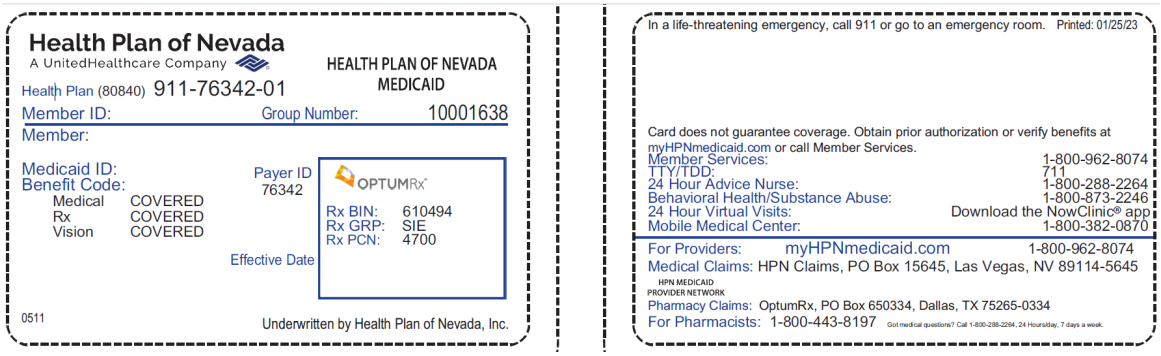
a. The member moves out of the service area.
b. The plan does not, because of moral or religious objections, cover the service the recipient seeks.
c. The recipient needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services 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. Members that use LTSS must be allowed to request disenrollment if the provider's change in status from a network provider to an out-of-network provider with HPN Medicaid would cause the member to have to change their residential, institutional, or employment supports provider, and, as a result, the member would experience a disruption in their residence or employment.
e. 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.

Members must renew their information with the Division of Social Services (DSS) to confirm they are still eligible for Medicaid. Medicaid members will receive redetermination paperwork from DSS to update their information, and they must return that information before the due date specified, or they will be terminated from Medicaid. Members can email or mail in their information for review. They can complete their redetermination over the phone or in person with DSS. DSS also has an online portal where members can update their information or complete their renewal: AccessNevada.nv.gov.
Nevada Medicaid includes the member's redetermination date on the eligibility page of the Electronic Verification System (EVS). When checking a member's eligibility for Medicaid, please note and share the redetermination date with the member to ensure they are aware of this important date.

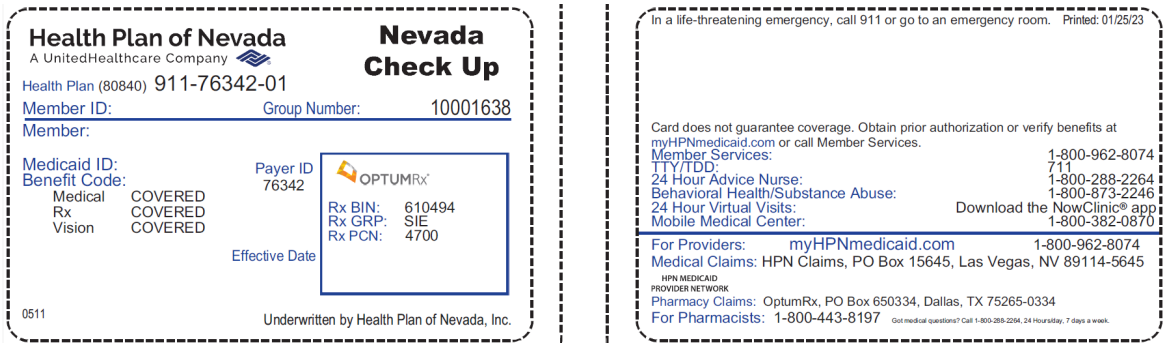
8.3 Member ID Cards

HPN Medicaid 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.**

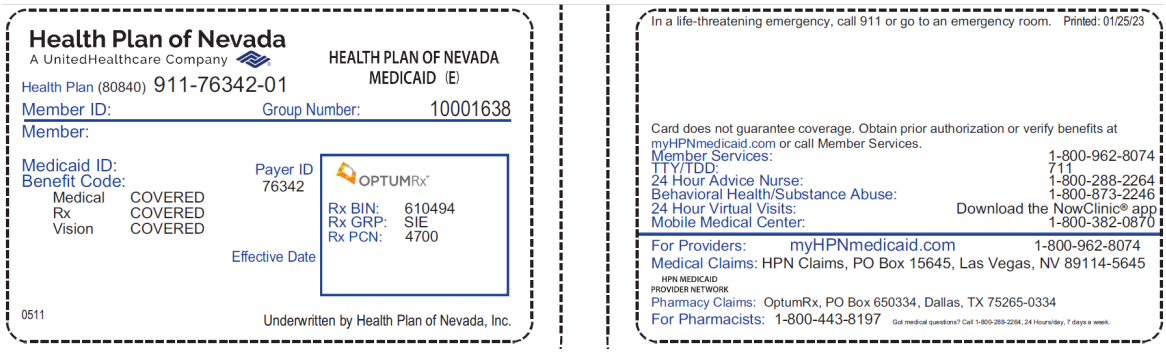
Medicaid sample health plan ID card



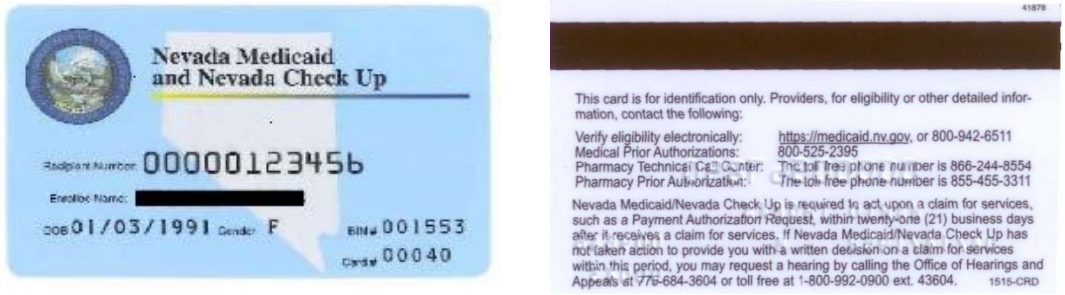
Nevada Check Up sample health plan ID card



Nevada Expansion sample health plan ID card



Sample State ID card



8.4 PCP Assignment

All Medicaid members are assigned a primary care physician upon enrollment with the health plan and should receive required care from this designated physician.

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 are 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 and Divorce of Care

HPN Medicaid may initiate a PCP change for a member under the following circumstances:

- Specialized care is required for an acute or chronic condition;
- The member's residence has changed such that the distance to the PCP is greater than 15 miles/10 minutes. Such change will be made only with the consent of the member;
- The PCP ceases to participate in our HPN Medicaid network;
- Legal action has been taken against the PCP, which excludes participation;
- The claims or encounter history illustrates the member is receiving services from a PCP other than the PCP originally selected by or assigned to the member;
- Per the PCP's written request that the member be reassigned to a different PCP; or
- At the discretion of HPN Medicaid, if determined to be in the best interest of the member.

HPN Medicaid 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 Medicaid 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

The physician 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 Medicaid 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 HPN Medicaid and were in the Medicaid Fee for Service or other MCO Lock-In program will be included in the HPN Medicaid 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 (NCQA) accreditation standards.

Member Rights

1. To be treated with respect and dignity and every effort made to protect their privacy.
2. 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 in accordance with 42 CFR 438.10.
3. To select a primary care provider (PCP), including specialists as their PCP if the member has a chronic condition, within the limits of HPN's extensive provider list including the right to refuse care from specific practitioners.
4. To participate with their PCP in the decision-making process regarding their care, including the right to refuse treatment.
5. To be provided the opportunity to voice grievances or appeals about the plan and/or the care provided and to pursue resolution of the grievance or appeal.
6. To formulate Advance Directives.
7. 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.
8. 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.
9. To have a candid, easy to understand, discussion of available treatment options and alternatives for their conditions, regardless of cost or benefit coverage.
10. To ensure the member is free to exercise his or her rights without HPN, its Network Providers or NV Medicaid treating the member adversely.
11. To have timely access to care and services, taking into account the urgency of their medical needs.
12. To have direct access to women's health services for routine and preventive care.
13. To have direct access to medically necessary specialist care, in conjunction with an approved treatment plan developed with the primary care provider. Required authorizations should be for an adequate number of direct access visits.
14. To have a second opinion, at no cost, from a qualified health care professional within the network or arrangements made to obtain one outside the network.
15. To have adequate and timely services outside the network, if HPN's network is unable to provide necessary services covered under the contract.
16. To have access to emergency health care services in cases where a "prudent layperson" acting reasonably, would have believed that an emergency existed.

17. To have oral interpretation services available free of charge for all non-English languages.
18. To make recommendations regarding the organization's members' rights and responsibilities policies.
19. To continuation of on-going care corresponding to a plan of care at the time of enrollment.

Member Responsibilities

1. To cooperate with those providing health care services, including providers and health plan staff.
2. To provide, to the extent possible, information that HPN and its providers need in order to provide the best care possible.
3. To follow instructions and guidelines given by those providing health care services.
4. To know how HPN's Managed Care Program operates.
5. To maximize health habits by understanding their health problems.
6. To participate in developing and following up the health care plan and treatment goals that they, their physician and HPN have mutually agreed upon.
7. To consult their PCP and HPN before seeking non-emergency care in the service area. To consult their physician and HPN when receiving urgently needed care while temporarily outside the HPN service area.
8. To obtain a written referral from their physician before going to a specialist.
9. To obtain prior authorization from HPN and their physician for any routine or elective surgery, hospitalization, or diagnostic procedures.
10. To be on time for appointments and provide timely notification when canceling any appointment that cannot be kept.
11. To avoid knowingly spreading disease.
12. To recognize the risks and limitations of medical care and the health care professional.
13. 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.
14. To show respect for other patients, health care providers and plan representatives.
15. To abide by administrative requirements of HPN, health care providers, and government health benefit programs.
16. To report wrongdoing and fraud to appropriate resources or legal authorities.
17. To know their medications. To keep a list and bring it to appointments with providers, as applicable.
18. To address medication refill needs during office appointments. To notify the provider office that refills are needed. To not wait until the medication is gone. To report all side effects of medications to their primary care provider. To notify their primary care provider if they stop taking medications for any reason.
19. To ask questions during appointments regarding physical complaints, medications, any side effects, etc.
20. To report any on-going care corresponding to a plan of care at the time of enrollment.
21. To report any third-parties responsible for payment of services.

8.8 Member Grievances

As a provider for HPN Medicaid 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 interests to address any issues that are expressed, and we would like the opportunity to do so.

Please note, a provider may act on behalf of the member with the member's signed consent. Requests for grievance not submitted by the member will not be processed until the signed consent is received.

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

- services received through HPN Medicaid
- the care or services received from network 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 Medicaid
PO Box 14865
Las Vegas, NV 89114-4865

We handle a grievance seriously and will try to resolve it to the members' satisfaction. Oral interpreter services are also available.

Once we receive the grievance, the member/authorized representative will be sent a letter from us within **five calendar days** stating that we have received the grievance. HPN Medicaid's staff may also contact the member/authorized representative to clarify the situation. **Within 45 days** of the day we receive the grievance, we will send the member/authorized representative a letter with the outcome of the investigation. We may extend this time to 14 calendar days if additional information is needed and the extension will benefit the member. The member/authorized representative 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 10 for referrals to specialists' information. HPN Medicaid 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 or 2 business days, whichever is shorter, 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
- Services performed by Federally Qualified Health Centers (FQHC)
- Services performed by Rural Health Centers (RHC) services
- Services performed by Certified Community Behavioral Health Centers (CCBHC)

- The first mental health or SUD assessment completed in a twelve (12) month period
- Intensive Crisis Stabilization Services (ICSS)
- Tobacco cessation treatments
- Emergency services
    - Emergency services are defined as covered inpatient and outpatient services that are as follows:
        - Furnished by a provider that is qualified to furnish these services under Title 42.
        - Needed to evaluate or stabilize an emergency medical condition
- Procedures performed in the physician's office with billed charges less than $1500.00 per CPT code

A medical director adverse decision notification letter is mailed to the requesting care provider and the member. The adverse determination notification letter includes the specific reason for denial, the benefit or criteria upon which the denial is based, and the offer for peer to peer review. This notification letter also contains information on the members' 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 Medicaid will provide a letter called a 'Notice of Adverse Benefit Determination' to the requesting provider and the member when it takes an adverse action or makes an adverse determination. HPN Medicaid 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 provider may act on behalf of the member with the member's signed current consent. Current consent is defined as consent received on or after the denial of services. Requests for appeals not submitted by the member will not be processed until the required signed current consent is received.

A member or provider on behalf of a member has the right to file one **appeal** within 60 calendar days of the date on the Notice of Adverse Benefit Determination for any of the following issues:

- The services requested were denied or limited
- The services previously authorized are reduced, suspended, or stopped
- Part or all of the payment for a service received is denied
- For a resident of a rural area with only one vendor, the denial of an enrollee's request to exercise his/her right to obtain services out of network.
- HPN Medicaid does not meet required timeframes (e.g., authorization, claims processing, or appeal resolution).

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 Medicaid will send a letter within five calendar days informing the member/authorized representative that the appeal was received. HPN Medicaid will provide a written decision no later than 30 calendar days after receipt of the appeal. HPN Medicaid may extend this time by up to 14 calendar days if the member/authorized representative 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 member's doctor asks for or indicates the member's health could be seriously harmed by waiting 30 calendar days for a decision,
- the member requests,

HPN Medicaid will review requests for expedited appeals to determine if clinical justification supports the request.

If HPN Medicaid determines, based on clinical records, the request for an expedited appeal is not justified, it will be changed to a standard appeal. HPN Medicaid will give the member/authorized representative prompt oral notice of the denial, whenever possible and send a written notice within two (2) calendar days.

HPN Medicaid will not take punitive action against a provider who requests expedited resolution or supports an expedited appeal.

HPN Medicaid will decide on an expedited appeal no later than 72 hours after we receive the appeal. HPN Medicaid 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/authorized representative with the decision. HPN Medicaid will send written notice of our decision within 72 hours of the appeal being received in company.

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 delivered to the address below:

HPN Medicaid
P.O. Box 14865
Las Vegas, NV 89114-4865

HPN Medicaid
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.

Expedited appeals may be filed via email, 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, providers on behalf of the member, and providers on their own behalf (under certain circumstances), may access the state fair hearing process only after they have exhausted the HPN Medicaid internal appeal process. Members and providers are notified of the fair hearing process with the Notice of Adverse Benefit Determination and the Notice of Resolution of Appeal letters. 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 90 days of the denial per the notification of fair hearing rights. HPN Medicaid participates in the state fair hearing process and is bound by the decision of the Fair Hearing Officer. If HPN Medicaid or the Fair Hearing Officer reverses an action to deny, limit, or delay services that were not furnished while the appeal was pending, HPN Medicaid authorizes or provides the disputed services promptly and as expeditiously as the member's health condition requires.

Providers may request a state fair hearing on behalf of a member, with the written consent of the member, for the following circumstances:

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

Providers may request a state fair hearing on their own behalf pursuant to NRS 422.306.

Expedited State Fair Hearing

Members, or a provider on behalf of a member, may file for an expedited fair hearing (via Nevada Medicaid) 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 Nevada Medicaid. If Nevada Medicaid grants the member an expedited state fair hearing, the health plan will follow procedures and processes as requested by Nevada Medicaid. All expedited fair hearings are held telephonically due to time constraints.

HPN Medicaid will participate in the state fair hearing process for its members/patients and providers. HPN Medicaid 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 1-775-684-3604, emailing medicaidhearings@nvha.nv.gov, or mailing your request to 9850 Double R Blvd, Ste. 200, Reno, NV 89521.

Continuation of Benefits While Appeals and State Fair Hearings Are Pending

The member's authorized benefits must be continued if that member requests them to continue while the appeal or State Fair Hearing is being considered. HPN Medicaid will continue the enrollee's benefits if the enrollee or provider files the appeal in a timely manner. Timely means filing the appeal on or before the later of the following: within ten days of the Notice of Adverse Benefit Determination or not more than ten days after the date of action or intended effective date of the proposed action. In addition, HPN Medicaid will continue benefits if **all** the following are met:

- the appeal involves the termination, suspension, or reduction of previously authorized course of treatment;
- the services were ordered by an authorized provider;
- the original period covered by the original authorization has not expired;
- the enrollee requests an extension of benefits.

Duration of Continued or Reinstated Benefits

If at the member's request HPN Medicaid will continue or reinstate the member's benefits while the appeal or state fair hearing is pending, the benefits must be continued until one of the following occurs:

- The member withdraws the appeal or State Fair Hearing
- Ten calendar days after HPN Medicaid mails the Notice of Adverse Benefit Determination, providing the resolution of the appeal against the member, unless the member, with the 10-day timeframe has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached;
- A state fair hearing office issues a hearing decision adverse to the member; or
- The time period of service limits of a previously authorized service has been met.

If the final resolution of the appeal or State Fair Hearing is adverse to the member, HPN Medicaid 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 Medicaid must authorize/furnish the services promptly.

8.11 Provider Responsibilities and Network Information

Eligibility Verification

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 Medical Adjudication Department (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 https://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 Online Provider Center 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 Medicaid 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 Medicaid is committed to providing our members with the most accurate and up-to-date information about our network. Care providers must furnish HPN Medicaid with complete information on changes to their address, license, certification, board specialties, corporate name or corporate ownership.

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

PCP Responsibilities and Expectations

Primary care physicians (PCPs) have the primary responsibility for managing and coordinating the overall health care of members. PCPs are responsible for providing, or arranging for, the appropriate and cost-effective provision of health care to members. Providers are required to attend state-delivered provider training. 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 Medicaid participating PCP or obstetrician for information, referral and treatment for emergency medical conditions.
- Ensuring continuity and coordination of the member's healthcare
- Maintaining a current medical record for the member, including documentation of all services provided by the PCP, specialists, and out-of-network Providers, including family planning and emergency services
- Communicate with the members' 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

Specialist Responsibilities

Providers are required to attend state-delivered provider training. 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

8.12 Filing a Provider Dispute for a HPN Medicaid and Nevada Check Up Claim

Filing a Provider Claim Reconsideration

A provider has the right to file a reconsideration request when a disagreement occurs regarding the claims adjudication process. 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 below - **Filing a Provider Appeal for a Medicaid Claim.**

Reconsiderations or resubmission or any follow-up must be clearly identified and submitted within 30 calendar days from the date on the remittance advice. For a reconsideration request, the provider is responsible for providing additional medical information (e.g., intensity of service, severity of illness, risk factors) that might not have been submitted with the original/initial request that supports the level of care/services requested.

Submit claims(s) to:

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

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

1. Claim submission and claim denied for payment (Step 1 of 3)
2. Provider must submit a second claim reconsideration including EOP with an explanation for the dispute (Step 2 of 3). Provider is notified of decision by EOP. Please see Section 13.14 for the claim reconsideration process.
3. Provider submits claim reconsideration requesting further review and includes any additional information and/or reiterates their reasons for dispute. Decision remains unchanged. Provider is informed of their appeal rights via EOP (Step 3 of 3)

After completing the claims reconsideration process above if the provider is not satisfied with the outcome of the claim's 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:

Health Plan of Nevada Medicaid
ATTN: Claim Reconsiderations
P.O. Box 15645
Las Vegas, Nevada 89114-5645

Filing a Provider Appeal for a Medicaid Claim

Providers have the right to appeal a claim that has been denied. Claim-related appeals should be submitted to the HPN Medicaid 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. Appeals must be received no later than 60 calendar days from the date on the EOP listing the claim as denied. If your appeal is rejected (e.g., for incomplete information), there is no extension to the original 60 calendar days. Appeal requests for subsequent same service claim submissions will not be considered. That is, if a provider resubmits a claim that has already been denied and another denial is received, the provider does not have another 60-day window in which to submit an appeal. Such appeal requests will be rejected. The process is outlined below:

1. Provider submits appeal to the address listed below within 60 calendar days from the date on the EOP listing the claim as denied
2. The health plan acknowledges appeal request in writing within 3 calendar days.
3. The health plan renders decision on appeal and notifies provider in writing of decision within 30 days. The provider can pursue state fair hearing for the following disputes if they disagree with the plan's decision:
    a. Denial or limited authorization of a requested service
    b. Reduction, suspension, or termination of a previously authorized service
    c. Denial, in whole or part, of payment for a service
    d. Demand for recoupment
    e. Failure of the contractor to meet specified timeframes (e.g., authorization, claims processing, and appeal resolution)

Providers may request a state fair hearing on their own behalf pursuant to NRS 422.306.

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

Health Plan of Nevada Medicaid
ATTN: CR&R/Appeals
P.O. Box 14865
Las Vegas, Nevada 89114
Fax: 702-266-8813

If you have any questions regarding claims payment or need assistance filing your appeal verbally, please contact the Member Services department at **(800) 962-8074.**

8.13 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 member's behalf
- When it is necessary to coordinate the member's 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 of Care, 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.

Release of information in response to a court order must be reported to the member in a timely manner, and provider must comply with all applicable federal and state procedures for individual medical records and any other health and enrollment information, including 42 CFR 431 Subpart F and all other laws regarding confidentiality, disclosure, the privacy of minors, and the privacy of individually identifiable health information.

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 or paper file in record contains the patient's name or patient ID number
- Personal/Demographic Data – Personal/biographical data includes: age, sex, race, ethnicity, primary language, disability status, 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 and/or behavioral 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
- Hospitals and Mental Hospitals
    - Identification of the member
    - Physician name
    - Date of admission
    - Initial and subsequent stay review dates
    - Reasons and plan for continued stay if applicable
    - Justification for emergency admission if applicable and
    - 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 Medicaid; and 2) prior admissions as necessary
- Advance directive for ages 18 and over

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
- All other aspects of patient care, including ancillary services

Providers will cooperate with medical record assessments of content for legibility, organization, completion, and conformance to the standards listed above.

8.14 Access Standards

HPN Medicaid 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 Medicaid 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 provide reasonable and adequate hours of operation, including twenty-four (24) hour availability of information, referral, and treatment for emergency medical conditions. Primary care physicians must have backup for absences.
HPN Medicaid's appointment standards for Medicaid and Nevada Check Up members are outlined below.

Primary Care Physician (PCP) Standards (Adult & Ped)

- Urgent PCP appointments must be available within two (2) calendar days
- Emergent care PCP appointments are available in the same day
- Routine care PCP appointments are available within 10 business days.
  (This standard does not apply to regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently.

Specialty Standards

- Emergency appointments same day 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
- Obstetrics/Gynecology other than prenatal care appointments are available within 10 business days
- Access to a child/adolescent specialist(s) if requested by the parent(s)
  - Appointments to maintain efficacy of treatment for conditions that are not urgent or emergent, but where treatments are more medically effective when delivered sooner than routine care services will be provided to members as follows:
    - Within fourteen (14) calendar days of the first request, or within the timeframe recommended by the referring provider

Behavioral Health Standards (Adult & Ped)

- Emergency (life threatening) appointments immediately
- Expedited (non-life threatening) appointments within 6 hours
- Urgent at risk appointments within 48 hours
- Routine appointments within 10 business days
- Outpatient mental and SUD treatment routine appointments within 10 business days

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 Medicaid or maternity care primary care physician, or immediately if an emergency exists.

Physical, Occupational, or Speech Therapy

- Routine appointments within 15 business days

Home Health, Private Duty Nursing, and Personal Care Services

Initiation of ongoing services according to the member's identified needs will be provided as follows:

- Same day for members with urgent needs
- Non-urgent care within fourteen (14) calendar days

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
    - 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 Medicaid 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.

8.15 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 Medicaid 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 except for treatment any members in need of the services you provide.

8.16 Cultural Competency

HPN Medicaid recognizes cultural competency as a necessary component of member rights. It is our desire to integrate cultural competency into all systems of HPN Medicaid, including quality improvement efforts. The health plan maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all members, including those with limited English proficiency or physical or mental disabilities.

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, 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 and respect the member's religious and health care beliefs.
- Understand and respect the role of the member's family and their decision-making process.
- Don't assume the diets of similar countries are the same.

We are pleased to offer Culturally and Linguistically Appropriate Services (CLAS) education opportunities to our staff, providers, and community partners. We also offer many other helpful tools to help support the advancement of health equity and cultural sensitivity in our communities. Our cultural competency training courses for providers offer CME's, CEU's, and CE's. We have launched a new platform for providers to access free accredited training courses that equip providers to deliver more tailored, person-centered care grounded in evidence-based practices. For more information on how to access education resources, please reach out to your provider advocate.

To assist our practitioners in delivering appropriate services to our diverse member population, Health Plan of Nevada Medicaid will now be providing language data spoken by Medicaid members.

Medicaid Member Counts by Primary Language Spoken

Primary Language Spoken	Medicaid	Nevada Check Up	Total All HPN Medicaid Members	Percentage of Medicaid Population
English	160352	8629	168,981	85.52%
Spanish, Castilian	25464	2433	27,897	14.12%
Chinese	243	15	258	0.13%
Vietnamese	143	3	146	0.07%
Russian	91	2	93	0.05%
French	62	2	64	0.03%
Tagalog	76	8	84	0.04%
Portuguese	18	8	26	0.01%
Japanese	11	2	13	0.01%
Central Khmer	9		9	0.00%

Laotian	8		8	0.00%
Ewe	1		1	0.00%
Not Assigned	2		2	0.00%

Source: Healthcare Informatics, 2025.

In support of your HPN Medicaid patients, Health Plan of Nevada Medicaid will provide access to our contracted language line vendor for your interpretation needs. To access this free service, please contact the Member Services Department who will confirm your patient's eligibility and connect you to the appropriate interpreter. To help determine your patient's language needs, "I speak…" cards are available in the "Forms" section of this Guide.

8.17 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 Medicaid. 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.

8.18 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 and 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 and Nevada Check Up members should have EPSDT/well-baby/well-child visits completed in accordance with the American Academy of Pediatrics Bright Futures periodicity schedule and the Medicaid Services Manual (MSM) Chapter 1500 at the following intervals listed.

Age Range			
Infancy	Early Childhood	Middle Childhood	Adolescence
Prenatal	12 months	5 years	11 years
Newborn	15 months	6 years	12 years
3-5 days	18 months	7 years	13 years
1 month	24 months	8 years	14 years
2 months	30 months	9 years	15 years
4 months	3 years	10 years	16 years
6 months	4 years		17 years
9 months			18 years
			19 years
			20 years
			21 years
8	**7**	**6**	**11**
Total			**32**

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 Medicaid 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
99202, 99203, **99204*, 99205***, 99211, 99212, 99213, **99214*, 99215***

***If using these billing codes, HPN Medicaid 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 Medicaid'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 Medicaid.
- 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 Medicaid 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 preventive 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 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 the HPN behavioral health team at 702-364-1484 or 1-800-873-2246.

8.19 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 Medicaid 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.

8.20 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 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**.

8.21 Children with Special Healthcare Needs (CSHCN)

Children who have, or are at risk for, chronic physical, developmental, behavioral, or emotional conditions; and also require health and related services of a type and amount beyond that required

by children in general; and are receiving services through family-centered, community-based, coordinated care systems are known as CSHCN. 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 Medicaid's pediatric case management team. HPN Medicaid'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.

8.22 Maternity Risk Screen Form & Obstetrical Case Management

Maternity Risk Screening Form

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 can be found in Section 23.

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 Medicaid's Provider Services department at 702-242-7088.

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

Obstetrical Case Management

HPN Medicaid 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.

8.23 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 180 calendar days will cause the claim to be denied.
- Providers submitting claims must be Nevada Medicaid contracted providers.
- All claims must contain the rendering/servicing 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 Medicaid
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 Nevada Medicaid, log onto: https://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.

Providers are able to provide and bill for co-located primary and behavioral health care.

8.24 Obstetrical Billing

The Division of Health Care Financing and Policy, which administers the Medicaid program, has mandated the method in which HPN Medicaid 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.

8.25 Quality Improvement

Health Plan of Nevada Medicaid (HPN Medicaid) 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 Medicaid routinely monitors and evaluates indicators of performance, such as mammography screening rates, childhood immunization rates and member satisfaction. Health care and service outcomes are also measured through special projects or quality initiatives. There are several committees and task forces responsible for setting quality improvement goals, monitoring indicators of performance and designing and evaluating quality performance initiatives. If you are interested in participating in our QI Program, please call 702-242-7735. For more information, you can view the Quality Corner section of the HPN Medicaid Provider Web site (www.healthplanofnevada.com/Provider) or call (702) 242-7735.

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

8.26 Contracting

As a health plan we comply with federal requirements, including the Affordability Care Act, when contracting with providers. The health plan will not employ or contract with Providers excluded from participation in the federal health care programs under Section 1128 of the Social Security Act.

Requests to become a contracted provider with Health Plan of Nevada Medicaid should be submitted with a Letter of Intent. Requests to add additional providers to your existing group contract should be submitted with a Provider Add Request. Both forms are available at the following link: https://www.healthplanofnevada.com/Provider/Join-Our-Network. In order to contract with Health Plan of Nevada Medicaid, providers must be enrolled, or in the process of enrolling, with Nevada Medicaid.

Requests for your contracted fee schedule rates should be submitted using the **"Request for Allowables" in Frequently Used Forms section 23**.

The contracting department can be reached at (702) 242-7088, Toll Free (800) 745-7065, or by email at Contracting@uhc.com.

8.27 Credentialing

Credentialing is the process of assessing and validating the qualifications of a licensed independent practitioner to provide services for Health Plan of Nevada (HPN) members. **Credentialing is a requirement for participation in the HPN provider network(s) and most providers must be credentialed prior to contracting.** Re-credentialing is conducted every three (3) years, unless the Credentialing Committee specifies a shorter period between reviews, issues are identified, or special credentialing is required.

Effective February 28, 2025, Nevada Medicaid implemented centralized credentialing. Credentialing activities will be handled by Nevada Medicaid's contracted Credentialing Verification Organization (CVO). All HP providers, both individual practitioners and organizational providers will be credentialed and recredentialed according to standards defined by State of Nevada Medicaid. Providers and facilities will still submit to the health plan to add providers to their groups and the health plan will facilitate credentialing process through Centralized Credentialing.

For questions regarding credentialing, please contact the Credentialing Department at **(702) 242-7559** or email NVSierraCred@uhc.com.

Information required for credentialing

Completion, by the provider, of the credentialing application and submission of evidence of professional licensure, malpractice insurance, DEA and state pharmacy certificates. The application must include attestations regarding:

- Reasons for any inability to perform the essential functions of the position, with or without accommodation,
- Lack of current illegal drug use and/or sobriety (completion of Health Status Form)
  If applicable: HPN requires you to provide the address and a full description of any rehabilitation program in which you are now participating or have participated in and to complete a Health Status Form which provides the name and title of the individual/organization (counselor / diversion program / treating provider) who can advocate on behalf of your sobriety status and/or program completion.
- History of loss of license or disciplinary activity,
- Felony convictions,
- History of loss or limitation of privileges or disciplinary activity,
- History of any malpractice claim or report to the National Provider Database (NPDB)
- Current malpractice insurance coverage,
- Correctness and completeness of the application.
- When a collaborating or supervising physician is required, the collaborating/supervising physician must already be contracted under the same practice/group.

The credentialing application will include a request for the practitioner's race, ethnicity, and spoken languages. Disclosure of this information is voluntary and is requested for reporting to the National Committee on Quality Assurance (NCQA), as well as to print in our provider directories. This information will be utilized to enable members to choose practitioners best able to meet their cultural and linguistic needs and will be available only upon request via a call to Member Services.

Primary verification is completed by the CVO.

Review and approval or disapproval by the Credentialing Committee

Notification to the provider of the CVO Committee's decision will come from HPN's credentialing department via email

- Initial credentialing and recredentialing Approvals will be sent within fourteen (14) days of the decision.
- Initial credentialing and recredentialing denials (for cause) will be sent within fourteen (14) days.
- Initial credentialing and recredentialing denial (administrative) will be sent within thirty (30) days.

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

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

Appeal Process (Applicable for recredentialing only)

If the provider disagrees with the recredentialing denial determination, a Fair Hearing can be requested. To request a Fair Hearing, you, or your legal counsel, must submit your request in writing, and include a copy of this notice, contact phone number, Medicaid provider number and your reason(s) for disagreeing with this determination. A request for a Fair Hearing must be received by the Nevada Medicaid Unit within ninety (90) calendar days from the date of this notice. Requests are to be submitted to:

Nevada Medicaid Hearings Unit
9850 Double R Blvd, Suite 200
Reno, Nevada 89521

Expired Credentialing

Providers are required to be re-credentialed every three (3) years. All HPN providers must be willing to cooperate in the re-credentialing process completed by the CVO. Providers should keep their CAQH attestation current. Any provider whose contract is terminated due to lapsed credentialing will no longer be paid as a contracted provider. A provider whose credentialing has expired may apply for initial credentialing.

Provider Credentialing Disapproval Reasons

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

At the time of initial credentialing:

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

limited, or has had action by a managed care organization that affected his/her participation
- Other reasons deemed by the committee to be appropriate.

At the time of re-credentialing:
- Any of the issues specified above under “Initial Credentialing”
- Unsatisfactory performance, including:
  - Quality of care issues
  - Risk management issues
  - UM Issues
  - Non-care complaints
  - Satisfaction survey results
  - Site visit or medical record review results
  - Concerns regarding the potential for imminent harm to the safety of members/enrollees
  - Number of member complaints
  - Other issues as identified by the Credentialing Committee

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