

silversummit healthplan™

2026 Provider Manual

PROVIDER SERVICES

1-844-366-2880 • TTY: 711

Updated 11-09-2026

SilverSummitHealthplan.com

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Welcome

Welcome to SilverSummit Healthplan (SSHP). Thank you for participating in our network of participating physicians, hospitals and other healthcare professionals. SilverSummit Healthplan is a managed care organization (MCO) in the state of Nevada and a subsidiary of Centene Corporation (Centene). SilverSummit Healthplan was established in July 2017 to deliver quality healthcare through local, regional, and community-based resources.

We strive to enhance the quality of care and support delivered to our members through an engaged and accountable network of qualified providers. Through advanced program innovation we will work to continually improve outcomes and effectiveness of our members' care.

We at SSHP, sincerely appreciate all that you do in taking great care of our members. Thank you for being in our network.

Sincerely,



Eric Schmacker
Plan President & CEO
SilverSummit Healthplan

How to Use This Provider Manual

SilverSummit HealthPlan is committed to assisting its provider community by supporting their efforts to deliver well-coordinated and appropriate healthcare to our members. SilverSummit Healthplan is also committed to disseminating comprehensive and timely information to its providers through the Provider Manual. This manual contains comprehensive information about SilverSummit Healthplan operations, and benefits. All policies and procedures throughout this manual are written in accordance with the contract between SilverSummit Healthplan and the State of Nevada Department of Health and Human Services (Nevada Medicaid). The most up-to-date version can always be viewed from our website **www.SilverSummitHealthplan.com**. You will be notified of updates via notices posted on our website and/or in Explanation of Payment (EOP) notices.

Billing Guide

For a comprehensive instruction on submitting claims, checking claims status, code auditing and editing, and claim appeals, please see the SilverSummit Healthplan Billing Guide, which is available on our website **www.SilverSummitHealthplan.com**.

Key Contacts and Important Phone Numbers

The following table includes several important telephone and fax numbers available to your office. When calling SilverSummit Healthplan, please have the following information available:

- NPI (National Provider Identifier) number
- Tax ID Number (TIN) number
- Member's SilverSummit Healthplan ID number or Medicaid ID number

Website: www.SilverSummitHealthplan.com

Member Services/Provider Services	Toll-Free Numbers	Fax Number
Provider Services Monday – Friday 8 a.m. to 6 p.m. PST	1-844-366-2880 TTY: 1-844-804-6086	1-855-252-0568
Member Services Monday – Friday 8 a.m. to 6 p.m. PST *Language translation services for members available (in person, video and telephonic)*	1-844-366-2880 TTY: 1-844-804-6086	1-866-694-3734
MTM - Non-Emergency Transportation for Members in the Urban area only	1-844-879-7341	
24 Hour Nurse Advice Line (24/7 Availability)	1-844-366-2880	
Prior Authorization	**Toll-Free Numbers**	**Fax Number**
Authorization Request	1-844-366-2880	1-844-367-7022
Authorization Request (Behavioral Health)	1-844-366-2880	1-866-535-6974 (IP/RTC/PHP Requests) 1-855-868-4940 (IOP/Outpatient requests)
Concurrent Review	1-844-366-2880	1-844-518-7889
Case management	1-844-366-2880	1-844-851-1023
Summit Behavioral Health	**Toll-Free Numbers**	**Fax Number**
24/7, 365 days per year	1-844-366-2880	
Pharmacy	**Toll-Free Numbers**	**Fax Number**
Prior Authorization Request	1-866-399-0928	1-833-645-2736 Please fax the medication prior authorization form.
Claims Information		
Paper Claims Submission	**Claims Appeals**	
SilverSummit Healthplan Attention: Claims PO Box 5090 Farmington, MO 63640-5080	SilverSummit Healthplan Attention: Claims Appeals PO Box 5090 Farmington, MO 63640-5080	

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Medical Necessity Authorizations Appeals			
Medication: Silversummit Healthplan Pharmacy Appeals Department P.O. Box 31398 Tampa, FL 33631 Non-Specialty/Retail Medications: fax request to 1-888-865-6531 Specialty/Buy and Bill Medications: fax request to 1-844-235-5091	**Behavioral Health:** SilverSummit Health Plan Appeals Department PO Box 1037 Van Nuys, CA 91410-0378 Phone 1-844-366-2880 TDD/TTY 1-844-804-6086 Relay 711 Fax 1-866-714-7991	**Evolent (Radiology and PT):** Evolent Specialty Services, Inc. Appeals Department P.O. Box 3618 Portland, ME 04104	**Medical:** SilverSummit Healthplan Appeal Department 2500 North Buffalo Drive Suite 250 Las Vegas, NV 89128 Fax 1-855-742-0125
Electronic Claims Submission			
SilverSummit Healthplan c/o Centene EDI 1-800-225-2573, ext. 6075525 • E-mail to: EDIBA@centene.com			

Secure Provider Portal

SSHP offers a robust secure provider portal with functionality that is critical to serving members and to ease administration for the providers. All providers and their office staff have the opportunity to register for our secure provider website in just four-easy steps. Here, we offer tools that make obtaining and sharing information easy! It's simple and secure! To register, go to **www.SilverSummitHealthplan.com**. At the top of the home page, select the Login link to begin the registration process.

Functionality

The Portal can be accessed at **www.SilverSummitHealthplan.com**. All users of the secure provider portal must complete a registration process.

Once registered, providers may:

- Check eligibility and view their member roster
- View the specific benefits for a member
- View the status of all claims that have been submitted regardless of how submitted
- Update provider demographic information (address, office hours, etc.)
- For primary care providers, view, and print patient lists. The patient list will indicate the member's name, ID number, date of birth, care gaps, and disease
- management enrollment
- Submit authorizations and view the status of authorizations that have been submitted for members
- View, submit, copy and correct claims
- Submit batch claims via an 837 file
- View and download explanations of payment (EOP)

- View a member's health record, including visits (physician, outpatient hospital, therapy, etc.), medications, and immunizations
- View gaps in care specific to a member, including preventive care or services needed for chronic conditions
- Send and receive secure messages with SSHP staff
- Access both patient and provider analytic tools
- Manage Account access allows you to perform functions as an account manager such as adding portal accounts needed in your office, and managing permission access for those accounts
- Visually track your claims. See which have been approved or denied with the new color-coded tracker.
- Easily view Denial Codes.
- Submit claims reconsiderations and add comments using expanded text fields, attach documentation and opt in/out for reconsideration status change emails.

Disclaimer

Providers agree that all health information, including that related to patient conditions, medical utilization and pharmacy utilization, available through the portal or any other means, will be used exclusively for patient care and other related purposes as permitted by the HIPAA Privacy Rule.

Member Profile

The eligibility groups covered by SilverSummit Healthplan include Temporary Aid to Needy Families, Children's Health Insurance Program, and Children with special needs. Voluntary participation is available for Seriously Mentally Ill (SMI) and Seriously Emotionally Disturbed (SED) children and adults, and Native Americans.

Verifying Eligibility

To verify member eligibility, please use one of the following methods:

- **Log on to our Secure Provider Portal** at www.SilverSummitHealthplan.com Using our secure provider website, you can check member eligibility. You can search by date of service and either of the following: member name and date of birth, or member Medicaid ID and date of birth.
- **Call our automated member eligibility IVR system.** Call our toll-free number from any touch-tone phone and follow the appropriate menu options to reach our automated member eligibility-verification system 24 hours a day at: 1-844-366-2880. The automated system will prompt you to enter the member Medicaid ID and the month of service to check eligibility.
- **Call SilverSummit Healthplan Provider Services.** If you cannot confirm a member's eligibility using the methods above, call our toll-free number 1-844-366-2880. Follow the menu prompts to speak to a Provider Services Representative to verify eligibility before rendering services. Provider Services will need the member's name or member Medicaid ID to verify eligibility.
- **Call Availity Essentials.** Availity Essentials is a multi-payer alternative to our in-house provider portals. Availity's intuitive interface supports multiple workflows to give you the information you need

to serve our members. Aside from checking eligibility, you can also manage claims and submit prior authorization requests. Our goal of partnering with Availity is for improved member care, enhanced provider experience, increased access to clinical data and ultimately improved quality scores. You can also contact Availity Client Services at 1-800-282-4548, Monday through Friday from 8:00AM–8:00PM EST. You can also contact Availity Client Services at 1-800-282-4548, Monday through Friday from 8:00AM–8:00PM EST.

Through SilverSummit Healthplan's Secure Provider Portal, PCPs are able to access a list of eligible members who have selected their services or were assigned to them. The Patient List is reflective of all demographic changes made within the last 24 hours. The list also provides other important information including date of birth and indicators for patients whose claims data show a gap in care, such as a missed Early Periodic Screening, Diagnosis and Treatment (EPSDT) exam. To view this list, log on to www.SilverSummitHealthplan.com.

- Eligibility changes can occur throughout the month and the Patient List does not prove eligibility for benefits or guarantee coverage. Use one of the above methods to verify member eligibility on the date of service.

All new SilverSummit Healthplan members receive a SilverSummit Healthplan member ID card. Members will keep their state issued ID card to receive services not covered by SilverSummit Healthplan (such as dental or hospice services). A new card is issued only when the information on the card changes, if a member loses a card, or if a member requests an additional card.

> Possession of a member ID card is not a guarantee of eligibility. Use one of the above methods to verify member eligibility on the date of service.

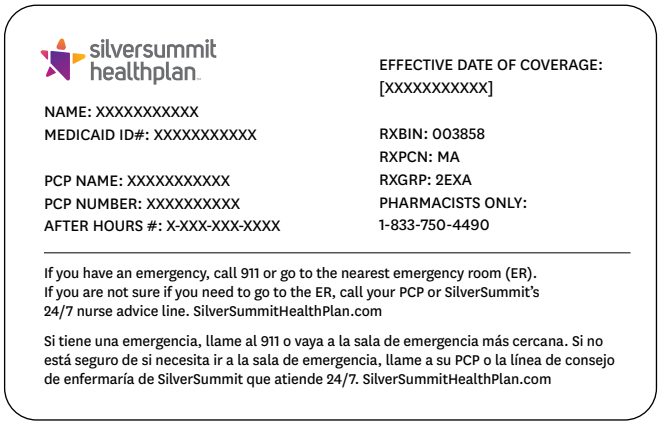
Member Identification Card

Whenever possible, members should present both their SilverSummit Healthplan member ID card and a photo ID each time services are rendered by a provider. If you are not familiar with the person seeking care as a member of our health plan, please ask to see photo identification.

If you suspect fraud, please contact Provider Services immediately at 1-844-366-2880.

Members must also keep their state-issued Medicaid ID card in order to receive benefits not covered by SilverSummit Healthplan.

SilverSummit ID Card (Front)



SilverSummit ID Card (Back)



Online Resources

Our website can significantly reduce the number of telephone calls providers need to make to the health plan. Utilizing the website allows immediate access to current provider and member information 24 hours a day, seven days a week.

- Please contact your Provider Relations Specialist or our Provider Services department with any questions or concerns regarding the website at 1-844-366-2880.
- Prior Authorization List
- Forms, e.g. the Required Claim Reconsideration and Appeal Form
- SilverSummit Healthplan News
- Clinical Guidelines
- Provider Bulletins
- Contract Request Forms
- Provider Consultant Contact Information
- Provider Training Manual
- Provider Education Training Schedule
- Cultural Competency Training

Contracting and Credentialing

Contracting

To join the SilverSummit Healthplan Network, providers must submit a completed **Application form**.

For requests to add new practitioners to an existing group contract, providers must complete and submit a **Provider Data Quality (PDQ) Request Form**.

Both forms and additional information are available at Become a Provider | Nevada Medicaid | SilverSummit Healthplan.

Centralized Credentialing

Credentialing establishes that healthcare providers have the qualifications to render services based on licensure, certification, work history and other relevant elements.

Centralized Credentialing process means a single Credentialing Verification Organization (CVO) conducts primary source verification (PSV) of practitioner credentials and qualifications for all Nevada Medicaid providers, streamlining the process and aligning outcomes.

Nevada Medicaid has contracted with Verisys (**https://verisys.com**) to provide CVO services, which includes PSV and the facilitation of a centralized Credentialing Committee.

Once an application to join the network is accepted, SilverSummit Healthplan will submit a request to the CVO to authorize and initiate the credentialing process. The CVO confirms the credentialing application data with third-party sources and performs queries of state and federal databases. The CVO evaluates those results against National Committee for Quality Assurance (NCQA) standards, Centers for Medicare and Medicaid Services (CMS) guidelines and Nevada Medicaid credentialing requirements. The CVO coordinates the centralized Credentialing Committee who renders the credentialing decision. SilverSummit Healthplan will notify providers of the credentialing results.

Providers are required to complete re-credentialing at least every three years (36 months) from the initial credentialing date. Recredentialing activities will be coordinated by the CVO and the Centralized Credentialing Committee will render the credentialing decision. SilverSummit Healthplan will notify providers of the credentialing results. A provider must successfully complete recredentialing to remain a participating provider within the SilverSummit Healthplan Network.

Note: *In order to maintain a current provider profile, providers are required to notify SilverSummit Healthplan of any relevant changes to their credentialing information in a timely manner.*

Which Providers Must be Credentialed?

All of the following providers are required to be credentialed:

MEDICAL PRACTITIONERS

- Medical doctors
- Oral surgeons
- Chiropractors
- Podiatrists
- Mid-level practitioners (non-physician)
- Other medical practitioners

BEHAVIORAL HEALTHCARE PRACTITIONERS

- Psychiatrists and other physicians
- Addiction medicine specialists
- Doctoral or master's-level psychologists
- Master's-level clinical social workers
- Master's-level clinical nurse specialists or psychiatric nurse practitioners
- Other behavioral healthcare specialists

Credentialing Requirements

All Practitioners/Providers (including facilities and clinics) must be enrolled in Nevada Medicaid or have an active application under review, prior to initiating the credentialing process.

Individual practitioners: Authorize SilverSummit Healthplan to access information on file with CAQH (Council for Affordable Quality Health Care) at **www.CAQH.org**. At a minimum, the following information must be submitted or available in CAQH when applying for participation with SilverSummit Healthplan. *Additional information or clarification may be requested by the CVO, Verisys.*

A completed, signed and dated Nevada Credentialing application
A signed attestation of the correctness and completeness of the application, history of loss of license and/or clinical privileges, disciplinary actions, and/or felony convictions; lack of current illegal substance registration and/ or alcohol abuse; mental and physical competence, and ability to perform the essential functions of the position, with or without accommodation (attestation must be no more than 120 days old at time of submission for enrollment)
If not present and current on the application, a copy of the provider's current malpractice insurance policy face sheet that includes expiration dates, amounts of coverage and provider's name, or evidence of compliance with Nevada regulations regarding malpractice coverage or alternate coverage
Current state license in each practicing state
Current Drug Enforcement Administration (DEA) registration Certificate, and copy of state-controlled substance certificate (if applicable)
Curriculum vitae listing, at minimum, a five-year work history (not required if work history is completed on the application)
Proof of highest level of education – copy of certificate or letter certifying formal post-graduate training
Copy of Clinical Laboratory Improvement Amendments (CLIA), if applicable

Facilities/Hospitals and Clinic/Ancillary Providers: Upon initiation of the credentialing process, the CVO will request a completed credentialing application from the provider. The provider must submit the following information to the CVO. *Additional information or clarification may be requested by the CVO, Verisys.*

A completed, signed and dated Nevada Facility Credentialing application
A signed and dated attestation no more than 120 days
State Facility Licensure
Other applicable State/Federal/Licensures (e.g., CLIA, DEA, Pharmacy, or Department of Health)
Current General Liability coverage (document showing the amounts and dates of coverage)
Accreditation/certification by a National Accrediting Organization (e.g., TJC/JCAHO, etc.)
If not accredited by a nationally recognized body, site survey results by a government agency

Note: *Failure of an applicant to adequately respond to a request for missing or expired information may result in closure of the application process prior to a committee decision.*

Recredentialing

Providers must complete recredentialing at least every 36 months from the date of the initial credentialing decision. The purpose of this process is to identify any changes in the practitioner's licensure, sanctions, certification, competence, or health status that may affect the ability to perform services the provider is under contract to provide. This process includes all practitioners and ancillary providers/facilities previously credentialed to practice within the SilverSummit Healthplan network.

Providers will receive a notification from the CVO when it is time to re-credential. All SilverSummit Healthplan providers must be willing to cooperate in the recredentialing process and provide a completed recredentialing application or current CAQH data and any other requested documentation in a timely manner. Reminders will be sent to the providers, as needed, to ensure compliance with the recredentialing request.

Between credentialing cycles, the CVO and SilverSummit Healthplan conduct monthly ongoing monitoring activities to ensure providers have not incurred exclusions, licensure sanctions, legal activity, or other negative indicators prior to their standard recredentialing cycle.

A provider's agreement may be terminated at any time if SilverSummit Healthplan determines that the provider no longer meets network participation requirements.

How long does it take to process a credentialing application?

The CVO strives to process credentialing applications in a timely and efficient manner. Items that may cause delays include:

- An incomplete application is submitted and/or CAQH data is expired.
- Items such as licenses or insurance coverage expire during the credentialing process.
- Requested documents are not submitted with the application.
- Additional outreach and follow-up from the CVO to the provider is necessary.

SilverSummit Healthplan will notify providers of credentialing approvals or administrative denials within thirty (30) calendar days of credentialing result notification from the CVO.

Right to Review and Correct Information

To review and/or correct erroneous information used in the credentialing/re-credentialing process, contact the CVO, Verisys at 855-743-6161 or outreachsupport@verisys.com.

Right to Be Informed of Application Status

The CVO maintains a dedicated customer service team and will provide credentialing status updates upon request. Contact Verisys at 855-743-6161 or outreachsupport@verisys.com.

Right to Appeal Adverse Credentialing Determinations

Depending on the reasons related to credentialing denial decision, an opportunity may be offered to submit additional information and/or submit an appeal request. Appeal rights, when applicable, will be

explained in the denial or termination letter. SilverSummit Heatlhplan will notify providers of adverse credentialing determinations within fourteen (14) calendar days.

A practitioner seeking participation in the SilverSummit Heatlhplan Network who has been reviewed by the centralized Credentialing Committee and has been disapproved for initial credentialing or re-credentialing, will not be allowed to reapply for one (1) year from the date of the denial.

Disclosure of Ownership and Control Interest Statement

Federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose:

- The identity of all owners with a control interest of 5% or greater
- Certain business transactions as described in 42 CFR 455.105
- The identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity, or who is an agent or managing employee of the provider group or entity

SilverSummit Healthplan furnishes providers with the Disclosure of Ownership and Control Interest Statement as part of the initial contracting process and again at the time of recredentialing. This form should be completed and returned along with the signed provider agreement. If there are any changes to the information disclosed on this form, an updated form should be completed and submitted to SilverSummit Healthplan within 30 days of the change. Please contact the SilverSummit Healthplan Provider Relations Department at 1-844-366-2880 if you have questions or concerns regarding this form, or if you need to obtain another copy of the form.

Guidelines for Providers

Appointment Availability and Access Standards

SilverSummit Healthplan follows the availability requirements set forth by applicable regulatory and accrediting agencies. SilverSummit Healthplan monitors compliance with these standards on at least an annual basis and will use the results of appointment standards monitoring to first, ensure adequate appointment availability and second, reduce unnecessary emergency room utilization.

Appointment Access and Availability

Service Type	Maximum Appointment Wait Time from the Day of Request for Routine Care		
	Urban	Rural	Frontier
Primary Care (adult)*	Ten (10) business days	Fifteen (15) business days	Fifteen (15) business days
Primary Care (pediatric)*	Ten (10) business days	Fifteen (15) business days	Fifteen (15) business days
Outpatient Mental Health and SUD Treatment (adult)	Ten (10) business days	Ten (10) business days	Ten (10) business days
Outpatient Mental Health and SUD Treatment (pediatric)	Ten (10) business days	Ten (10) business days	Ten (10) business days
Obstetrics/Gynecology, other than prenatal care	Ten (10) business days	Fifteen (15) business days	Fifteen (15) business days
Prenatal Care in first (1st) and second (2nd) trimester	Seven (7) calendar days	Ten (10) calendar days	Ten (10) calendar days
Prenatal Care in third (3rd) trimester or for high-risk pregnancies	Three (3) calendar days	Five (5) calendar days	Five (5) calendar days
Physical, Occupational, or Speech Therapy	Fifteen (15) business days	Twenty (20) business days	Twenty (20) business days

*The appointment wait time standards for primary care do not apply to regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than would be allowed by the standards.

Ongoing LTSS Standard

Ongoing home health, private duty nursing and personal care services	Fourteen calendar days of the need(s) identified.

Definitions

Term	Definition
Urban Counties:	Carson City, Urban Clark, and Urban Washoe
Rural Counties:	Douglas County, Lyon County, Rural Clark, Rural Washoe, and Storey County
Frontier Counties:	Churchill County, Elko County, Esmeralda County, Eureka County, Humboldt County, Lander County, Lincoln County, Mineral County, Nye County, Pershing County, and White Pine County

Office Wait Times

Unless the provider is delayed or unavailable due to an emergency, urgent case, serious problem or unknown patient need that requires more services or education than was described at the time the appointment was scheduled SilverSummit HealthPlan Members shall not wait longer than one (1) hour for a scheduled appointment. This includes time spent in the waiting room and in the exam room.

Covering Providers

PCPs and specialty physicians must arrange for coverage with another provider during scheduled or unscheduled time off and preferably with another SilverSummit Healthplan network provider. In the event of unscheduled time off, please notify our Provider Services department of coverage arrangements as soon as possible. The covering physician is compensated in accordance with the fee schedule in their agreement, and, if not a SilverSummit Healthplan network provider, he/she will be paid as a non-participating provider.

Telephone Arrangements

PCPs and Specialists must:

- Answer the member's telephone inquiries on a timely basis
- Prioritize appointments
- Schedule a series of appointments and follow-up appointments as needed by the member
- Please notify member when making appointment if they will be seeing their PCP or will be seeing the Nurse Practitioner or Physician's Assistant.
- Identify and, when possible, reschedule broken and no-show appointments
- Identify special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, non-compliant individuals, or those people with cognitive impairments)
- Adhere to the following response time for telephone call-back waiting times:
  - ► After-hours telephone care for non-emergent, symptomatic issues within 30 minutes
  - ► Same day for non-symptomatic concerns
- Schedule continuous availability and accessibility of professional, allied, and supportive personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider's absence
- After-hour calls should be documented in a written format in either an after-hour call log or some other method, and then transferred to the member's medical record

NOTE: If after-hour urgent care or emergent care is needed, the PCP or his/her designee should contact the urgent care center or emergency department in order to notify the facility. Notification is not required prior to member receiving urgent or emergent care.

SilverSummit Healthplan will monitor appointment and after-hours availability on an ongoing basis through its Quality Improvement Program ("QIP").

24-Hour Access

SilverSummit Healthplan PCPs and specialty physicians are required to maintain sufficient access to facilities and personnel to provide covered physician services and shall ensure that such services are accessible to members as needed 24 hours a day, 365 days a year as follows:

- A provider's office phone must be answered during normal business hours
- During after-hours, a provider must have arrangements for the following:
  - Emergency Situations:
    - Members who are experiencing an emergency should be told to dial 911 and should be advised to go to the nearest emergency room.
  - Non-Emergent Situations members should have:
    - Access to a covering physician,
    - Urgent Care instructions
    - An answering service for a physician or qualified professional to call the member back,
    - Triage service, or
    - A voice message that provides a second phone number that is answered.
    - Any recorded message must be provided in English and Spanish, if the provider's practice includes a high population of Spanish speaking members.

Examples of Unacceptable After-Hours Coverage include, but are not limited to:

- The Provider's office telephone number is only answered during office hours.
- The Provider's office telephone is answered after-hours by a recording that tells patients to leave a message.
- The Provider's office telephone is answered after-hours by a recording that directs patients to go to an Emergency Room for any services needed; and
- A Clinician returning after-hours calls outside 30 minutes.

The selected method of 24-hour coverage chosen by the member must connect the caller to someone who can render a clinical decision or reach the PCP or specialist for a clinical decision. Whenever possible, the PCP, specialty physician, or covering medical professional must return the call within 30 minutes of the initial contact. After-hours coverage must be accessible using the medical office's daytime telephone number.

SilverSummit Healthplan will monitor providers' offices After-Hour Coverage through surveys and through mystery shopper calls conducted by SilverSummit Healthplan Provider Network staff.

Cultural Competency

Cultural competency within SilverSummit Healthplan is defined as the willingness and ability of a system to value the importance of culture in the delivery of services to all segments of the population. It is the use of a systems perspective which values differences and is responsive to diversity at all levels in an organization. Cultural Competency is developmental, community focused, and family oriented.

In particular, it is the promotion of quality services to understand racial/ethnic groups through the valuing of differences and integration of cultural attitudes, beliefs and practices into diagnostic and treatment methods and throughout the system to support the delivery of culturally relevant and competent care. It is also the development and continued promotion of skills and practices important in clinical practice,

cross-cultural interactions and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner. Please visit our website for **Cultural Competency Training**.

SilverSummit Healthplan is committed to the development, strengthening, and sustaining of healthy provider/member relationships. Members are entitled to dignified, appropriate, and quality care. When healthcare services are delivered without regard for cultural differences, members are at risk for sub-optimal care. Members may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process. Providers should note that the experience of a member begins at the front door. Failure to use culturally competent and linguistically competent practices could result in the following:

- Feelings of being insulted or treated rudely
- Reluctance and fear of making future contact with the office
- Confusion and misunderstanding
- Treatment non-compliance
- Feelings of being uncared for, looked down on, and devalued
- Parents resisting to seek help for their children
- Unfilled prescriptions
- Missed appointments
- Misdiagnosis due to lack of information sharing
- Wasted time
- Increased grievances or complaints

SilverSummit Healthplan, as part of its credentialing, will evaluate the cultural competency level of its network providers and provide access to training and tool kits to assist providers in developing culturally competent and culturally proficient practices. All network providers will complete the Cultural Competency training at least annually. Network providers must ensure:

- Members understand that they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them
- Medical care is provided with consideration of the member's race/ethnicity and language and its impact/influence on the member's health or illness
- Office staff that routinely interact with members have access to and participate in Cultural Competency training and development at least annually
- Office staff responsible for data collection make reasonable attempts to collect race-and language-specific member information. Staff will also explain race/ethnicity categories to a member so that the member is able to identify the race/ethnicity of themselves and their children
- Treatment plans are developed with consideration of the member's race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, gender identity, sexual orientation, and other characteristics that may influence the member's perspective on healthcare

- Office sites have posted and printed materials in English and Spanish, and other prevalent non-English languages required by Nevada Medicaid

The road to developing a culturally competent practice begins with the recognition and acceptance of the value of meeting the needs of your patients. SilverSummit Healthplan is committed to helping you reach this goal. Take into consideration the following as you provide care to the SilverSummit Healthplan members:

- What are your own cultural values and identity?
- How do or can cultural differences impact your relationship with your patients?
- How much do you know about your patient's culture and language?
- Does your understanding of culture take into consideration values, communication styles, spirituality, language ability, literacy, and family definitions?
- Do you embrace differences as allies in your patients' healing process?

The U.S Department of Health and Human Services' Office of Minority Health has published a suite of online educational programs to Advance Health Equity at Every Point of Contact through development and promotion of culturally and linguistically appropriate services. Visit Think Cultural Health at https://thinkculturalhealth.hhs.gov/ to access these free online resources.

Prohibited Practices in the Delivery of Health Care

SilverSummit Healthplan is committed to ensuring that all members receive equitable access to quality health care without discrimination and expects its participating providers to treat members without regard to race, national origin, creed, color, gender, gender identity, sexual orientation, religion, age, health status, or disability, except where medically indicated. Prohibited practices include, but are not limited to:

- Denying a member, a covered service or availability of a facility
- Providing a SilverSummit Healthplan member a covered service that is different or in a different manner, or at a different time or at a different location than to other "public" or private pay members (examples: different waiting rooms or appointment times or days)

Advance Directives

SilverSummit Healthplan is committed to ensure that its members are aware of and are able to avail themselves of their rights to execute advance directives. SilverSummit Healthplan is equally committed to ensuring that its providers and staff are aware of and comply with their responsibilities under federal and state law regarding advance directives.

PCPs and providers delivering care to SilverSummit Healthplan members must ensure adult members 18 years of age and older receive information on advance directives and are informed of their right to execute advance directives. Providers must document such information in the permanent medical record.

SilverSummit Healthplan recommends to its PCPs and physicians that:

- The first point of contact for the member in the PCP's office should ask if the member has executed an advance directive and the member's response should be documented in the medical record

- If the member has executed an advance directive, the first point of contact should ask the member to bring a copy of the advance directive to the PCP's office and document this request in the member's medical record
- An advance directive should be a part of the member's medical record and include mental health directives

If an advance directive exists, the physician should discuss potential medical emergencies with the member and/or designated family member/significant other (if named in the advance directive and if available) and with the referring physician, if applicable. Any such discussion should be documented in the medical record.

In addition to Advance Directives, Nevada also supports the POLST program. A Physician Order for Life-Sustaining Treatment (POLST) is a medical order that states what kind of medical treatment patients want toward the end of their lives. The form is printed on bright pink paper and signed by both a doctor and patient and helps give seriously ill patients more control over their end-of-life care. Through a conversation between the patient and healthcare provider, patient wishes are translated to actionable medical orders. Additionally, the POLST program coordinates efforts between healthcare settings to assure POLST medical orders are transferred with the patient and, very importantly, unlike an Advance Directive, emergency medical services are able to honor the directives on the POLST. To learn more about Nevada's POLST program and to order forms, please access www.nevadapolst.org.

Providers Voluntarily Leaving the Network or Closing Offices

If a provider closes a practice, the paramount concern during any change is the continuity of patient care to ensure that no patient is neglected. Once continuity of care has been addressed, Providers should:

- Transfer all patient care to another provider immediately. If a member is being transferred to another provider's care this should be to another provider who is in the network. If they do not have a specific provider in mind, members will be re-assigned based on the algorithm.
- Review all previously scheduled office appointments to determine the appropriate action; immediately contact a physician of the same specialty to arrange patient care or provide patients with a list of practitioners of the same specialty within the area.
- Send a letter to active patients notifying them of the practice closure. Provide patients with information on where their medical records will be stored in the future and the length of time that the records will be retained. Include a permanent mailing address or post office box number for future record requests.
- Send a notification to SilverSummit Healthplan by completing the PDQ Request Form on the website or by mailing the notification to:

  SilverSummit Healthplan Provider Services
  2500 N. Buffalo Dr. Ste 250
  Las Vegas, NV 89128

Ensure availability and accessibility of office medical records as needed for the continuity of patient care. If no referral is made to another provider, the notification to SilverSummit must include where medical records will be stored with guidelines on how to access the information.

SilverSummit Health Plan will notify affected members in writing of a provider termination, by the later of thirty (30) Calendar days prior to the effective date of the termination or fifteen (15) Calendar Days after receipt of issuance of the termination notice to each Member who received his/her primary care from, or was seen on a regular basis by the terminated Network Provider.

Providers must continue to render covered services to members who are existing patients at the time of termination until the later of 60 days or until SilverSummit Healthplan can arrange for appropriate healthcare for the member with a participating provider.

Primary Care Providers (PCP)

The Primary Care Provider (PCP) is the cornerstone of SilverSummit Healthplan service delivery model. The PCP serves as the "Medical Home" for the member. The Medical Home concept assists in establishing a member-provider relationship, supports continuity of care, patient safety, leads to elimination of redundant services and ultimately more cost-effective care and better health outcomes.

SilverSummit Healthplan offers a robust network of primary care providers to ensure every member has access to a Medical Home within the required travel distance standards. Members can also access services through telehealth.

Service Type	Maximum Time or Distance (Minutes/Miles)		
	Urban (Urban Clark, Urban Washoe, Carson City)	**Rural** (Rural Clark, Rural Washoe, Douglas, Lyon, Storey)	**Frontier** (Churchill, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Mineral, Nye, Pershing, White Pine)
Primary Care (adult)	15/10	40/30	70/60
Primary Care (pediatric)	15/10	40/30	70/60
Obstetrics/Gynecology	15/10	40/30	70/60
Infectious Diseases (adult and pediatric)	60/40	110/90	145/130
Mental Health and SUD Treatment (adult)	45/30	75/60	110/100
Mental Health and SUD Treatment (pediatric)	45/30	75/60	110/100
Physical, Occupational, and Speech Therapy	45/30	75/60	110/100
Hospital	45/30	75/60	110/100
Pharmacy	15/10	40/30	70/60

We request that PCPs inform our Member Service department when a SilverSummit Healthplan member misses an appointment so we can monitor and provide outreach to the member about the importance of keeping appointments. This will assist our providers in reducing their missed appointments and reduce the inappropriate use of Emergency Room services.

Provider Types That May Serve as PCPs

Specialty types who may serve as PCPs include:

- Pediatrician
- Family General Practitioner
- Internist
- Obstetrician/Gynecologist
- Specialist who performs PCP functions for members with disabilities, chronic conditions, or complex conditions
- Nurse Practitioner

Members with disabling conditions, chronic illnesses or Children with Special Health Care Needs may request that their PCP be a specialist. The designation of the specialist as a PCP must be in consultation with the current PCP, member, and the specialist. The specialist serving as a PCP must agree to provide or arrange for all primary care, including routine preventive care, and provide those specialty medical services consistent with the member's disabling condition, chronic illness or Special Health Care Needs in accordance with the PCP responsibilities included in this manual. To initiate a PCP change to a specialist, members should contact member services at our toll-free number. The health plan will verify the change with the current PCP and the intended specialist to be assigned as the PCP and coordinate the PCP change.

Member Panel Capacity

All PCPs reserve the right to state the number of members they are willing to accept into their panel. SilverSummit Healthplan DOES NOT guarantee any provider will receive a certain number of members.

If a PCP declares a specific capacity for his/her practice and wants to make a change to that capacity, the PCP must contact SilverSummit Healthplan Provider Services at 1-844-366-2880. A PCP shall not refuse to treat members as long as the physician has not reached their requested panel size.

Providers shall notify SilverSummit Healthplan in writing at least 45 days in advance of his or her inability to accept additional Medicaid covered persons under SilverSummit Healthplan agreements. In no event shall any established patient who becomes a SilverSummit Healthplan member be considered a new patient.

PCP Assignment

SilverSummit Healthplan will use a PCP auto-assignment algorithm to assign an initial PCP to new members within five (5) business days to their effective date. Members are notified of their assigned PCP when they receive their SilverSummit member ID card. SilverSummit Healthplan members have the freedom to choose a PCP from our comprehensive provider network. If members would like to change their PCP, they may contact our member services team for assistance

The algorithm assigns members to a PCP by one or more of the following criteria:

1. Member's previous PCP, if known;
2. Member's geographic location (accessible per primary care time and distance standards);
3. Member's other family member's PCP, if known (including assigning all children within a family to the same PCP);
4. Assigning a CYSHCN (Children and Youth with Special Health Care Needs) to a practitioner experienced in treating the Member's condition(s), if known; and/or
5. Upon receipt of a claim for services rendered by a PCP to the Member.

Pregnant women should choose a pediatrician, or other appropriate PCP, for the care of their newborn baby before the beginning of the last trimester of gestation. In the event that the pregnant member does not select a pediatrician or other appropriate PCP, SilverSummit Healthplan will assign one for her newborn within 30 calendar days after birth.

Primary Care Provider (PCP) Responsibilities

PCP's responsibilities include, but are not limited, to the following:

- Delivery of covered medically necessary, primary care services and preventive services, including EPSDT screening services and Well Baby/Child Services
- Providing reasonable and adequate hours of operation, including twenty-four (24) hour availability of information, referral, and treatment for emergency medical conditions
- Referrals for specialty care and other covered medically necessary services in the SilverSummit Healthplan provider network
- Allowing members to self-refer for family planning, obstetrical, gynecological, mental health and substance abuse services, within the SilverSummit Healthplan provider network
- 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.
- Establish and maintain hospital admitting privileges sufficient to meet the needs of all linked members with at least one hospital within the required network adequacy distance requirements
- Manage the medical and healthcare needs of members to assure that all medically necessary services are made available in a culturally competent and timely manner while ensuring patient safety at all times including members with special needs and chronic conditions
- Educate members on how to maintain healthy lifestyles and prevent serious illness
- Offer hours of operation no less than the operating hours offered to commercial members or comparable to Medicaid FFS members if the PCP does not provide health services to commercial members
- Collaborate with SilverSummit Healthplan's Care Coordination Program as appropriate to include, but not limited to, performing member screening and assessment, development of plan of care to address risks and medical needs, linking the member to other providers, medical services, residential, social, community and other support services as needed for physical or mental illness

- Adhere to the EPSDT periodicity schedule for members under age 21 and ensure visits are coded and submitted correctly
- Follow established procedures for coordination of in-network and out-of-network services for members, including obtaining authorizations for selected inpatient and selected outpatient services as listed on the current prior authorization list, except for emergency services up to the point of stabilization; as well as coordinating services the member is receiving from another health plan during transition of care
- Share results of identification and assessment for any member with special healthcare needs with another health plan to which a member may be transitioning or has transitioned so services are not duplicated
- Transfer members' medical records to the receiving provider upon the change of PCP at the request of the new PCP and as authorized by the member within ten (10) business days from receipt of the request.
- Actively participate in and cooperate with all SilverSummit Healthplan quality initiatives and programs including assessment of all HEDIS and performance measures
- Provide notice to SilverSummit Healthplan of any updates necessary to the physician directory such as new address, new phone number, or change in group practice affiliation
- Participate in the HealtHIE Nevada statewide health information exchange (HIE).

Reassignment of Primary Care Provider (PCP) / Divorce of Care

Divorce of care may be necessary in certain justifiable circumstances where it becomes necessary for a provider to separate or divorce patient care and terminate the provider-patient relationship. However, this should be applied only as a last resort after all due diligence efforts have been exhausted. Capitated providers may be responsible for further charges.

If the provider 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. Some of the reasons include but are not limited to:

- Disruptive behavior
- Physical threats/abuse
- Verbal abuse
- Gross non-compliance with the treatment plan

The provider will be responsible for keeping adequate documentation in the member's medical records of the verbal and written warnings. The provider is obligated to provide care to the member until it is determined that the member has been transferred to the care of another physician.

The following process will be followed for PCP reassignment:

- Send a notice to the patient of the intent to divorce care. This will be sent through certified mail.
- A copy of the Divorce of Patient letter should be mailed to the Provider Services Department at:

  SilverSummit Healthplan Provider Services
  2500 N Buffalo Dr., Ste 250
  Las Vegas, NV 89128

- Allow the patient thirty (30) days to find alternative care

SilverSummit Health Plans customer service team will outreach to the member to assist in finding a new provider.

If you have questions regarding divorce of patient care, please contact the Provider Services Department at 1-844-366-2880.

Referrals

SilverSummit Healthplan prefers that the PCP coordinates healthcare services; however, PCPs are encouraged to refer a member when medically necessary care is needed that is beyond the scope of what the PCP can provide. Obtaining referrals from the PCP are not required as a condition of payment for services by SilverSummit Healthplan.

The PCP must obtain prior authorization from SilverSummit Healthplan for referrals to certain specialty providers as noted on the prior authorization list. All out-of-network services require prior authorization as further described herein except for family planning, emergency room, and table-top x-ray services. A provider is also required to promptly notify SilverSummit Healthplan when prenatal care is rendered.

SilverSummit Healthplan encourages specialists to communicate to the PCP the need for a referral to another specialist. This allows the PCP to better coordinate their members' care and become aware of the additional service request.

Providers are prohibited from making referrals for designated health services to healthcare entities with which the provider or a member of the providers' family has a financial relationship.

Specialist Responsibilities

SilverSummit Healthplan encourages specialists to communicate to the PCP the need for a referral to another specialist, rather than making such a referral themselves. This allows the PCP to better coordinate the members' care and ensure the referred specialty physician is a participating provider within the SilverSummit Healthplan network and that the PCP is aware of the additional service request. The specialty physician may order diagnostic tests without PCP involvement by following SilverSummit Healthplan referral guidelines.

Emergency admissions will require notification to SilverSummit Healthplan's Medical Management Department within the standards set forth in the Utilization Management section of this manual. All non-emergency inpatient admissions require prior authorization from SilverSummit Healthplan.

The specialist provider must:

- Maintain contact with the PCP
- Obtain authorization from SilverSummit Healthplan Medical Management Department ("Medical Management") if needed before providing services
- Coordinate the member's care with the PCP
- Provide the PCP with consult reports and other appropriate records within five business days
- Be available for or provide on-call coverage through another source 24-hours a day for management of member care

- Maintain the confidentiality of medical information
- Actively participate in and cooperate with all SilverSummit Healthplan quality initiatives and programs
- Participate in the HealtHIE Nevada statewide health information exchange (HIE)

SilverSummit Healthplan providers should refer to their contract for complete information regarding their obligations and mode of reimbursement. Such reimbursement shall be no less than the published Medicaid fee-for-service rate in effect on the date of service or its equivalent (such as a DRG case rate), unless mutually agreed to by both SilverSummit Healthplan and the provider in the provider contract.

SilverSummit Healthplan providers should refer to their contract for complete information regarding providers' obligations or contact their Provider Relations Specialist with any questions or concerns.

Hospital Responsibilities

SilverSummit Healthplan utilizes a network of hospitals to provide services to SilverSummit Healthplan members. Hospital services providers must be qualified to provide services under the Medicaid program. All services must be provided in accordance with applicable state and federal laws and regulations.

Hospitals must:

- Notify the PCP immediately or no later than the close of the next business day after the member's emergency room visit
- Obtain authorizations for all inpatient and selected outpatient services as listed on the current prior authorization list, except for emergency stabilization services
- Notify SilverSummit Healthplan Medical Management department by sending an electronic file of the ER admission by the next business day. The electronic file should include the member's name, Medicaid ID, presenting symptoms/diagnosis, DOS, and member's phone number
- Notify SilverSummit Healthplan Medical Management department of all admission within one business day
- Participate in the HealtHIE Nevada statewide health information exchange (HIE)
- Notify SilverSummit Healthplan of the births of newborns within 24 hours of birth for enrolled members
- Allow SilverSummit Healthplan to have access to their electronic medical records (EMR) for discharge planning

Same Day and Co-located Primary and Behavioral Health Care Services

SilverSummit Healthplan supports the integration of primary and behavioral health care services by promoting same-day and co-located care. This approach enables network providers to offer both primary and behavioral health services in the same location, on the same day, ensuring a comprehensive care experience for patients.

To facilitate this model, our systems are designed to handle same-day and co-located services. These configurations streamline claims processing, including same-day billing when applicable, so providers can efficiently submit claims for both primary and behavioral health services delivered on the same day.

For more information, please refer to SilverSummit Healthplan's Provider Billing Manual, available on our website www.SilverSummitHealthplan.com.

Provider Relations and Services

Provider Relations

SilverSummit Healthplan's Provider Relations department is committed to supporting our providers as they care for our members. Through provider orientation, ongoing training and support of daily business operations, we will strive to be your partners in good care. Upon credentialing approval and contracting, each provider will be assigned a Provider Relations Specialist. Within 30 days of the provider's effective date, the Provider Relations Specialist will contact the provider to schedule an orientation.

Reasons to Contact a Provider Relations Specialist

- Report any changes to your practice (locations, NPI, TIN numbers)
- Initiate credentialing of a new practitioner
- Schedule an in-service training for new staff
- Conduct ongoing education for existing staff
- Obtain clarification of policies and procedures
- Obtain clarification of a provider contract
- Request fee schedule information
- Obtain membership roster
- Obtaining Provider Profiles
- Learn how to use electronic solutions on web authorizations, claims submissions and member eligibility
- Open/close patient panel
- Challenges with claims payments

Provider Services

Provider Services is available at SilverSummit Healthplan at 1-844-366-2880 Monday through Friday, 8am to 6pm PST and closed on New Year's Day, Martin Luther King Day, Memorial Day, Independence Day, Labor Day, Thankgiving Day and Christmas Day.

Rights and Responsibilities

Member Rights

SilverSummit Healthplan members have certain rights. We expect our network providers and staff to respect the following member rights.

- To be treated with respect, dignity, and privacy
- To pick or change doctors from the provider network

- To be able to get in touch with their provider
- To go to any provider or clinic for family planning services
- To get care right away if you have a medical emergency
- To be told what their illness or medical condition is
- To be told treatment options and what their provider thinks is best
- To make decisions about healthcare
- To give permission before the start of diagnosis, treatment or surgery
- To refuse treatment
- To have the personal information in medical records kept private
- To report any complaint or grievance about their provider or medical care
- To appeal action that reduces or denies services based on medical criteria
- To receive interpretation services
- To not be pressured into making decisions about treatment
- To not be discriminated against due to race, color, national origin or health status or the need for healthcare services
- To request a second opinion
- To be notified at the time of enrollment and annually of your disenrollment rights
- To make an Advance Directive
- To file any complaint with Nevada Nevada Medicaid if your Advance Directive is not followed
- To choose a provider who gives member care whenever possible and appropriate
- To receive accessible healthcare services similar to services given under Medicaid FFS. This includes similar amount, duration and scope
- To get enough services to be reasonable expected to achieve the goal of the treatment.
- To not have services denied or reduced just because of a specific diagnosis, type of illness or medical condition
- To use member rights without any negative effects from Nevada Nevada Medicaid, SilverSummit Healthplan, its providers or contractors
- To receive all written member information from SilverSummit Healthplan:
  - At no cost to you
  - In languages other than English
  - In other ways, to help with the special needs of members who may have trouble reading the information for any reason
- To get interpretation services for free in any language (via in person, telephonic and video)
- To be told that interpretation services are available and how to get them
- To get help understanding the requirements and benefits of SilverSummit Healthplan from Nevada Nevada Medicaid and its Enrollment Broker

Member Responsibilities

Members have certain responsibilities. Treatment can work better if members adhere to the following guidelines. Members are responsible to:

- Notify Nevada Medicaid or Nevada Check Up if:
  - Member family size changes
  - Member moves out of the state or have other address changes
  - Member receives or have health coverage under another policy, other third party, or there are changes to that coverage
- Work on improving member's own health
- Tell SilverSummit Healthplan when they go to the emergency room
- Talk to their provider about preauthorization of services they recommend
- Be aware of cost-sharing responsibilities and make payments they are responsible for
- Inform SilverSummit Healthplan if their member ID card is lost or stolen
- Show their member ID card and Nevada Medicaid ID card when getting healthcare services
- Know SilverSummit Healthplan procedures, coverage rules, and restrictions the best of their ability
- Contact SilverSummit Healthplan when they need information or have questions
- Give providers accurate and complete medical information
- Follow prescribed treatment, or tell provider the reason(s) treatment cannot be followed as soon as possible
- Ask their providers questions to help understand treatment. Learn about the possible risks, benefits, and costs of treatment alternatives. Make care decisions after they have thought about all of these things
- Be actively involved in their treatment. Understand their health problems and be a part of making treatment goals with their provider as much as possible
- Follow the grievance process if they have concerns about their care

Provider Rights

SilverSummit Healthplan providers have the **right** to:

- Be treated by their patients and other healthcare workers with dignity and respect
- Receive accurate and complete information and medical histories for members' care
- Have their patients act in a way that supports the care given to other patients and that helps keep the doctor's office, hospital, or other offices running smoothly
- Expect other network providers to act as partners in members' treatment plans
- Expect members to follow their directions
- Make a complaint or file an appeal against SilverSummit Healthplan and/or a member
- File a grievance with SilverSummit Healthplan on behalf of a member, with the member's consent

- Have access to information about SilverSummit Healthplan quality improvement programs, including program goals, processes, and outcomes that relate to member care and services
- Contact SilverSummit Healthplan Provider Services with any questions, comments, or problems
- Collaborate with other healthcare professionals who are involved in the care of members
- Not be prohibited or otherwise restricted as a healthcare professional to act within the lawful scope of practice, from advising or advocating on behalf of a recipient who is his or her patient

Provider Responsibilities

SilverSummit Healthplan providers have the **responsibility** to:

- Help members or advocate for members to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment, including the right to:
  - Recommend new or experimental treatments
  - Provide information regarding the nature of treatment options
  - Provide information about the availability of alternative treatment options, therapies, consultations, and/or tests, including those that may be self-administered
  - Be informed of the risks and consequences associated with each treatment option or choosing to forego treatment as well as the benefits of such treatment options
  - Treat members with fairness, dignity, and respect
- Not discriminate against members on the basis of race, color, national origin, disability, age, religion, mental or physical disability, or limited English proficiency
- Maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality
- Give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider's practice/office/facility
- Provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA
- Allow members to request restriction on the use and disclosure of their personal health information
- Provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records
- Provide clear and complete information to members, in a language they can understand, about their health condition and treatment, regardless of cost or benefit coverage, and allow the member to participate in the decision-making process
- Tell a member if the proposed medical care or treatment is part of a research experiment and give the member the right to refuse experimental treatment
- Allow a member who refuses or requests to stop treatment the right to do so, as long as the member understands that by refusing or stopping treatment the condition may worsen or be fatal
- Respect members' advance directives and include these documents in the members' medical record
- Allow members to appoint a parent, guardian, family member, or other representative if they can't fully participate in their treatment decisions

- Allow members to obtain a second opinion, and answer members' questions about how to access healthcare services appropriately
- Follow all state and federal laws and regulations related to patient care and patient rights
- Develop a report based on SilverSummit Healthplan specification to submit monthly clinical data feed from the EMR system within one year of participating in the Silver summit provider network. Comply with SilverSummit Healthplan Medical Management program as outlined the provider manual
- Disclose overpayments or improper payments to SilverSummit Healthplan
- Provide members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status
- Obtain and report to SilverSummit Healthplan information regarding other insurance coverage
- Notify SilverSummit Healthplan in writing if the provider is leaving or closing a practice
- Contact SilverSummit Healthplan to verify member eligibility or coverage for services, if appropriate
- Invite member participation, to the extent possible, in understanding any medical or behavioral health problems they may have and to develop mutually agreed upon treatment goals, to the extent possible
- Provide members, upon request, with information regarding office location, hours of operation, accessibility, and languages, including the ability to communicate with sign language
- Offer office hours-of-operation to Medicaid members no less than those offered to commercial members
- Coordinate and cooperate with other service providers who serve Medicaid members such as Head Start Programs, Healthy Start Programs, Nurse Family Partnerships and school-based programs as appropriate
- Provide services in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth in the Participating Provider Agreement
- Review and follow clinical practice guidelines distributed by SilverSummit Maintain complete and accurate diagnosis coding and reporting in accordance with ICD-10-CM coding guidelines
- Participate on Board of Directors and Quality Committees for both Clark and Washoe counties if requested
- All network Primary Care Providers (PCPs) to provide EPSDT preventive health services to their assigned EPSDT eligible members and to participate in the Vaccines for Children Program and Nevada Check Up Program
- To participate in data collection initiatives, such as HEDIS and other contractual or regulatory programs, and allow use of provider performance data

Policies and Procedures

Provider Manual Updates

This manual will be updated at least annually, or more frequently as mandated by changes that impact the basic business functions of doing business with SilverSummit Healthplan. Providers will be notified when an updated Provider Manual is available. Such changes will be communicated no later than 30 calendar days of the effective date of the change.

Access to SilverSummit Healthplan Policies and Procedures

Any provider contracted with SilverSummit Healthplan may review relevant policies and procedures at any time through our provider portal or by making a request to their Provider Relations representative. All SilverSummit Healthplan policies and procedures are written in accordance with the SilverSummit Healthplan and Nevada Medicaid Agency contract.

Grievances and Appeals Process

A member, or member's authorized representative, may file a grievance or appeal verbally or in writing. A provider acting on behalf of the member and with member's written consent, may file a grievance or appeal. Please know this authorization is required for both standard and expedited requests.

SilverSummit Healthplan will give members reasonable assistance in completing all forms and taking other procedural steps of the grievance and appeal system, including the Nevada Medicaid Fair Hearing process. Reasonable assistance includes talking with Member and Provider Service representatives to learn about the Grievance and Appeals process, providing translation services, communication in alternative languages and toll-free numbers with TTY/TDD and interpreter capability (via in person, telephonic and video).

Grievances

A member grievance is defined as any member expression of dissatisfaction about any matter related to the member's care or provider's operation, activities, or behavior, including access to care, quality of services provided, dissatisfaction with health plan staff or providers, dissatisfaction with the denial of an expedited appeal timeframe, and failure to respect the rights of the member by SilverSummit Healthplan.

The grievance process allows the member; or the member's authorized representative (family member, etc. acting on behalf of the member or provider acting on the member's behalf with the member's written consent), to file a grievance either orally, electronically, or in writing. The member will be allowed to file a grievance at any time from the date of learning of the basis of the grievance. SilverSummit Healthplan shall acknowledge receipt of each grievance in writing.

Grievances may be submitted by written notification to:	**SilverSummit Healthplan** **Attn: Grievances and Appeals Department** **2500 N. Buffalo Drive, Suite 250** **Las Vegas, NV 89128**

Any individuals who make a decision on grievances will not be involved in any previous level of review or decision making. In any case where the reason for the grievance involves clinical issues or relates to denial of expedited resolution of an appeal, SilverSummit Healthplan shall ensure that the decision makers are healthcare professionals with the appropriate clinical expertise in treating the member's condition or disease. [42 CFR § 438.406]

SilverSummit Healthplan values its providers and will not take punitive action, including and up to termination of a provider agreement or other contractual arrangements, for providers who file a grievance on a member's behalf. SilverSummit Healthplan will provide assistance to both members and providers with filing a grievance by contacting our Member and Provider Services Department at 1-844-366-2880.

Grievance Acknowledgement

Staff receiving grievances orally will acknowledge the grievance and attempt to resolve them immediately. Staff will document the substance of the grievance. The Grievance and Appeal Coordinator will date stamp written grievances upon initial receipt and send an acknowledgment letter, which includes a description of the grievance procedures and resolution time frames, within three (3) business days of receipt.

Grievance Resolution Time Frame

Grievance Resolution will occur as expeditiously as the member's health condition requires, not to exceed 45 calendar days from the date of the initial receipt of the grievance. Grievances will be resolved by the Grievance and Appeal Coordinator, in coordination with other SilverSummit Healthplan staff as needed. In our experience, many grievances can be resolved at the customer service level to the satisfaction of the member, representative or provider filing the grievance

The Grievance and Appeal Coordinator will provide written resolution to the member, representative or provider within three (3) business days of the resolution, not to exceed total alloted time for the review.

The grievance response shall include, but not be limited to, the decision reached by SilverSummit Healthplan, the reason(s) for the decision, the policies or procedures which provide the basis for the decision, and a clear explanation of any further rights available to the member, if any. A copy of verbal complaints logs and records of disposition or written grievances shall be retained for ten (10) years.

Appeals

An appeal is the request for review of an "Adverse Benefit Determination." An "Adverse Benefit Determination" is the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or part of payment for a service; failure to cover or provide services in a timely manner, as defined by the Nevada Medicaid Agency (Agency); failure to process grievance, appeals, or expedited appeals within required timeframes; or the denial of a member's request to exercise his/her right under 42 CFR 438.52(b)(ii) to obtain services outside SilverSummit Healthplan network.

For an appeal, SilverSummit Healthplan will advise the member of the right to request continuation of benefits as set forth in this policy while the appeal is pending, and that the member may in such a case be held liable for the cost of those benefits if the appeal is not decided in favor of member. SilverSummit Healthplan will provide members written notice of the reason for any extension to the timeframe for processing an appeal that is not requested by the member.

Claim Reconsideration

For claim reconsiderations, please see the SilverSummit Healthplan Billing Guide located on the Provider Resources page of our website.

Standard Appeals

The member or member's authorized representative (with written consent) may file an appeal orally or in writing within 60 days from the date of the adverse benefit determination. A written notice of acknowledgement is sent to the member within three (3) business days for all oral and written requests.

The acknowledgment shall state that the member's appeal will be resolved within 30 calendar days from the date of filing the appeal.

The decision must be written on a form approved by the Nevada Medicaid Agency with reasonable detail for the basis of the decision.

Expedited Appeals

A member has the right to request an expedited appeal. Expedited appeals may be filed when SilverSummit Healthplan or the member's provider determines that the time expended in a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. No punitive action will be taken against a provider that requests an expedited resolution or supports a member's appeal. In instances where the member's request for an expedited appeal is denied, the appeal must be transferred to the timeframe for standard resolution of appeals.

Decisions for expedited appeals are issued as expeditiously as the member's health condition requires, not exceeding 72 hours from the initial receipt of the appeal.

Extension of Grievance and Appeals Timeframe

SilverSummit Healthplan may extend this timeframe by up to an additional 14 calendar days if the member requests the extension or if SilverSummit Healthplan provides evidence satisfactory to the Nevada Medicaid Agency that a delay in rendering the decision is in the member's interest. For any extension not requested by the member, SilverSummit Healthplan shall provide written notice to the member of the reason for the delay. SilverSummit Healthplan shall make reasonable efforts to provide the member with prompt verbal notice of any decisions that are not resolved wholly in favor of the member and shall follow-up within two (2) calendar days with a written adverse benefit determination. If the member is unhappy with the determination to extend the resolution timeline, they may file a grievance with the health plan.

Written notice shall include the following information:

a. The decision reached by SilverSummit Healthplan;
b. The date of decision;
c. For appeals not resolved wholly in favor of the member the right to request a state fair hearing and information as to how to do so; and
d. The right to request to receive benefits while the hearing is pending and how to make the request, explaining that the member may be held liable for the cost of those services if the hearing decision upholds the SilverSummit Healthplan decision.

Medical Necessity Authorizations Appeals			
Medication: Silversummit Healthplan Pharmacy Appeals Department P.O. Box 31398 Tampa, FL 33631 Non-Specialty/Retail Medications: fax request to 1-888-865-6531 Specialty/Buy and Bill Medications: fax request to 1-844-235-5091	**Behavioral Health:** SilverSummit Health Plan Appeals Department PO Box 1037 Van Nuys, CA 91410-0378 Phone 1-844-366-2880 TDD/TTY 1-844-804-6086 Relay 711 Fax 1-866-714-7991	**Evolent (Radiology and PT):** Evolent Specialty Services, Inc. Appeals Department P.O. Box 3618 Portland, ME 04104	**Medical:** SilverSummit Healthplan Appeal Department 2500 North Buffalo Drive Suite 250 Las Vegas, NV 89128 Fax 1-855-742-0125

State Fair Hearing

SilverSummit Healthplan members are required to complete the internal appeals process prior to requesting a State Fair Hearing from the Nevada Medicaid. Once a member completes the internal appeals process and is not satisfied with the outcome, the member can then move forward with a State Fair Hearing from the NV Medicaid. (For grievances, SilverSummit Healthplan will send the member a resolution letter which will inform members that grievances are not eligible for referral to the State Fair Hearing process.)

The appeals resolution letter will also include information about the member's right to a State Fair Hearing following the completion of our appeals process and a description of each step in the State Fair Hearing process, including that:

- A State Fair Hearing must be requested within 90 calendar days from our notice of resolution.
- Procedures for exercising the rights to appeal or request a State Fair Hearing, representation, specific regulations that support or a change in federal or state law that requires the action, the individual's right to request a state fair hearing or, in the case of an action based on change in the law, the circumstances under which a State Fair Hearing will be granted.
- The health plan will give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate teletypewriter (TTY)/ telecommunications device for the deaf (TTD) and interpreter capability. We will also assist member and/or the members representative to arrange for non-emergency transportation services to attend and be available to present evidence at the appeal hearing.

SilverSummit Healthplan policies and procedures reflect all of the Nevada Medicaid's requirements regarding the State Fair Hearing process as outlined in MSM Chapter 3100, complying with decisions reached as a result of the State Fair Hearing process.

Reporting

SilverSummit Healthplan uses a Member Data Management (MDM) system within our Customer Relations Management platform to enter and track all member and provider grievances, inquiries, and appeals received from our members through verbal or written interaction. This MDM system enables maintenance of an internal database for tracking grievances, inquiries, and appeals routed for investigation. The Grievance and Appeal Coordinator uses the MDM system to designate the deadline for each investigation summary and its proposed resolution. SilverSummit Healthplan maintains all grievance, appeal, and inquiry data and correspondence for at least ten (10 years).

All grievance and appeal data is reportable, by broad categories and subcategories to support effective monitoring and our ongoing quality improvement efforts. The Grievance and Appeal Coordinator is responsible for trend analysis and tracking corrective action plans. SilverSummit Healthplan will submit to Nevada Medicaid the monthly and quarterly reports documenting all grievance and appeals activities as requested. The reporting can be customized to include required data entry fields for appropriately maintaining records of grievances and appeals according to Nevada Medicaid requirements.

SilverSummit Quality Improvement Team has final authority over, and responsibility for, the grievance and appeals process. The Performance Improvement Team (PIT), which reports to the Quality Improvement Committee (QIC), regularly reviews the detail for all member and provider grievances and appeals. The QIC will devote a portion of each meeting to reviewing all complaints, grievances, and appeals to identify trends or issues requiring follow-up or improvement. The PIT is also responsible for maintaining compliance with contractual, federal, state, and accrediting body requirements such as NCQA. The scope of this committee will also include tracking and analysis of member grievances and appeals, including type and timeliness of resolution, performing barrier and root cause analysis, and making recommendations regarding corrective actions, as indicated.

SilverSummit Healthplan will include information in the Member Handbook, online and via the appeals process to members of their right to appeal directly to the Nevada Medicaid Agency. A SilverSummit Healthplan member can request a Nevada Medicaid Agency Appeal only after exhausting the SilverSummit Healthplan internal appeal process and receiving an Adverse Benefit Determination.

Benefit Explanations and Limitations

SilverSummit Healthplan network providers supply a variety of medical and behavioral health benefits and services, some of which are itemized on the following pages. For specific information not covered in this provider manual, please contact Provider Services at 1-844366-2880. A Provider Service Representative will be happy to assist you.

SilverSummit Healthplan covers, at a minimum, those core benefits and services specified in our Agreement with Nevada Medicaid and defined in the Nevada Medicaid Services Manual, administrative rules, and department policies and procedure handbook.

Covered Services

This list is not intended to be an all-inclusive list of covered services, but it substantially provides current guidelines. All services are subject to benefit coverage, limitations, and exclusions as described in applicable plan coverage guidelines.

Use the Pre-Auth Needed? Tool at **www.SilverSummitHealthplan.com** to quickly determine if a specific service requires authorization.

All Out-of-Network (Non-Par) services require prior authorization, excluding family planning, emergency room, and tabletop x-ray.

- Ambulance/Emergency Transportation
- Birth Control/Family Planning
- Disposable Medical Supplies
- Durable Medical Equipment
- Orthotics & Prosthetics
- Doctor Visits
- Emergency Room
- Eye Exams and Eyeglasses
- Health Kids/Early Periodic Screening Diagnosis and Treatment (EPSDT) or Preventive Health Services for Children
- Hearing Tests
- Home and Community Based State Plan Services
- Home Health Care
- Hospice Care
- Hospital Care
- Immunizations
- Lab and Radiology Services
- Maternity Care
- Mental Health/Substance Abuse Services
- Midwife Services
- Non-Emergency Transportation
- Nursing Home Services
- Occupational Therapy Services
- Over-the-Counter Drugs with a Prescription
- Personal Care Services
- Physical Therapy Services
- Preventive Screenings
- Private Duty Nursing
- Prescription Drugs
- Specialists
- Speech and Hearing Services
- Tobacco Cessation

Sterilization

Sterilization procedures, such as tubal ligation and vasectomy, are covered when coordinated through PCP and delivered by a network provider. As a provider, you must counsel the member regarding alternative methods of birth control that are available, that the sterilization procedure is permanent, and that the surgery cannot be 100% guaranteed to make him/her sterile. Inform the member that the signed consent may be withdrawn at any time and that he/she will not lose any health services or benefits.

The member must be at least 21 years of age, mentally competent, and not in an institution at the time he/she voluntarily signs the consent form. The member must give informed consent and sign the Sterilization Consent Form FA-56 before the procedure in order to receive coverage.

Abortion

An abortion is only covered in cases where the mother's life is in danger or pregnancy is the result of rape or incest, in accordance with Nevada state laws.

The physician requesting authorization of coverage for an abortion must complete the correct affidavit and declaration form(s) listed below prior to performing the procedure. The signed consent form and supported documentation must be submitted with the claim to obtain payment.

- Nevada Abortion Affidavit for Incest FA-53
- Nevada Abortion Affidavit for Rape FA-52
- Nevada Abortion Declaration for Incest FA-55
- Nevada Abortion Declaration for Rape FA-54

Hysterectomy

Hysterectomy surgery is covered when it is considered medically necessary and performed by a network provider. The provider and member must complete the Patient Acknowledgement for Hysterectomy Form FA-50 prior to performing the procedure. The consent form must accompany the claim to obtain payment.

Women's Health Care

SilverSummit Healthplan will provide direct access to a health specialist in network for core benefits and services necessary to provide women routine and preventive healthcare services in addition to the member's PCP if the provider is not a women's health specialist. Members are allowed to utilize their own PCP or any family planning service provider for family planning services without the need for a referral or a prior authorization.

In addition, members will have the freedom to receive family planning services and related supplies from an out of network provider without any restrictions. Family planning services include examinations, assessments, traditional contraceptive services, preconception and inter-conception care services.

SilverSummit Healthplan will make every effort to contract with all local family planning clinic and providers and will ensure reimbursement whether the provider is in or out of network.

Silver Summit's Medical Ride Program

Members may be eligible to receive transportation to/from non-emergency medical appointments at no cost. These trips do NOT include ambulance trips. Silver Summit HealthPlan works with SafeRide Health for rural Members and MTM for urban Members to provide:

- Curb-to-curb rides
- Door to door rides
- Gas Mileage Reimbursement

There are two ways to arrange non-emergency medical transportation (NEMT).

1. Call 1-844-366-2880, and select rural or urban to be routed to either Safe Ride or MTM.
2. If you are a rural member, use the SafeRide Member Portal External Link (different from the SilverSummit Healthplan Member Portal)

Please have the following information ready when you call or make an online reservation:

- Member ID number
- Member date of birth
- Drop-off address
- Telephone number
- Doctor's name
- Date and time of appointment
- Pick-up address

School-Based Services

School-based health services provide basic health services and offer specific school programs to promote a healthy lifestyle. Care Managers will work with parents/guardians, school districts, community centers, and the PCP to provide these programs.

Value Added Benefits

Value Added Benefits	Contact Information
Households can earn cash rewards on Visa gift card Rewards Program for certain wellness visits and immunizations that includes pregnancy rewards	Contact SSHP Customer Service
Free Gym membership	Contact SSHP Customer Service
Free cell phone/1000 free minutes/1 GB data OR SIM card/1000 free minutes/1.5 GB data - with unlimited texting from SafeLink	Contact SSHP Customer Service
Free Weight Watchers Membership (Conditions may apply)	Refer members through SSHP Case Management
Member Connections for community resources	Contact SSHP Customer Service
Financial assistance for ID Cards, birth certificate and GED	Contact SSHP Customer Service
Free bus passes for qualified	Refer members through SSHP Case Management
Free Boys and Girls Club Membership	Member can present SSHP ID Card
Enhanced OTC Benefit	CVS OTCHS 1-888-262-6298

Network Development and Maintenance

SilverSummit Healthplan maintains a network of qualified providers in sufficient numbers and locations that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical needs of its members, both adults and children, without excessive travel requirements, and that is in compliance with Nevada Medicaid's access and availability requirements. All providers who provide services to Medicaid members agree to comply with all federal and state laws.

SilverSummit Healthplan offers a network of primary care providers to ensure every member has access to a Medical Home within the required travel distance standards.

In addition, SilverSummit Healthplan will have available, at a minimum, the following providers:

Provider Type, Description

- Hospital, Outpatient Surgery
- Hospital, Inpatient
- Hospital, Outpatient
- Psychiatric Hospital, Inpatient
- Behavioral Health Outpatient Treatment
- Intermediate Care Facility/MR (Public)
- Special Clinics
- Nursing Facility
- Physician, MD/Osteopath DO
- Podiatrist
- Dentist
- Hearing Aid Dispenser & Related Supplies
- Advanced Practice Registered Nurse (APRN)
- Optometrist
- Psychologist
- Radiology & Noninvasive Diagnostic Centers
- Pharmacy
- Home Health Agency
- Personal Care Aide (Home Care)
- Ambulance – Air or Ground
- Durable Medicaid Equipment (DME), Disposables, Prosthetics
- Therapy – Physical, Occupational, Respiratory, Speech
- Chiropractor
- Intravenous Therapy (TPN)
- Home and Community Based Waiver – Individuals with Intellectual Disabilities and Related Conditions
- Adult Day Health Care
- Optician/Optical Businesses
- Laboratory – Pathology/Clinical
- Swing-bed (Acute Hospitals)
- End Stage Renal Disease (ERSD) Facility
- Ambulatory Surgery Centers (Medicare Certified) Free-Standing
- Indian Health Programs
- Home and Community Based Waiver for the Frail Elderly
- IHS/Tribal Hospital (Inpatient)
- IHS/Tribal Hospital (Outpatient)
- Targeted Case Management
- Home Based Habilitation Services
- Medical (Rehabilitation and Long-Term Acute Care (LTAC) Specialty Hospitals
- Elderly in Adult Residential Care Waiver
- Physically Disabled Waiver
- Home and Community Based Assisted Living Waiver – Augmented Personal Care Services
- School Based Services
- Residential Treatment Center (RTC)
- Hospice Services
- Hospice Long Term Care
- Intermediate Care Facility/ IID (Private)
- Nurse Anesthetist
- Nurse Midwife
- Critical Access Hospital (CAH), Inpatient
- Audiologist
- Physician's Assistant
- Indian Health Services – Inpatient (non-tribal)
- Indian Health Services – Outpatient (non-tribal)
- ESRD
- Behavioral Health Rehabilitation Treatment
- Personal Care Aide (PCA) - Intermediary Services Organization
- Applied Behavior Analysis
- Doulas

SilverSummit Healthplan will also use Community Mental Health Centers (CMHCs) to cover Mental Illness Rehabilitative services as required.

In the event SilverSummit Healthplan's network is unable to provide medically necessary services required under the contract, SilverSummit Healthplan shall ensure timely and adequate coverage of these services through an out of network provider until a network provider is contracted and will ensure coordination with respect to authorization and payment issues in these circumstances.

For assistance in making a referral to a specialist or subspecialties for a SilverSummit Healthplan member, please contact our Medical Management team at 1-844-366-2880 and we will identify a provider to make the necessary referral.

Non-Discrimination

We do not limit the participation of any provider or facility in the network, and/or otherwise discriminate against any provider or facility based solely on any characteristic protected under state or federal discriminate laws. We also do not discriminate for reimbursement or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. If SilverSummit Healthplan declines to include individual or groups of providers in our network, we will give the affected providers written notice of the reason for its decision.

Furthermore, we do not and have never had a policy of terminating any provider who:

- advocated on behalf of a member
- filed a complaint against us
- appealed a decision of ours

Tertiary Care

SilverSummit Healthplan offers a network of tertiary care inclusive of trauma centers, burn centers, level III (high risk) nurseries, rehabilitation facilities and medical sub specialists available 24-hours per day in the geographical service area. In the event SilverSummit Healthplan's network is unable to provide the necessary tertiary care services required, SilverSummit Healthplan shall ensure timely and adequate coverage of these services through an out of network provider until a network provider is contracted and will ensure coordination with respect to authorization and payment issues in these circumstances.

Medical Management

SilverSummit Healthplan Medical Management department hours of operation are Monday through Friday from 8:00 a.m. to 6:00 p.m., PST (excluding holidays). After normal business hours, our 24/7 nurse advice hotline staff is available to answer questions about prior authorization.

Medical Management services include the areas of utilization management, care management, disease management and quality review. The department clinical services are overseen by the SilverSummit Healthplan Medical Director ("Medical Director"). The VP of Medical Management has responsibility

for direct supervision and operation of the department. To reach the Medical Director or VP of Medical Management contact Medical Management at 1-844-366-2880.

Integrated Care

We use a multi-disciplinary Integrated Care Team to offer and coordinate integrated care. The Program focuses on a person-centered holistic approach to wellness (medical, behavioral and social aspects) while avoiding duplication of services in a collaborative manner between the Plan, the member and his/her family, and providers (including community providers for populations/services which may be provided outside of contracted services), when appropriate.

Our overarching goal is to help each and every SilverSummit Healthplan member achieve the highest possible levels of wellness, functioning, and quality of life, while demonstrating positive clinical results. Integrated care is an integral part of the range of services that we provide to all members. Through this program, we continually strive to achieve optimal health status through member engagement and behavior change motivation. Integrated care does this through a comprehensive approach that includes:

- Strong support for the integration of both physical and behavioral health services, social service needs, and social determinants
- Assisting members in achieving optimum health, functional capability, and quality of life
- Empowering members through assistance with referrals and access to available benefits and resources, including non-covered benefits
- Working collaboratively with members, family and significant others, providers, and community organizations to assist members using a holistic approach to care
- Maximizing benefits and resources through oversight and cost-effective utilization management
- Rapid and thorough identification and assessment of program participants, especially members with special health care needs
- A team approach that includes staff with expertise and skills that span departments and services
- Information technologies that support care coordination within plan staff and among members, providers and caregivers
- Multifaceted approaches to engage members in self-care and improve outcomes
- Multiple, continuous quality improvement processes that assess the effectiveness of integrated care, and identify areas for enhancement to fully meet member priorities
- Assessment of member's risk factors and needs
- Contact with high-risk members discharging from hospitals to ensure appropriate discharge appointments are arranged and members understand treatment recommendations
- Active coordination of care linking members to behavioral health practitioners, and as needed, medical services; including linkage with a physical health care manager for members with coexisting behavioral and physical health conditions; and residential, social and other support services where needed
- Development of a care management plan of care

- Referrals and assistance to community resources and/or behavioral health practitioners
- For members not hospitalized but in need of assistance with overcoming barriers to obtaining behavioral health services or compliance with treatment, we offer Care Coordination

The model emphasizes direct member contact, such as telephonic out-reach and educational materials. Additionally, some specific programs may provide face-to-face education, because it more effectively engages members and, allows staff to provide information that can address member questions in real time and better meet member needs. Participating members also receive written materials, preventive care and screening reminders, invitations to community events, and can call anytime regarding healthcare and psychosocial questions or needs.

Recognizing that each member's clinical condition and psychosocial situation is unique, integrated interventions and information to meet each member's unique circumstance will vary from one member to another, including those with the same diagnosis.

Coordination of Care

Our Care Coordinators are licensed social workers who can make decisions about what level of care is needed based on the social and medical needs of the members and can assess members who are in crisis. Our Care Coordination functions include:

- Coordinate with SilverSummit Healthplan, member advocates or providers for members who may need medical or behavioral health or social services
- Assist members with locating a Provider
- Assist members with scheduling provider appointments
- Coordinate requests for out-of-network providers by determining need/access issues involved
- Provide educational promotion and
- Provide member follow up

Our coordination of care process is designed to ensure the coordination and continuity of care during the movement between providers and settings. During transitions, patients with complex medical needs are at risk for poorer outcomes due to medication errors and other errors of communication among the involved providers and between providers and patients/caregivers.

Continuity of healthcare means different things to different types of caregivers, and can be of several types:

- Continuity of information. It includes that information on prior events used to give care that is appropriate to the patient's current circumstance
- Continuity of personal relationships, recognizing that an ongoing relationship between patients and providers is the foundation that connects care over time and bridges discontinuous event
- Continuity of clinical management

Providers must adhere to the Covered Services & Authorization Guidelines (CSAG) located on the website at www.silversummithealthplan.com when rendering services. We do not retroactively authorize treatment.

Communication with Primary Care Provider

SilverSummit Healthplan requires Primary Care Provider (PCPs) to consult with their member's behavioral health providers. In many cases the PCP has extensive knowledge about the member's medical condition, mental status, psychosocial functioning, and family situation. Communication of this information at the point of referral or during the course of treatment is encouraged with member consent, when required.

Providers can identify the name and number for a member's PCP on the front-side of the member ID Card. Practitioners/Providers should refer members with known or suspected untreated physical health problems or disorders to the PCP for examination and treatment. Providers should communicate not only with the member's PCP whenever there is a behavioral health problem or treatment plan that can affect the member's medical condition or the treatment being rendered by the PCP, but also with other behavioral health clinicians who may be providing service to the member. Examples of some of the items to be communicated include:

- Prescription medication, especially when the medication has potential side effects, such as weight gain, that could complicate medical conditions, such as diabetes;
- The member is known to abuse over the counter, prescription or illegal substances in a manner that can adversely affect medical or behavioral health treatment;
- The member has lab work indicating need for PCP review and consult;
- The member is receiving treatment for a behavioral health diagnosis that can be misdiagnosed as a physical disorder (panic symptoms can be confused with heart attack symptoms); and
- The member's progress toward meeting the goals established in their treatment plan.

We provide a form for your convenience in communicating with PCP and other providers available at www.SilverSummitHealthplan.com and recommend that you use all available means to coordinate treatment for members in your care. All communication attempts and coordination activities must be clearly documented in the member's medical record.

If you are unable to locate or contact other providers serving your member, please contact us for additional information.

We require that providers report specific clinical information to the member's PCP in order to preserve the continuity of the treatment process. With appropriate written consent from the member, it is the provider's responsibility to keep the member's PCP abreast of the member's treatment status and progress in a consistent and reliable manner. Such consent shall meet the requirements set forth in 42 CFR 2.00 et seq., when applicable. If the member requests this information not be given to their PCP, the provider must document this refusal in the member's treatment record, and if possible, the reason why.

The following information should be included in the report to the PCP:

- A copy or summary of the intake assessment

- Written notification of member's non-compliance with treatment plan (if applicable)
- Member's completion of treatment
- The results of an initial psychiatric evaluation, and initiation of and major changes in psychotropic medication(s)
- The results of functional assessments

Caution must be exercised in conveying information regarding substance use disorders, which is protected under separate federal law. We monitor communication with the PCP and other caregivers through audits. Failure to adhere to these requirements can be cause for termination from the network.

Providers must adhere to the Covered Services & Authorization Guidelines (CSAG) located on the website at www.SilverSummitHealthplan.com when rendering services. We do not retroactively authorize treatment.

Continuity of Care

We authorize any existing covered services with no changes for 30 days after enrollment or until we are able to complete a comprehensive assessment and determine if the current course of treatment is medically necessary. In the case of BH services, when members are newly enrolled and have been previously receiving behavioral health services, we will continue to authorize care as needed to minimize disruption and promote continuity of care for up to 90 days. In the event that a member is receiving care/services from an out-of-network provider, we use the transition period to determine whether the provider is willing to contract and if not, to determine whether it is clinically appropriate to transition the care to a network provider, as described below.

Clinical Training

The Provider Training Team provides training for network providers, stakeholders, and caregivers within our network. Training opportunities will support provider's ability to provide quality services to members. All trainings are provided free of charge, and are conducted in person, group, regional, facility based, and/or remote webinar trainings. Training is available for behavioral health and physical health providers, stakeholder groups, caregivers, and other non-clinical professions. Topics offered to providers include, but are not limited to:

- Motivational Interviewing
- Mental Health First Aid (certified trainers)
- Screening Brief Intervention and Referral to Treatment
- Behavioral Health/Physical Health Screening & Referral
- Integrated Healthcare
- Trauma Informed Care
- Diagnosis-specific Overviews
- Substance Abuse Overview

- SMART Goals
- Behavioral Management & De-escalation
- Cultural Competency
- Poverty Competency
- Disability Sensitivity
- People First Language
- Person Centered Approach
- Evidence Based Practices (including but not limited to)
  - Trauma Focused Cognitive Behavioral Therapy
  - Recovery Model
  - Strengths Based Model
  - Positive Psychology
- Peer Support
- When to refer to Primary Care
- Referral for Care Management
- Behavioral Health 101
- Psychiatric Medications

The Training team is committed to achieving the following goals:

- Promoting provider competence and opportunities for skill-enhancement across disciplines
- Promoting member recovery through integrated, member-centered care
- Sustaining and expanding the use of Evidence Based Practices (e.g., Motivational Interviewing, Stages of Change, Impact Model, Positive Psychology, Trauma Focused Cognitive Behavioral Therapy)
- Assisting providers in meeting Mandatory State or Licensure Requirements
- Providing Continuing Education credits when applicable

The opportunity to provide additional clinical trainings to providers is the responsibility of the Network, Quality, and Training Team. The Training Team can be reached directly at **clinicaltraining@cenpatico.com** to request any of the above training topics or request a new topic.

For behavioral training requests and/or more information, please contact our Clinical Provider Training Department at **bh_training@centene.com**. For all other training requests, please email **providertrainingrequest@SilverSummitHealthplan.com**.

Member Concerns About Provider

Members who have concerns about our providers should contact us to register their concerns. All concerns are investigated, and feedback is provided on a timely basis. It is the provider's responsibility to provide supporting documentation to us if requested. Any validated concern will be taken into consideration when re-credentialing occurs and can be cause for termination from our provider network.

Monitoring Satisfaction

We conduct periodic satisfaction surveys of our members and providers. These surveys enable us to gather useful information to identify areas for improvement. Providers may be requested to participate in the annual survey process. The survey includes a variety of questions designed to address multiple facets of the providers experience with our delivery system and providers should call the Provider Relations department to address concerns as they arise. Feedback from providers enables us to continuously improve systems, policies and procedures. We will also collect feedback from members at the Members Advisory Committee and other Quality Committees.

Complex Care Management Program

SilverSummit Healthplan's care management model is designed to help your SilverSummit Healthplan members obtain needed services, whether they are covered within the SilverSummit Healthplan array of covered services, from community resources, or from other non-covered venues. Our model will support our provider network whether you work in an individual practice or large multi-specialty group setting. Members with identified needs are assessed for Care Management and/or Complex Case Management enrollment. Members with needs may be identified via clinical rounds, referrals from other staff members, via hospital census, via direct referral from Providers, and via self-referral from other health professionals.

The program is based upon a coordinated care model that uses a multi-disciplinary care management team in recognition that a holistic approach yields better outcomes. The goal of our program is to help members achieve the highest possible levels of wellness, functioning, and quality of life, while decreasing the need for disruption at the PCP or specialist office with administrative work.

The program includes a systematic approach for early identification of eligible members, needs assessment, and development and implementation of an individualized care plan that includes member/family education and actively links the member to providers and support services as well as outcome monitoring and reporting back to the PCP. It is the PCP's responsibility to contact Care Management for updates. We will coordinate access to services not included in core benefit package such as, dental, vision and services. Our program incorporates clinical determinations of need, functional status, and barriers to care such as lack of caregiver supports, impaired cognitive abilities and transportation needs.

A care management team is available to help all providers manage their SilverSummit Healthplan members. Listed below are programs and components of special services that are available and can be accessed through the care management team. We look forward to hearing from you about any SilverSummit Healthplan members that you think can benefit from the addition of a SilverSummit Healthplan's care management team member. To contact a care manager call: 1-844-366-2880.

Start Smart for Your Baby®

Start Smart for Your Baby (Start Smart) is our special program for women who are pregnant. This program provides educational materials that tackle the most critical issues affecting the child's development during pregnancy. Start Smart offers a preventive approach that encourages prenatal education for the expectant mother in an effort to achieve the best possible outcome. Start Smart encourages pregnant

women to keep their prenatal care appointments; educates members and their families about pregnancy; identifies members who may be at high risk for developing complications; and provides support in dealing with medical, socioeconomic and environmental issues that may contribute to complications.

Identifying pregnant members as early as possible, providing them with adequate prenatal care and guidance as well as addressing complications as effectively as possible should result in improved outcomes for both the mother and the newborn.

Complex Teams

These teams will be led by licensed registered nurses, or licensed clinical social workers, with either adult or pediatric expertise as applicable. For both adult and pediatric teams, staff will be familiar with evidence-based resources and best practice standards and experience with the population, the barriers and obstacles they face, and socioeconomic impacts on their ability to access services. The complex teams will manage care for members whose needs are primarily functional as well as those with complex conditions such as, but not limited to: congestive heart failure (CHF), coronary arterial disease (CAF), hypertension (HTN), diabetes, chronic obstructive pulmonary disease (COPD), asthma, severe mental illness (SMI), high risk or high costs Substance Use Disorders (SUD), Severe Cognitive and/or Developmental Limitation, recipients in supportive housing, HIV, children and adults with special healthcare needs, and members with other complex conditions.

MemberConnections© Program

MemberConnections© is SilverSummit Healthplan's outreach program designed to provide education to our members on how to access healthcare and develop healthy lifestyles in a setting where they feel most comfortable.

The program components are integrated as a part of our care management program in order to link SilverSummit Healthplan and the community served. The program recruits staff from the communities serviced to establish a grassroots support and awareness of SilverSummit Healthplan within the community. The program has various components that can be provided depending on the need of the member.

Members can be referred to MemberConnections© through numerous sources. Members who call the SilverSummit Healthplan Customer Service department may be referred for more personalized discussion on the topic they are inquiring about. Care managers may identify members who would benefit from one of the many MemberConnections© components and complete a referral request. Providers may request MemberConnections© referrals directly to the MemberConnections© Representative or their assigned care manager. Community groups may request that a MemberConnections© Representative come to their facility to present to groups they have established or at special events or gatherings. Various components of the program are described below.

Community Connections: MemberConnections© Representatives are available to present to group settings during events initiated by state entities, community groups, clinics, or any other approved setting. This form of community connections is extremely useful in rural areas where home visits may be the only mode of communication. Presentations may typically include what Medicaid coordinated care is all about,

overview of services offered by SilverSummit Healthplan, how to use the health plan and access services, the importance of obtaining primary preventive care, and other valuable information related to obtaining services from providers and SilverSummit Healthplan.

Home Connections: MemberConnections© Representatives are available on a full-time basis whenever a need or request is received from a care manager, member or provider. All home visits are unscheduled due to the fact that the care manager has been unable to make contact with the member. Some home visits can be scheduled when it involves them delivering a cell phone to the member in order to have easier access to the member. Topics covered during a home visit include overview of covered benefits, how to schedule an appointment with the PCP, the importance of preventive healthcare, appropriate use of preventive, urgent and emergency care services, obtaining medically necessary transportation, and how to contact the health plan for assistance.

Phone Connections: MemberConnections© Representatives may contact new members or members in need of more personalized information to review the health plan material over the telephone. All the previous topics may be covered, and any additional questions answered.

Chronic Care/Disease Management Programs: As a part of SilverSummit Healthplan services, Chronic Care Management Programs (CCMP) offered to members. Chronic Care Management/Disease Management is the concept of reducing healthcare costs and improving quality of life for individuals with a chronic condition, through integrative care.

Chronic care management supports the physician or practitioner/patient relationship and plan of care; emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health.

SilverSummit Healthplan programs include but are not limited to anxiety, asthma, bipolar and schizoaffective disorder, COPD, coronary artery disease, depression, diabetes, perinatal depression, and perinatal substance use. Our programs promote a coordinated, proactive, disease-specific approach to management that will improve members' self-management of their condition, improve clinical outcomes, and control high costs associated with chronic medical conditions.

Not all members having the targeted diagnoses will be enrolled in the CCMP. Members with selected disease states will be stratified into risk groups that will determine need and level of intervention. High-risk members with co-morbid or complex conditions will be referred for care management program evaluation.

To refer a member for chronic care management:

- Call SilverSummit Healthplan Health Coaches at 1-844-366-2880
- Visit the Provider Portal on our website **www.SilverSummitHealthplan.com**

Supportive Housing

The SilverSummit Supportive Housing Program will support improved health outcomes as well as housing retention and self-sufficiency, including promotion of moving from supportive housing to permanent housing. The Care Manager will work with the member, circle of support, and providers as well as supportive housing providers to develop and implement a care plan that addresses the full range of the member's needs including primary and preventive care, medication management, behavioral health services, vocational guidance, skill building, and problem solving. The Care Manager will also connect the member to peer supports as desired by the member and help them address and manage barriers in accessing treatment or recovery efforts.

Our staff, with support from the Housing Specialist, will train supportive housing providers on prevalent co-morbid medical/behavioral health conditions (such as HTN, diabetes, depression) to enhance their ability to refer members to us for assessment of new or changed conditions, as well as de-escalation techniques and the support we can provide for members experiencing escalation or crisis. Supportive housing staff will help train our staff on resources and community supports for homelessness.

Supportive Employment

The Program is intended to support member self-sufficiency and improve quality of life, leading to improved health outcomes. Our effort is to address all member needs, including social determinants of health, and to ensure our members have access to supportive employment and other services to identify and secure stable employment. We look forward to connecting our members to organizations for resume building and industry recognized certifications such as Certified Medical Administrative Assistant (CMAA), Certified Logistics Technician (CLT) and Microsoft Office Specialist (MOS).

Peer Support Specialists

SilverSummit Healthplan affiliates partner with local mental health centers and other community organizations to increase peer support services for members. Our affiliates work with these providers to increase referrals to peer support services which include, but are not limited to, member drop-in centers (for in-the-moment peer to peer support) and telephonic support (telephonic warm-lines to connect with members state-wide). SilverSummit Healthplan recognizes that a peer support connection can be a powerful component to impact the social, emotional and practical support in a member's life.

Provision of all components of the EPSDT service must be clearly documented in the PCP's medical record for each member. SilverSummit Healthplan's Quality team and the Quality Improvement Committee (QIC) are designated to assist with the functions to support and effectively carry out the operations of the EPSDT Program.

Emergency Care Services

SilverSummit Healthplan defines an emergency medical condition as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
2. serious impairments of bodily functions, or
3. serious dysfunction of any bodily organ or part as per 42 CFR 438.114.(a)

SilverSummit Healthplan does not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.

Members may access emergency services at any time without prior authorization or prior contact with SilverSummit Healthplan. Providers should inform members that if they are unsure as to the urgency or emergency of the situation, they are encouraged to contact their Primary Care Provider (PCP) and/or SilverSummit Healthplan's 24-hour nurse advice hotline for assistance; however, this is not a requirement to access emergency services. SilverSummit Healthplan contracts with emergency services providers as well as non-emergency providers who can address the member's non-emergency care issues occurring after regular business hours or on weekends.

Emergency services are covered by SilverSummit Healthplan when furnished by a qualified provider, including non-network providers, and will be covered until the member is stabilized. Any screening examination services conducted to determine whether an emergency medical condition exists will also be covered by SilverSummit Healthplan. Emergency services will cover and reimburse regardless of whether the provider is in SilverSummit Healthplan's provider network and will not deny payment for treatment obtained under either of the following circumstances:

1. A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of Emergency Medical Condition; or
2. A representative from the Plan instructs the member to seek emergency services.

Once the member's emergency medical condition is stabilized, SilverSummit Healthplan requires Notification for hospital admission or Prior Authorization for follow-up care as noted elsewhere in this manual.

Medical Necessity

"Medical Necessity" or "Medically Necessary Care" means a healthcare service or product that is provided for under the Medicaid State Plan and is necessary and consistent with generally accepted professional standards to diagnose, treat or prevent illness or disease; regain functional capacity; or reduce or ameliorate effects of an illness, injury, or disability. The determination of medical necessity is made on the basis of the individual case and takes into account:

a. Type, frequency, extent, body site and duration of treatment with scientifically based guidelines of national medical or healthcare coverage organizations or governmental agencies.
b. Level of service that can safely and effectively furnish, and for which no equally effective and more conservative or less costly treatment is available.

c. Services are delivered in the setting that is clinically appropriate to the specific physical and mental/behavioral healthcare needs of the recipient.

d. Services are provided for medical or mental/behavioral reasons rather than for the convenience of the recipient, the recipient's caregiver, or the healthcare provider.

Medical Necessity shall take into account the ability of the service to allow recipients to remain in a community-based setting, when such a setting is safe, and there is no less costly, more conservative or more effective setting.

We will only place appropriate limits on a service based on criteria under the Title XI and Title XXI State plans, such as medical necessity or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose. The Health Plan's UR staff, including physicians, nurses and licensed behavioral health clinicians, will use clinical decision criteria to determine the medical necessity of covered service in alignment with the State of Nevada's definition of medical necessity. Clinical review criteria are developed using or based upon nationally recognized criteria reflecting evidence-based clinical practice, along with Nevada Medicaid program requirements, Our UR guidelines will ensure timely access to appropriate services that help members achieve the highest possible levels of health, wellness, functioning and quality of life.

Utilization Management

The SilverSummit Healthplan Utilization Management Program (UMP) is designed to ensure members of SilverSummit Healthplan Network receive access to the right care at the right place and right time. Our program is comprehensive and applies to all eligible members across all eligibility types, age categories, and range of diagnoses. The UMP incorporates all care settings including preventive care, emergency care, primary care, specialty care, acute care, short-term care, Health Homes, behavioral health, maternity care and ancillary care services.

SilverSummit Healthplan UMP seeks to optimize a member's health status, sense of well-being, productivity, and access to quality healthcare, while at the same time actively managing cost trends. The UMP aims to provide services that are a covered benefit, medically necessary, appropriate to the patient's condition, rendered in the appropriate setting and meet professionally recognized standards of care.

Our program goals include:

- Development of quality standards for the region with the collaboration of the Provider Standards Committee
- Monitoring utilization patterns to guard against over or under utilization
- Development and distribution of clinical practice guidelines in partnership with Quality to providers to promote improved clinical outcomes and satisfaction
- Identification and provision of case and/or population management for members at risk for significant health expenses or ongoing care
- Development of an infrastructure to ensure that all SilverSummit Healthplan members establish relationships with their PCPs to obtain preventive care

- Implementation of programs that encourage preventive services and chronic condition self-management
- Creation of partnerships with members/providers to enhance cooperation and support for UMP goals

Prior Authorizations

Failure to obtain the required approval or pre-certification may result in a denied claim(s). All services are subject to benefit coverage, limitations, and exclusions as described in applicable plan coverage guidelines. SilverSummit Healthplan providers are contractually prohibited from holding any SilverSummit Healthplan member financially liable for any service administratively denied by SilverSummit Healthplan for the failure of the provider to obtain timely authorization. All out-of-network services require prior authorization except for family planning, emergency room, post-stabilization services and tabletop x-rays.

National Performance-Based Gold Card Program

SilverSummit Healthplan may offer a Performance-Based Gold Card Program for select participating providers who consistently demonstrate high prior authorization approval rates for selected outpatient services. Providers participating in the program will not be required to wait for an authorization determination before rendering Gold Card eligible services following submission of the required pre-notification. Pre-notifications must be submitted through Availity, or for services managed by Evolent through the Evolent portal. The program applies only to specifically identified outpatient services and does not apply to inpatient services or services outside the designated Gold Card scope.

Participation in the program is limited to providers who meet established eligibility criteria and performance standards determined by the health plan. Eligibility is assessed at the Ordering/Referring Tax Identification Number (TIN) level and may be reviewed periodically to ensure ongoing compliance with utilization management, billing, and program integrity expectations. Participation does not waive medical necessity, member eligibility, coverage, benefit, or network requirements, and the health plan retains the right to conduct utilization review, audit, and program integrity activities in accordance with applicable federal and state requirements. Additional operational guidance, including eligible services and implementation details, will be communicated to participating providers as applicable.

Providers may be removed from the program if monitoring or audit activities identify concerns related to utilization patterns, billing practices, fraud, waste, abuse, or noncompliance with program requirements.

Services That Require Prior Authorization

ANCILLARY SERVICES

- Air Ambulance Transport
- Durable Medical Equipment
- Private Duty Nursing
- Orthotics/Prosthetics
- Genetic Testing
- Quantitative Urine Drug Screen
- Physical, Occupational, Speech Therapy-Treatment (initial evaluations by participating providers do not require authorization)

OUT-OF-NETWORK PROVIDERS

- All out-of-network providers require prior authorization excluding emergency room services and Family Planning.

PROCEDURES/SERVICES

- Potentially Cosmetic
- Bariatric Surgery
- High Tech Imaging administered by Evolent, i.e., CT, MRI, PET
- Obstetrical Ultrasound – Two allowed in nine months; prior authorization required for additional u/s except if rendered by a perinatologist
- Pain Management (except post-op)
- Outpatient Mental Health (OMH) Services
- Rehabilitative Mental Health (RMH) Services
- Day Treatment
- Electroconvulsive Therapy (ECT)
- Applied Behavioral Analysis (ABA)
- Outpatient Alcohol and Substance Abuse Services

INPATIENT AUTHORIZATION

All elective/scheduled admission notifications requested at least five days prior to the scheduled date of admit including but not limited to:

- Medical Admissions
- Surgical Admissions
- All services performed in out-of-network facilities
- Rehabilitation facilities
- Observation stays exceeding 48 hours require Inpatient Authorization/Concurrent Review
- Inpatient Mental Health Services
- Inpatient Alcohol and Substance Abuse Detox and treatment
- Residential Treatment Center (RTC) Services

Please visit **www.SilverSummitHealthplan.com** and use the "Pre-Auth Needed?" tool to determine if a service requires Prior Authorization. Providers must adhere to the Covered Services & Authorization Guidelines (CSAG) located on the website at **www.SilverSummitHealthplan.com** when rendering services. We do not retroactively authorize treatment.

Procedures for Requesting a Medical or Behavioral Prior-Authorization

The preferred method for submitting authorizations is through the secure provider portal **www.SilverSummitHealthplan.com**. The provider must be a registered user on the secure provider portal. If the provider is not already a registered user on the secure provider portal and needs assistance or training on submitting prior authorizations, the provider should contact his or her dedicated Provider Relations Specialist. Other methods of submitting the prior authorization requests are as follows:

- Call the Medical Management Department at 1-844-366-2880. Please note: The Medical Management normal business hours are Monday – Friday 8am to 5pm PST. After normal business hours, our 24/7 nurse advice hotline staff are available to answer questions about prior authorization. Voicemails left after hours and will be responded to on the next business day.

- Fax medical prior authorization requests utilizing the Prior Authorization fax forms posted on **www.SilverSummitHealthplan.com**. Please note: faxes will not be monitored after hours and will be responded to on the next business day.
- For behavioral health prior authorization requests, utilizing the Outpatient Treatment Request (OTR) forms posted on **www.SilverSummitHealthplan.com**. Network Practitioners may call the Customer Service department at 1-844-366-2880 to check status of an OTR. Network practitioners should allow up to fourteen (14) business days to process non-urgent requests. OTR forms for services requiring authorization are located at **www.SilverSummitHealthplan.com.**
  - The OTR must be completed in its entirety. The diagnoses as well as all other clinical information must be evident. Failure to complete an OTR in its entirety can result in authorization delay and/or denials.
  - We will not retroactively certify routine sessions. The dates of the authorization request must correspond to the dates of expected sessions. Treatment must occur within the dates of the authorization.

Our utilization management decisions are based on medical necessity and established Clinical Practice Guidelines. We do not reimburse for unauthorized services and each provider agreement with us precludes network providers from balance billing (billing a member directly) for covered services with the exception of copayment and/or deductible collection, if applicable. Our authorization of covered services is an indication of medical necessity, not a confirmation of member eligibility, and not a guarantee of payment.

Timeframes for Prior Authorization Requests

Authorization must be obtained prior to the delivery of certain elective and scheduled services. The following timeframes are required for prior authorization and notification.

Service Type	Timeframe
Scheduled admissions	Prior Authorization required at least five business days prior to the scheduled
Elective outpatient services	Prior Authorization required at least five business days prior to the elective outpatient
Emergent inpatient admissions	Notification within one business day
Observation – 23 hours or less	Notification within one business day for non-participating providers
Observation – greater 48 hours	Requires inpatient prior authorization within one business day
Maternity admissions	Notification within one business day, with delivery outcome
Newborn admissions	Notification within one business day
Neonatal Intensive Care Unit (NICU) admissions	Notification within one business day

Any prior authorization request that is faxed or sent via the website after normal business hours (8:00 am – 5:00 pm Monday – Friday PST, excluding holidays) will be processed the next business day.

Failure to obtain authorization may result in administrative claim denials.

Authorization Determination Timelines

SilverSummit Healthplan decisions are made as expeditiously as the member's health condition requires.

Type	Timeframe
Preservice/Urgent	72 hours or 2 business days
Preservice/Non-Urgent	2 business days
Concurrent review	24 hours

Clinical Information

SilverSummit Healthplan clinical staff request clinical information minimally necessary for clinical decision making. All clinical information is collected according to federal and state regulations regarding the confidentiality of medical information. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), SilverSummit Healthplan is entitled to request and receive protected health information (PHI) for purposes of treatment, payment and healthcare operations, with the authorization of the member.

Information necessary for authorization of covered services may include but is not limited to:

- Member's name, member ID number
- Provider's name and telephone number
- Facility name, if the request is for an inpatient admission or outpatient facility services
- Provider location if the request is for an ambulatory or office procedure
- Reason for the authorization request (e.g., primary and secondary diagnosis, planned surgical procedures, surgery date)
- Relevant clinical information (e.g., past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed)
- Admission date or proposed surgery date, if the request is for a surgical procedure
- Discharge plans
- For obstetrical admissions, the date and method of delivery, estimated date of confinement, and information related to the newborn or neonate including the date of birth and gender of infant must be provided to SilverSummit
- Healthplan within 2 business days or before discharge

If additional clinical information is required, a nurse or medical service representative will notify the caller of the specific information needed to complete the authorization process. For outpatient behavioral health services, required clinical information can also be found on Outpatient Treatment Request (OTR) fax forms posted on www.SilverSummitHealthplan.com.

Clinical Decisions

SilverSummit Healthplan affirms that utilization management decision making is based on appropriateness of care and service and the existence of coverage. SilverSummit Healthplan does not reward practitioners or other individuals for issuing denials of service or care.

Delegated providers must ensure that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

The treating physician/clinician, in conjunction with the member, is responsible for making all clinical decisions regarding the care and treatment of the member. Failure to obtain authorization for services that require plan approval may result in payment denials.

Review Criteria

SilverSummit Healthplan has adopted utilization review criteria developed by McKesson InterQual® products to determine medical necessity for healthcare services. InterQual appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. InterQual criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, ancillary services and inpatient mental health. Criteria are established and periodically evaluated and updated with appropriate involvement from physicians. InterQual is utilized as a screening guide and is not intended to be a substitute for practitioner judgment. Physical, Occupational and Speech Therapy will be reviewed using a therapy specific policy, which can be found at **www.SilverSummitHealthplan.com**. Substance Use services are authorized utilizing ASAM criteria. Outpatient and rehabilitative mental health services are reviewed based on InterQual, Silversummit Community Based Services Medical Necessity Criteria as well as Level of Care Utilization System (LOCUS) for adults and the Child and Adolescent Screening Intensity Instrument (CASII) for children and adolescents. The Medical Director, or other healthcare professional that has appropriate clinical expertise in treating the member's condition or disease, reviews all potential adverse determination and will make a decision in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm in the screening criteria.

ASAM and the McKesson InterQual criteria sets are proprietary and cannot be distributed in full, however, a copy of the specific criteria relevant to any individual need for authorization is available upon request. Both ASAM and InterQual criteria are reviewed on an annual basis by our Provider Advisory Committee that is comprised of Network Providers as well as our clinical staff. We are committed to the delivery of appropriate service and coverage, and offers no organizational incentives, including compensation, to any employed or contracted UM staff based on the quantity or type of utilization decisions rendered. Review decisions are based only on appropriateness of care and service criteria, and UM staff is encouraged to bring inappropriate care or service decisions to the attention of the Medical Director.

Providers may obtain the criteria used to make a specific adverse determination by contacting Medical Management at 1-844-366-2880. Practitioners also have the opportunity to discuss any adverse decisions with a physician or other appropriate reviewer at the time of notification to the requesting practitioner/facility of an adverse determination. The Medical Director may be contacted through Provider Services by calling SilverSummit Healthplan main toll-free phone number at 1-844-366-2880 and asking for a Peer Review with the Medical Director. A care manager may also coordinate communication between the Medical Director and requesting practitioner.

Members or healthcare professionals with the member's consent may request an appeal related to a medical necessity decision made during the authorization or concurrent review process orally or in writing to:	**SilverSummit Healthplan** **Complaint and Grievance Department** **2500 N. Buffalo Drive, Suite 250** **Las Vegas, NV 89128**

Psychotropic Medication Utilization Review (PMUR)

For psychotropic medications, we utilize a comprehensive Psychotropic Medication Utilization Review (PMUR) program that has become a best practice across our affiliated health plans. Since implementing the PMUR process, our affiliates have seen a dramatic decrease in polypharmacy due to physician awareness of and improved compliance with quality and clinical practice guidelines.

Second Opinion

Members or a healthcare professional with the member's consent may request and receive a second opinion from a qualified professional within the SilverSummit Healthplan network. If there is not an appropriate provider to render the second opinion within the network, the member may obtain the second opinion from an out-of-network provider at no cost to the member. Out-of-network and in-network providers require prior authorization by SilverSummit Healthplan when performing second opinions.

Assistant Surgeon

Reimbursement for an assistant surgeon's service is based on the procedure itself and the assistant surgeon's presence at the time of the procedure. Hospital medical staff by-laws that require an assistant surgeon be present for a designated procedure are not in and of themselves grounds for reimbursement as they may not constitute medical necessity, nor is reimbursement guaranteed when the patient or family requests that an assistant surgeon be present for the surgery, unless medical necessity is indicated.

New Technology

SilverSummit Healthplan evaluates the inclusion of new technology and the new application of existing technology for coverage determination. This may include medical procedures, drugs and/or devices. The Medical Director and/or Medical Management staff may identify relevant topics for review pertinent to the SilverSummit Healthplan population. The Clinical Policy Committee (CPC) reviews all requests for coverage and makes a determination regarding any benefit changes that are indicated.

If you need a new technology benefit determination or have an individual case review for new technology, please contact the Medical Management department at 1-844-366-2880.

Notification of Pregnancy

Members that become pregnant while covered by SilverSummit Healthplan may remain a SilverSummit Healthplan member during their pregnancy. The managing physician should notify the SilverSummit Healthplan prenatal team by completing the Notification of Pregnancy (NOP) form within five days of the first prenatal visit. Providers are expected to identify the estimated date of confinement and delivery facility. See the Care Management section for information related to our Start Smart for Your Baby® program and our 17-P program for women with a history of early delivery.

Concurrent Review and Discharge Planning

Nurse and other appropriately licensed care managers such as licensed behavioral health clinicians, as appropriate, perform ongoing concurrent review for inpatient admissions through onsite or telephonic methods through contact with the hospital's Utilization and Discharge Planning departments and when necessary, with the member's attending physician. The care manager will review the member's current status, treatment plan and any results of diagnostic testing or procedures to determine ongoing medical necessity and appropriate level of care. Concurrent review decisions will be made within one business day of receipt of clinical information. For length of stay extension requests, clinical information must be submitted by 3:00 p.m. PST on the day review is due. Written or electronic notification includes the number of days of service approved, and the next review date.

Routine, uncomplicated vaginal or C-section delivery does not require concurrent review, although; the hospital must notify SilverSummit Healthplan within two business days of delivery with complete information regarding the delivery status and condition of the newborn.

Retrospective Review

Retrospective review is an initial review of services provided to a member, but for which authorization and/or timely notification to SilverSummit Healthplan was not obtained due to extenuating circumstances (i.e., member was unconscious at presentation, member did not have their Medicaid card or otherwise indicated Medicaid coverage, services authorized by another payer who subsequently determined member was not eligible at the time of service). Requests for retrospective review must be submitted promptly. A decision will be made within 30 calendar days following receipt of request, not to exceed 90 calendar days from date of service. Presumptive eligibility rules apply.

For Behavioral Health Services: By standard practice, we **do not** provide retro authorization, however there are certain unique circumstances in which there may be an exception. Retro authorizations will only be granted in rare cases, such as eligibility issues. All requests for retro authorizations must be submitted within 180 days of the date of service and should include a cover letter explaining why authorization was not obtained. You should provide medical records that will be used to determine if medical necessity was met for the services provided. Repeated requests for retro authorizations may result in termination from the provider network due to inability to follow policies and procedures.

Peer Clinical Review Process

If the Utilization Manager is unable to certify the requested level of care based on the information provided, the Utilization Manager will initiate the peer review process.

For outpatient service requests, the clinical information submitted will be forwarded to an appropriate clinician of like specialty of the requesting provider for review and respond. When a determination is made where no peer-to-peer conversation has occurred, a provider can request to speak with the Clinical Consultant who made the determination. If the member is dissatisfied with the decision of the medical director, the member may, within ten (10) calendar days of notification of the decision, file a written or oral notice of appeal, with an oral filing followed by a written, signed notice of appeal within five (5) calendar days, with SilverSummit Healthplan to be heard by a Peer Review committee

As a result of the Peer Clinical Review process, we will make a decision to approve, modify, or deny authorization for services. Treating practitioners may request a copy of the medical necessity criteria used in any denial decision. The treating practitioner may request to speak with the Peer Reviewer who made the determination after any denial decision. If you would like to discuss a denial decision, contact us at 1-844-385-2192.

Adverse Benefit Determination

When we determine that a specific service does not meet criteria and will therefore not be authorized, we will submit a written notice of action to the treating network practitioner or provider rendering the service(s) and the member. The notification will include the following information/ instructions:

- The reason(s) for the proposed action in clearly understandable language
- A reference to the criteria, guideline, benefit provision, or protocol used in the decision, communicated in an easy-to-understand summary
- A statement that the criteria, guideline, benefit provision, or protocol will be provided upon request
- Information on how the provider may contact the Peer Reviewer to discuss decisions and proposed actions. When a determination is made where no peer-to-peer conversation has occurred, the Peer Reviewer who made the determination (or another Peer Reviewer if the original Peer Reviewer is unavailable) will be available within one (1) business day of a request by the treating provider to discuss the determination
- Instructions for requesting an appeal including the right to submit written comments or documents with the appeal request; the member's right to appoint a representative to assist them with the appeal, and the timeframe for making the appeal decision
- For all urgent precertification and concurrent review clinical adverse decisions, and instructions for requesting an expedited appeal
- The right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these service

Guidelines for Psychological/Neuropsychological Testing

Psychological/Neuropsychological testing must be prior authorized for outpatient services. Testing, with prior authorization, may be used to clarify questions about a diagnosis as it directly relates to treatment.

IT IS IMPORTANT TO NOTE:

- Testing will not be authorized by us for ruling out a medical condition
- Testing is not used to confirm previous results that are not expected to change
- A comprehensive initial assessment (90791) should be conducted by the requesting Psychologist prior to requesting authorization for testing. No authorization is required for this assessment if the practitioner is contracted and credentialed with us
- Providers should submit a request for Psychological Testing that includes the specific tests to be performed
- Providers may access our Psychological/Neuropsychological Testing Authorization Request Form on the website. Please refer to fax guidance on the form for submission guidance
- Testing requested by the court or state agencies for the purpose of placement, is not considered medically necessary and may not be reimbursed

Advanced Diagnostic Imaging

As part of a continued commitment to further improve the quality of advanced imaging care delivered to our members, SilverSummit Healthplan is using Evolent to provide prior authorization services and utilization. Evolent focuses on radiation awareness designed to assist providers in managing imaging services in the safest and most effective way possible.

Prior authorization is required for the following outpatient radiology procedures:

- CT /CTA
- MRI/MRA

Oncology Pathways Solutions Program

SilverSummit Healthplan Oncology Pathway Solutions program provides prior authorization management for all infusible, injectable, and oral chemotherapy agents, supportive drugs/symptom management drugs and radiation oncology. The program emphasizes and supports the selection of Preferred Pathways for patient care and is administered by Evolent.

Key Provisions

- Emergency room, observation and inpatient imaging procedures do not require authorization
- It is the responsibility of the ordering physician to obtain authorization
- Providers rendering the above services should verify that the necessary authorization has been obtained. Failure to do so may result in claim non-payment

To reach Evolent and obtain an authorization for radiology, please call 1-800-424-4841. Evolent also provides an interactive website which may be used to obtain on-line authorizations. Please visit RadMD.com for more information or call our Provider Services department.

Cardiac Solutions

SilverSummit Healthplan in collaboration with Evolent, will launch a cardiac imaging program to promote healthcare quality for patients with possible cardiac disease.

Under this program, prior authorization will be required for certain cardiac studies to determine if the cardiac test or procedure is the most appropriate next step in a patient's diagnosis or treatment—and to recommend an alternate approach when indicated. By supporting the most efficient diagnosis and management of cardiac disease, Evolent addresses unnecessary procedures and promotes the least invasive, most medically appropriate approach.

Evolent has developed proprietary utilization management guidelines for these cardiac modalities. These consensus-based guidelines draw on current literature, American College of Cardiology (ACC) appropriateness criteria, recommendations from the American Heart Association, and input from our Cardiac Advisory Board and other experts. Our guidelines are transparent and available throughout our programs. Evolent also includes references to the Choosing Wisely campaign by the American Board of Internal Medicine (ABIM) Foundation, which provides specialty society considerations for the selection of appropriate tests.

How does this program improve patient health?

Managing cardiac studies will promote the use of optimal diagnostic methods in the assessment and treatment of cardiac diseases. Based on criteria adapted from the ACC and AMA, this program will minimize patients' radiation exposure by using the most efficient and least invasive testing options available.

Program Components

- Evidence-based clinical guidelines and proprietary algorithms to support clinically appropriate diagnostic options for each patient
- Consultations with cardiologists related to elective cardiac diagnostic imaging, when needed
- Quality assessment of imaging providers to ensure the highest technical and professional standards

How the Program Works

In addition to the other procedures that currently require prior authorization for members, prior authorization will be required for the following cardiac procedures:

- Myocardial Perfusion Imaging (MPI)
- MUGA Scan
- Echocardiography
- Stress Echocardiography

The following services do not require authorization through Evolent:

- Inpatient advanced radiology services
- Observation setting advanced radiology services
- Emergency Room radiology services

To reach Evolent and obtain authorization, please call 1-800-424-4841 for radiology and cardiac authorizations. Evolent also provides an interactive website which may be used to obtain on-line authorizations. Please visit RadMD.com for more information.

Clinical Practice Guidelines

Medical

SilverSummit Healthplan clinical and quality programs are based on evidence based preventive and clinical practice guidelines. Whenever possible, SilverSummit Healthplan adopts guidelines that are published by nationally recognized organizations or government institutions as well as state-wide collaborative and/or a consensus of healthcare professionals in the applicable field.

SilverSummit Healthplan providers are expected to follow these guidelines and protocols and adherence to the guidelines will be evaluated at least annually as part of the Quality Improvement Program. Following is a sample of the clinical practice guidelines adopted by SilverSummit Healthplan:

- American Academy of Pediatrics: Recommendations for Preventive Pediatric Health Care
- American Diabetes Association: Standards of Medical Care in Diabetes
- Center for Disease Control and Prevention (CDC): Adult and Child Immunization Schedules
- National Heart, Lung, and Blood Institute: Guidelines for the Diagnosis and Management of Asthma and Guidelines for Management of Sickle Cell
- U.S. Preventive Services Task Force Recommendations for Adult Preventive Health
- Federal requirements under the Mental Health Parity and Addiction Parity Act
- American Psychiatric Association

For links to the most current version of the guidelines adopted by SilverSummit Healthplan, visit our website at **www.SilverSummitHealthplan.com.**

Behavioral Health

We have adopted many of the clinical practice guidelines published by the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry as well as evidence-based practices for a variety of services. Clinical practice guidelines adopted for adults include but are not limited to treatment of:

- Major Depressive Disorder
- Bipolar Disorder
- Substance Use Disorders
- Schizophrenia
- Post-Traumatic Stress Disorder (PTSD)
- Panic Disorders
- ADHD
- Psychotropic Medication

For children, we have adopted guidelines for Depression in Children and Adolescents, Assessment and Treatment of Children and Adolescents with Anxiety Disorders and Attention Deficit/ Hyperactivity Disorder.

Clinical practice guidelines may be accessed through our website, or you may request a paper copy of the guidelines by contacting your Network Manager. Copies of our evidence-based practices can be obtained in the same manner. The Quality Improvement Committee (QIC) reviews and approves the guidelines annually.

For links to the most current version of the guidelines adopted by SilverSummit Healthplan, visit our website at **www.SilverSummitHealthplan.com**.

Speech, Physical or Occupational Therapy

The Specialty Therapy and Rehabilitation Services program utilizes current practice guidelines from the respective National Associations for each discipline to help guide reviewers in determining best practices and medical necessity. Some examples of current practice guidelines can be found in the resources listed below. This list is not all-inclusive and updated resources are utilized as they become available.

- Guide to Physical Therapist Practice 3.0. Alexandria, VA: American Physical Therapy Association; 2014. Available at: **apta.org** (Accessed 4/26/2016.)
- American Speech Language Hearing Association, Medical Review Guidelines for Speech-Language Pathology Services (2001).
- Clark GF. Guidelines for documentation of Occupational Therapy (2003). *Am J Occupational Therapy*. 2003 Nov-Dec; 57(6):646-9.

Pharmacy

SilverSummit Healthplan is committed to providing appropriate, high quality, and cost-effective drug therapy to all SilverSummit Healthplan members. We work with providers and pharmacists to ensure medications used to treat a variety of conditions and diseases are covered.

SilverSummit Healthplan covers prescription drugs and certain over-the-counter (OTC) drugs when ordered by a Nevada Medicaid provider. The pharmacy program does not cover all medications. Some medications require prior authorization (PA) or have limitations on age, dosage and/or maximum quantities.

This section provides an overview of SilverSummit Healthplan's pharmacy program.
For more detailed information and pharmacy claims billing information, please visit our website at **www.SilverSummitHealthplan.com**.

Preferred Drug List (PDL)

The SilverSummit Health Plan Preferred Drug List (PDL) can be found online at www.SilverSummitHealthplan.com, and describes the circumstances under which contracted pharmacy providers will be reimbursed for medications dispensed to members covered under the program. The PDL includes drugs available without PA and those agents that have the restrictions. The PA list includes those drugs that require prior authorization for coverage. The PDL does not:

- Require or prohibit the prescribing or dispensing of any medication
- Substitute for the independent professional judgment of the provider or pharmacist
- Relieve the provider or pharmacist of any obligation to the member or others

The SilverSummit Healthplan PDL includes a broad spectrum of generic and brand name drugs. Some preferred drugs require Prior Authorization (PA). Medications requiring PA are listed with a "PA" notation.

The Preferred Drug List (PDL) and pharmaceutical management edits are posted on SilverSummit Healthplan's website. The availability of the current PDL is communicated to members and providers through the member and provider newsletter or other materials such as a postcard. Major changes in drug coverage and pharmaceutical management edits are communicated to providers and members by direct mail (e.g., fax, email, mail) as needed. All pharmaceutical management edits and coverage limitations meet State specific requirements, and any variances are preapproved by the individual State Medicaid Programs, where required.

The Preferred Drug List (PDL) contains information for pharmaceutical management procedures including:

- A list of covered pharmaceuticals, including restrictions and preferences, copayment information, if applicable.
- How to use the pharmaceutical management procedures including the prior authorization process and an explanation of limits or quotas on refills, doses & prescriptions.
- How to submit an exception request.
- The process for generic substitution, therapeutic interchange and step-therapy protocols.

Compounds

Compounded prescriptions must be submitted online, and each ingredient must have an active and valid NDC. Compounded medications may be subject to prior authorization based on ingredients submitted. Compounds that have a commercially available product are not reimbursable. Pharmacy providers can access detailed instructions on how to submit a compound claim by accessing the Express Scripts manual at Pharmacist Resource Center (express-scripts.com).

Pharmacy and Therapeutics Committee (P&T)

The Pharmacy and Therapeutics (P&T) Committee continually evaluates the therapeutic classes included in the PDL. The primary purpose of the Committee is to assist in developing and monitoring the SilverSummit Healthplan PDL and to establish programs and procedures that promote the appropriate and cost-effective use of medications. The P&T Committee schedules meetings, quarterly, with additional meetings scheduled as needed. SilverSummit Healthplan will follow all State policies regarding member notification when changes are made to the PA list.

Unapproved Use of Preferred Medication

Medication coverage under this program is limited to non-experimental indications as approved by the FDA. Other indications may also be covered if they are accepted as safe and effective using current medical and pharmaceutical reference texts and evidence-based medicine. Reimbursement decisions for specific non-approved indications will be made by SilverSummit Healthplan following requirements in Social Security Act 1927. Experimental drugs and investigational drugs are not eligible for coverage.

Prior Authorization Process

The SilverSummit Healthplan PDL includes a broad spectrum of brand name and generic drugs. Clinicians are encouraged to prescribe from the approved list for their patients who are members of SilverSummit Healthplan. Some drugs will require PA and that requirement will be indicated on the PDL. In addition, all brand name drugs not listed on the PDL will require prior authorization. If a request for prior authorization is needed, the information should be submitted by the physician/clinician/pharmacy to Centene Pharmacy Services on the SilverSummit Healthplan/Centene Pharmacy Services form: Medication Prior Authorization Request Form. This form should be faxed to Centene Pharmacy Services at 1-833-645-2736. This document is located on the SilverSummit Healthplan website at www.SilverSummitHealthplan.com. SilverSummit Healthplan will cover the medication if it is determined that:

1. The request meets all approved criteria.
2. Depending on the medication, other medications on the PDL have not worked.

All reviews are performed by a licensed clinical pharmacist using the criteria provided by the P&T Committee. Once approved, Centene Pharmacy Services notifies the physician/clinician by fax. If the clinical information provided does not meet the coverage criteria for the requested medication SilverSummit Healthplan we will notify the member and physician/clinician of alternatives and provide information regarding the appeal process.

If a patient requires a medication that does not appear on the PDL, the physician/clinician can request a PA for the medication. It is anticipated that such exceptions will be rare and that PDL medications will be appropriate to treat the vast majority of medical conditions. A phone or fax-in process is available for PA requests. Please see Centene Pharmacy Services Contact Information Section below.

CENTENE PHARMACY SERVICES INFORMATION

Centene Pharmacy Services Prior Authorization Phone:	**1-866-399-0928**
Prescriber Prior Authorization	**FAX: 1-833-645-2736**
Centene Pharmacy Services Mailing Address:	**Centene Pharmacy Services 5 River Park Place East, Suite 210, Fresno, CA 93720**
Express Scripts:	**1-833-750-4490**
RXBIN:	**003858**
RXPCN:	**MA**
RXGRP:	**2EXA**

96-Hour Emergency Supply Policy

State law allows a pharmacy to dispense a 96-hour (4-day) supply of medication to any patient awaiting a PA determination excluding narcotics. Pharmacies will only be allowed to dispense a 72-hour (3 day) supply of narcotics to any patient awaiting a PA determination. The purpose is to avoid interruption of current therapy or delay in the initiation of therapy. All participating pharmacies are authorized to provide a 96-hour supply of medication and will be reimbursed for the ingredient cost and dispensing fee for the 96- hour supply of medication, whether or not the PA request is ultimately approved or denied.

Newly Approved Products

New FDA approved drugs will be evaluated for safety and effectiveness for at least the first 6 months. They will require prior authorization prior to P&T approval. If SilverSummit Healthplan does not grant prior authorization, the member, physician/clinician, and pharmacy will be notified and provided information regarding the appeal process.

Step Therapy

Some medications listed on the SilverSummit Healthplan PDL may require specific medications to be used before the member can receive the step therapy medication. If SilverSummit Healthplan has a record that the required medication was tried first, the step therapy medications are automatically covered. If SilverSummit Healthplan does not have a record that the required medication was tried, the member or physician/clinician may be required to provide additional information. If SilverSummit Healthplan does not grant prior authorization, the member and physician/clinician will be notified and provided information regarding the appeal process.

Prospective DUR Response Requirements

SilverSummit Healthplan is committed to providing a safe and quality pharmacy benefit. Our pharmacy program will utilize prospective and concurrent drug utilization review (DUR) edits to detect potential problems at the point-of-service. All DUR messages appear in the claim response utilizing NCPDP standards. This allows the provider to receive and act on the appropriate DUR conflict codes. Pharmacy providers can find detailed instructions on the DUR system by accessing the Express Scripts provider manual at Pharmacist Resource Center (express-scripts.com).

Benefit Exclusions

The following drug categories are not part of the SilverSummit Healthplan PDL and are not covered by the 96-hour emergency supply policy:

- Fertility enhancing drugs
- Agents used for weight loss
- Drug Efficacy Study Implementation (DESI) and Identical, Related and Similar (IRS) drugs that are classified as ineffective
- Drugs and other agents used for cosmetic purposes or for hair growth
- Erectile dysfunction drugs prescribed to treat impotence
- Bulk powders

DESI drug products and known related drug products are defined as less than effective by the FDA because there is a lack of substantial evidence of effectiveness for all labeling indications and because a compelling justification for their medical need has not been established.

Injectable Drugs

Injections that are self-administered by the member and/or a family member and appear on the PDL are covered by the SilverSummit Healthplan pharmacy program. Some insulin pens, Glucagon Kit, Epinephrine, Sumatriptan, and Depo-Provera IM are covered by SilverSummit Healthplan and do not require a prior authorization. All other injectable drugs require prior authorization unless otherwise noted on the SilverSummit PDL.

Biopharmaceuticals and Specialty Medication

AcariaHealth is the provider of specialty medications for SilverSummit Healthplan. SilverSummit Healthplan provides a number of biopharmaceutical products through the Medical benefit. Most biopharmaceuticals and specialty medications require a prior authorization to be approved for payment by SilverSummit Healthplan.

Providers can request that AcariaHealth deliver the specialty drug to the office or the medication can be delivered to the member.

AcariaHealth phone number: 1-800-511-5144	**AcariaHealth FAX: 1-877-541-1503**

Dispensing Limits, Quantity Limits and Age Limits

Drugs may be dispensed up to a maximum 34-day supply for each new or refill non-controlled substance. A member may receive a 100-day supply for specific maintenance medications. A total of 80 percent (80%) of the days supplied must have elapsed before the prescription can be refilled. Controlled substances can't be filled until 90% of the day supplied has elapsed.

SilverSummit Healthplan may limit how much of a medication you can get at one time. Some medications on the SilverSummit Healthplan PDL may have age limits. Age limits are set for certain drugs based on

Food and Drug Administration (FDA) approved labeling and for safety concerns and quality standards of care. The age limit aligns with current FDA alerts for the appropriate use of pharmaceuticals.

Dispensing outside the quantity limit (QL) or age limit (AL) requires prior authorization. If the physician/clinician feels a member has a medical reason for getting a larger amount, he or she can ask for prior authorization. If SilverSummit Healthplan does not grant prior authorization the member, physician/clinician, and pharmacy will be notified and provided information regarding the appeal process.

Mandatory Generic Substitution

When generic drugs are available, the brand name drug will not be covered without SilverSummit Healthplan prior authorization. Generic drugs have the same active ingredient, work the same as brand name drugs. If the member or physician/clinician thinks a brand name drug is medically necessary, the physician/clinician can ask for prior authorization. The brand name drug will be covered according to our clinical guidelines if there is a medical reason the member needs the particular brand name drug. If SilverSummit Healthplan does not grant prior authorization, the member and physician/clinician will be notified and provided information regarding the appeal process.

Over-The-Counter Medications

The pharmacy program covers a large selection of OTC medications. All OTC medications must be written as a valid prescription by a licensed physician/clinician in order to be reimbursed. More than two prescription requests for OTC medications within the same therapeutic class will require prior authorization.

In addition to this coverage SilverSummit Healthplan offers an enhanced OTC benefit. We will cover up to $30 per member household, per quarter for commonly used OTC items through CVS OTC Health Solutions.

Working with the Pharmacy Benefit Manager

SilverSummit Healthplan works with Express Scripts to administer pharmacy benefits. Requests for Prior Authorization are processed by Centene Pharmacy Services. Certain drugs require prior authorization to be approved for payment by SilverSummit Healthplan. These include:

- All medications not listed on the PDL
- Some SilverSummit Healthplan preferred drugs (designated prior authorization (PA) on the PDL)

Drug Prior Authorization request are available at Centene Pharmacy Services through phone, fax or online.

1. Centene Pharmacy Services Telephonic Prior Authorization

a. Providers may call Centene Pharmacy Services to initiate a prior authorization by calling 1-866-399-0928

b. FAX 1-833-645-2736

2. **Complete the SilverSummit Healthplan/Centene Pharmacy Services form: Medication Prior Authorization Request Form is found on the SilverSummit Healthplan website at www.SilverSummitHealthplan.com.**

   a. FAX to Centene Pharmacy Services at 1-833-645-2736.

   b. Once approved, Centene Pharmacy Services notifies the prescriber by FAX.

   c. If the clinical information provided does not explain the reason for the requested prior authorization medication, Centene Pharmacy Services responds to the prescriber by FAX, offering PDL alternatives, where appropriate.

3. **Online Prior Authorization**

   a. CoverMyMeds is an online drug prior authorization program through Centene Pharmacy Services that allows prescribers to begin the prior authorization process electronically. Prescribers locate the correct form, complete the form online, and then submit the form to Centene Pharmacy Services via fax. CoverMyMeds simplifies the prior authorization submission process by automating drug prior authorizations for any medication

   b. CoverMyMeds can be found at www.covermymeds.com/main/prior-authorization-forms/.

Centene Pharmacy Services Contacts - Prior Authorization

Fax: 1-833-645-2736 **Phone: 1-866-399-0928** **(Monday - Friday 8:00 a.m.-8 p.m. CST)**	**Mailing Address** **Centene Pharmacy Services** **5 River Park Place East, Suite 210** **Fresno, CA 93720**

When calling, please have member information, including Medicaid ID number, member date of birth, complete diagnosis, medication history, and current medications readily available. If the request is approved, information in the online pharmacy claims processing system will be changed to allow the specific member to receive the specific drug.

If the request is denied, the member and physician/clinician will be notified and provided information regarding the appeal process.

Providers are requested to utilize the PDL when prescribing medications for SilverSummit Healthplan members. If a pharmacist receives a prescription for a drug that requires a PA request, the pharmacist should attempt to contact the provider to request a change to a product included in the SilverSummit Healthplan PDL.

In the event that a provider or member disagrees with the decision regarding coverage of a medication, the member or the provider, on the member's behalf, may submit an appeal, verbally or in writing. For additional information about appeals, please refer to the Appeals section herein.

PHARMACY PORTAL AND PROVIDER LINKS

For access to Express Scripts portal, click website: **Pharmacist Resource Center (express-scripts.com)** then click on Register that is located next to Log In, then follow the registration process..

- Express Scripts Provider Manual - Pharmacist Resource Center at **Pharmacist Resource Center (express-scripts.com)**
- Payer Sheets - Pharmacist Resource Center at **Pharmacist Resource Center (express-scripts.com)**
- Paper Claim Information can be found within the Pharmacist Resource Center at **Pharmacist Resource Center (express-scripts.com)**
- MAC Pricing - **https://www.caresource.com/documents/esi-mac-appeals-process/**

Quality Improvement

SilverSummit Healthplan culture, systems and processes are structured around its mission to improve the health of all enrolled members. The Internal Quality Assurance Program (IQAP) utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation and improvement in the delivery of healthcare provided to all members, including those with special needs.

This system provides a continuous cycle for assessing the quality of care and service among plan initiatives including preventive health, acute and chronic care, behavioral health, over-and under-utilization, continuity and coordination of care, patient safety, and administrative and network services. This includes the implementation of appropriate interventions and designation of adequate resources to support the interventions.

SilverSummit Healthplan recognizes its legal and ethical obligation to provide members with a level of care that meets recognized professional standards and is delivered in the safest, most appropriate settings. To that end, we will provide for the delivery of quality care with the primary goal of improving the health status of its members.

Where the member's condition is not amenable to improvement, SilverSummit Healthplan will implement measures to prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the member. This will include the identification of members at risk of developing conditions, the implementation of appropriate interventions and designation of adequate resources to support the interventions.

Whenever possible, the SilverSummit Healthplan IQAP supports these processes and activities that are designed to achieve demonstrable and sustainable improvement in the health status of its members.

Program Structure

The SilverSummit Healthplan Board of Directors has the ultimate authority and accountability for the oversight of the quality of care and service provided to members. The BOD oversees the IQAP and has established various committees and ad-hoc committees to monitor and support the IQAP.

The Quality Improvement Committee (QIC) is a senior management committee with physician representation that is directly accountable to the Board of Directors. The purpose of this committee

is to provide oversight and direction in assessing the appropriateness and to continuously enhance and improve the quality of care and services provided to members. This is accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems, the identification of opportunities to improve member outcomes, and the education of members, providers and staff regarding the QI and Medical Management programs.

The following sub-committees report directly to the Quality Improvement Committee:

- Credentialing Committee (CC)
- Pharmacy and Therapeutics Committee (P&T)
- Vendor Management Oversight Committee (VMOC)
- Population Health Management (Utilization Management and Case Management)
- Performance Improvement Team (PIT)
- Provider Advisory Board (PAB) and Provider Advisory Committee (PAC)
- Member Advisory Board (MAB) and Member Advisory Committee (MAC)
- Community Advisory Committee (CAC)
- Peer Review Committee (Ad Hoc Committee)
- Health Equity Committee (Social Determinants of Health and Cultural Competency Committee)
- In addition, there will be several work groups established to facilitate additional projects and work within the committees

Practitioner Involvement

SilverSummit Healthplan recognizes the integral role practitioner involvement plays in the success of its IQAP. Practitioner involvement in various levels of the process is highly encouraged through provider representation. SilverSummit Healthplan encourages PCP, behavioral health, specialty, and OB/GYN representation on key quality committees such as but not limited to, the QIC, Provider Advisory Committee, Credentialing Committee, Utilization Management Committee and select ad-hoc committees and work groups. Providers serving on these committees will receive monetary compensation.

Internal Quality Assurance Program (IQAP) Scope and Goals

The scope of the IQAP is comprehensive and addresses both the quality of clinical care and the quality of service provided to the SilverSummit Healthplan members. SilverSummit Healthplan's IQAP incorporates all demographic groups, care settings, and services in quality improvement activities, including preventive care, primary care, specialty care, acute care, short-term care, and ancillary services, and operations. The quality culture of SilverSummit Healthplan is committed to achieving the IHI Triple Aim – improve population health, improve the experience of care, and reduce per capita costs - as well as improve providers' experience with the Medicaid and Nevada Check Up programs.

SilverSummit Healthplan primary IQAP goal is to improve members' health status through a variety of meaningful quality improvement activities implemented across all care settings and aimed at improving quality of care and services delivered. The overarching goal will be to improve our Medicaid and Nevada Check Up members' health status and quality of life through a variety of meaningful quality improvement activities that are implemented across all care settings, culturally and linguistically appropriate, and aimed at facilitating the delivery of the most appropriate, medically necessary care in the most cost-effective and less restrictive setting.

To that end, the SilverSummit Healthplan IQAP monitors the following:

- Compliance with preventive health guidelines and practice guidelines
- Acute and chronic care management
- Provider network adequacy and capacity
- Behavioral healthcare
- Delegated entity oversight
- Continuity and coordination of care
- Medical Management, including under and over utilization
- Compliance with member confidentiality laws and regulation
- Employee and provider cultural competency
- Provider appointment availability
- Provider and Plan after-hours telephone accessibility
- Member experience
- Provider satisfaction
- Member grievance system
- Provider complaint system
- Member enrollment and disenrollment
- Department performance and service
- Patient safety
- Discharge planning
- Marketing practices

Patient Safety and Quality of Care

Patient Safety is a key focus of SilverSummit Healthplan IQAP. Monitoring and promoting patient safety are integrated throughout many activities across SilverSummit Healthplan but primarily through identification of potential and/or actual quality of care events. A potential quality of care issue is any alleged act or behavior that may be detrimental to the quality or safety of patient care, is not compliant with evidence-based standard practices of care or that signals a potential sentinel event, up to and including death of a member.

SilverSummit Healthplan employees (including medical management staff, member services staff, provider services, complaint coordinators, etc.), panel practitioners, facilities or ancillary providers, members or member representatives, Medical Directors or the BOD may advise the Quality Improvement (QI) Department of potential quality of care issues. Adverse events may also be identified through claims-based reporting. Potential quality of care issues require investigation of the factors surrounding the event in order to make a determination of their severity and need for corrective action up to and including review by the Peer Review Committee as indicated.

Potential quality of care issues received in the QI department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

Performance Improvement Process

SilverSummit Healthplan QIC reviews and adopts an annual IQAP Program Description and Work Plan based on managed care Medicaid appropriate industry standards. The QIC adopts traditional quality/risk/utilization management approaches to problem identification with the objective of identifying improvement opportunities. Most often, initiatives are selected based on data that indicates the need for improvement in a particular clinical or non-clinical area and includes targeted interventions that have the greatest potential for improving health outcomes or the service.

Performance improvement projects, focused studies and other QI initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these studies are used to evaluate the appropriateness and quality of care and services delivered against established standards and guidelines for the provision of that care or service. Each QI initiative is also designed to allow SilverSummit Healthplan to monitor improvement over time.

SilverSummit Healthplan develops an IQAP Work Plan annually for the upcoming year. The IQAP Work Plan serves as a working document to guide quality improvement efforts on a continuous basis. The Work Plan integrates QIC activities, reporting and studies from all areas of the organization (clinical and service) and includes timelines for completion and reporting to the QIC as well as requirements for external reporting. Studies and other performance measurement activities and issues to be tracked over time are scheduled in the IQAP Work Plan.

SilverSummit Healthplan communicates activities and outcomes of its IQAP to both members and providers through avenues such as the member newsletter, provider newsletter and the SilverSummit Healthplan web portal at www.SilverSummitHealthplan.com.

At any time, SilverSummit Healthplan providers may request additional information on SilverSummit Healthplan programs including a description of the IQAP and a report on SilverSummit Healthplan progress in meeting the IQAP goals by contacting the Quality Improvement department.

Healthcare Effectiveness Data and Information Set (HEDIS®)

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) which allows comparison across health plans. HEDIS gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences. HEDIS reporting is a required part of NCQA Health Plan Accreditation and the Nevada State Medicaid contract.

As both the Nevada and Federal governments move toward a healthcare industry that is driven by quality, HEDIS rates are becoming more and more important, not only to the health plan, but to the individual provider as well. Nevada purchasers of healthcare use the aggregated HEDIS rates to evaluate the effectiveness of a Health Insurance Company's ability to demonstrate an improvement in preventive health outreach to its members. Physician specific scores are being used as evidence of preventive care from primary care office practices. The rates then serve as a basis for physician incentive programs such as 'pay for performance' and 'quality bonus funds'. These programs pay providers an increased premium based on scoring of such quality indicators used in HEDIS.

Critical Incident Reporting

A Critical Incident is an event or occurrence that causes harm to a member or that indicate a risk to a member's health or welfare.

Nevada State Medicaid requires SilverSummit Healthplan to report ALL actual or suspected critical incidents involving members to the Department of Health Care and Finance (Nevada Medicaid) within 24 hours or 1 business day of becoming aware of the incident.

Nevada Medicaid considers the following as Critical Incidents that must be reported:

- Homicide or attempted homicide **BY a member**
- Major injury or major trauma that has the potential to cause prolonged disability or death **OF** a member that occurs at a facility licensed by the State to provide publicly funded BH services.
  An unexpected death **OF** a member that occurs in a facility licensed by the State to provide publicly funded Behavioral Services.
- Other types of Incidents that must be reported include Abuse, neglect or exploitation **OF** a member (not to include child abuse). Violent acts allegedly committed **BY** a member. Arson, Extortion.
- Abuse, neglect, exploitation or unexpected death of a Member (not to include child abuse);
- Unauthorized leave of a mentally ill offender or a sexual or violent offender from a mental health facility, secure Community Transition Facilities (Eval & Treatment Centers, Crisis Stabilization & Secure Detox Units) that accept involuntary admissions; and
- **ANY** event **involving** a member that has attracted or is likely to attract media attention.
- ALL PROVIDERS CONTRACTED WITH SSHP MUST REPORT AN ACTUAL OR ALLEGED CRITICAL INCIDENT TO THE QUALITY IMPROVEMENT DEPARTMENT BY SUBMITTING A CRITICAL INCIDENT FORM. This form is located in Provider tab>Provider Resources>Provider Forms

Under Medicaid Forms, click the link and use this fillable form. Please include as much detail as possible but include only the facts. Email to critical_incident@SilverSummitHealthplan.com

Providers will follow the Nevada Nevada Medicaid process and requirements for submission of all critical incidents. Upon receipt and notification of critical incident review requests from Nevada Medicaid, we may require providers to participate in the quality review process.

Early and Periodic Screening, Diagnostic & Treatment

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21, provision of which is mandated by state and federal law. EPSDT services include periodic screening, vision, dental and hearing services. In addition, the need for corrective treatment disclosed by such child health screenings must be arranged (directly or through referral) even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.

SilverSummit Healthplan and its providers will provide the full range of EPSDT services as defined in, and in accordance with, Nevada state regulations and AMA policies and procedures for EPSDT services.

Such services shall include, without limitation, periodic health screenings and appropriate up to date immunization schedules using the Advisory Committee on Immunization Practices (ACIP) recommended immunization schedule and the American Academy of Pediatrics periodicity schedule for pediatric preventative care.

This includes provision of all medically necessary services whether specified in the core benefits and services or not, except certain carved out/excluded/prohibited services that have been identified herein.

The following minimum elements are to be included in the periodic health screening assessment:

- Comprehensive health and development history (including assessment of both physical and mental development)
- Comprehensive unclothed physical examination
- Immunizations appropriate to age and health history
- Assessment of nutritional status
- Laboratory tests (including finger stick hematocrit, urinalysis [dipstick], sickle cell screening (if not previously performed); blood lead levels must be tested pursuant to the EPSDT provider manual
- Developmental assessment
- Vision screening and services, including at a minimum, diagnosis and treatment for defects in vision, including eyeglasses
- Dental screening and services coordinated through FFS
- Hearing screening and services, including at a minimum, diagnosis and treatment for defects in hearing, including hearing aids
- Health education and anticipatory guidance, and Annual Well-Child visits for members under age 21

How are HEDIS rates calculated?

HEDIS rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claim and encounter data submitted to the health plan. Measures typically calculated using administrative data include annual mammogram, annual chlamydia screening, appropriate treatment of asthma, antidepressant medication management, access to PCP services, and utilization of acute and mental health services, to name a few measures.

Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of member medical records to abstract data for services rendered but that were not reported to the health plan through claims/encounter data. Accurate and timely claim/encounter data and submission of appropriate CPT II codes can reduce the necessity of medical record reviews (see SilverSummit Healthplan website and HEDIS Quick Reference Guide for more information on reducing HEDIS medical record reviews and improving your HEDIS scores). Measures typically requiring medical record review include childhood immunizations, well child visits, diabetic HbA1c, eye exam, and controlling high blood pressure, cervical cancer screening, and prenatal care and postpartum care.

When will Medical Record Reviews (MRR) be completed for HEDIS?

SilverSummit Healthplan may contract with a national MRR vendor to conduct the HEDIS MRR on its behalf. Medical record review audits for HEDIS are usually conducted March through May each year. At that time, you may receive a call from a medical record review representative if any of your patients are selected in the HEDIS samples. Your prompt cooperation with the representative is greatly needed and appreciated.

As a reminder, protected health information (PHI) that is used or disclosed for purposes of treatment, payment or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member/patient. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with SilverSummit Healthplan which allows them to collect PHI on our behalf.

What can be done to improve my HEDIS scores?

- Understand the specifications established for each HEDIS measure.
- Submit claim/encounter data for each and every service rendered. All providers must bill (or report by encounter submission) for services delivered, regardless of contract status. Claim/encounter data is the most clean and efficient way to report HEDIS. If services are not billed or not billed accurately, they are not included in the calculation. Accurate and timely submission of claim/encounter data will positively reduce the number of medical record reviews required for HEDIS rate calculation.
- Ensure chart documentation reflects all services provided.
- Bill CPT II codes related to HEDIS measures such as diabetes, body mass index (BMI calculations, eye exam and blood pressure.
- Utilize appropriate Provider Quick reference guides with updated coding.

If you have any questions, comments, or concerns related to the annual HEDIS project or the medical record reviews, please contact the Quality Improvement department at the toll-free phone number at 1-844-366-2880.

Regulatory Matters

Waste, Fraud and Abuse

SilverSummit Healthplan takes the detection, investigation, and prosecution of fraud, waste, and abuse very seriously, and has a Fraud, Waste, and Abuse (FWA) program that complies with Nevada and federal laws. SilverSummit Healthplan, in conjunction with its management company, Centene, successfully operates a Special Investigations Unit (SIU). SilverSummit Healthplan performs front and back-end audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic audits during the claims payment process. To better understand this system; please review the Billing and Claims Handbook located on the "Provider Resources" section of our website at www.SilverSummitHealthplan.com. SilverSummit Healthplan performs retrospective audits which in some cases may result in taking actions against those providers who, individually or as a practice, commit fraud, waste, and/or abuse. These actions include but are not limited to:

- Remedial education and/or training to prevent the billing irregularity
- More stringent utilization review
- Recoupment of previously paid monies
- Termination of provider agreement or other contractual arrangement
- Civil and/or criminal prosecution
- Any other remedies available to rectify

SilverSummit Healthplan instructs and expects all its contractors and subcontractors to comply with applicable laws and regulations, including but not limited to the following:

- Federal and State False Claims Act
- Qui Tam Provisions (Whistleblower)
- Anti-Kickback Statute
- Physician Self-Referral Law (Stark Law)
- HIPAA
- Social Security Act
- US Criminal Codes

Involuntary termination will occur when a Contractor/ Subcontractor fails to comply with the above laws and regulations or there is any finding of fraud, waste or abuse as a result of Program Integrity actions.

SilverSummit Healthplan requires all its contractors and subcontractors to report violations and suspected violations on the part of its employees, associates, persons or entities providing care or services to all SilverSummit Healthplan members. Examples of such violations include bribery, false claims, conspiracy to commit fraud, theft or embezzlement, false statements, mail fraud, healthcare fraud, obstruction of a state and/or federal healthcare fraud investigation, money laundering, failure to provide medically necessary services, marketing schemes, prescription forging or altering, physician illegal remuneration schemes, compensation for prescription drug switching, prescribing drugs that are not medically necessary, theft of the prescriber's DEA number or prescription pad, identity theft or members' medication fraud.

FWA Training is available via our company website – we have a training program providers can download in PDF format. We also include FWA training in our Provider Orientation packets.

Post Processing Claims Audit

A post-processing claims audit consists of a review of clinical documentation and claims submissions to determine whether the payment made was consistent with the services rendered. To start the audit, Centene Auditors, on behalf of SilverSummit Healthplan, request medical records for a defined review period. Providers have two weeks to respond to the request; if no response is received, a second and final request for medical records is forwarded to the provider. If the provider fails to respond to the second and final request for medical records, or if services for which claims have been paid are not documented in the medical record, SilverSummit Healthplan will recover all amounts paid for the services in question.

Centene Auditors, on behalf of SilverSummit Healthplan, review cases for common FWA practices including:

- Unbundling of codes
- Up-coding services
- Add-on codes billed without primary CPT
- Diagnosis and/or procedure code not consistent with the member's age
- Use of exclusion codes
- Excessive use of units
- Misuse of Benefits
- Claims for services not rendered

Centene Auditors, on behalf of SilverSummit Healthplan, consider state and federal laws and regulations, provider contracts, billing histories, and fee schedules in making determinations of claims payment appropriateness.

If necessary, a clinician of like specialty may also review specific cases to determine if billing is appropriate. Auditors issue an audit results letter to each provider upon completion of the audit, which includes a claims report which identifies all records reviewed during the audit.

If the Auditor determines that clinical documentation does not support the claims payment in some or all circumstances, SilverSummit Healthplan will seek recovery of all overpayments. Depending on the number of services provided during the review period, SilverSummit Healthplan may calculate the overpayment using an extrapolation methodology.

Extrapolation is the use of statistical sampling to calculate and project overpayment amounts. It is used by Medicare Program Safeguard Contractors, CMS Recovery Audit Contractors, and Medicaid Fraud Control Units in calculating overpayments, and is recommended by the OIG in its Provider Self-Disclosure Protocol (63 Fed. Reg. 58,399; Oct. 30, 1998).

To ensure accurate application of the extrapolated methodology, Centene / SilverSummit Healthplan use RAT-STATS 2007 Version 2, the OIG's statistical software tool, to select random samples, assist in evaluating audit results, and calculate projected overpayments.

Providers who contest the overpayment methodology or wish to calculate an exact overpayment figure may do so by downloading RAT STATS and completing the extrapolation overpayment. Audit findings are reported to the Nevada Program Integrity Department and may also be reported to the Nevada Healthcare Fraud Control Unit.

Suspected Inappropriate Billing

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential FWA hotline at 1-866-685-8664. SilverSummit Healthplan and Centene take all reports of potential fraud, waste, and/or abuse very seriously and investigate all reported issues.

NOTE: Due to the evolving nature of fraudulent, wasteful, and abusive billing, SilverSummit Healthplan and Centene may enhance the FWA program at any time. These enhancements may include but are not

limited to creating, customizing or modifying claim edits, upgrading software, modifying forensic analysis techniques, or adding new subcontractors to help in the detection of aberrant billing patterns.

Medical Records Standards

SilverSummit Healthplan providers must keep accurate and complete medical records. Such records will enable providers to render the highest quality healthcare service to members. They will also enable SilverSummit Healthplan to review the quality and appropriateness of the services rendered. To ensure the member's privacy, medical records should be kept in a secure location.

All medical record requests should be submitted back to the Plan in a timely manner and at no cost to the Plan per Artcile IV of your agreement with SilverSummit.

SilverSummit Healthplan requires providers to maintain all records for members for at least ten (10) years. See the Member Rights section of this handbook for policies on member access to medical records.

Required Information

Medical records means the complete, comprehensive member records including, but not limited to, x-rays, laboratory tests, results, examinations and notes, accessible at the site of the member's participating primary care physician or provider, that document all medical services received by the member, including inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable state rules and regulations, and signed by the medical professional rendering the services.

Providers must maintain complete medical records for members in accordance with the following standards:

- Member's name, and/or medical record number on all chart pages
- Personal/biographical data is present (i.e., employer, home telephone number, spouse, next of kin, legal guardianship, primary language, etc.)
- Prominent notation of any spoken language translation or communication assistance
- All entries must be legible and maintained in detail
- All entries must be dated and signed or dictated by the provider rendering the care.
- Significant illnesses and/or medical conditions are documented on the problem list and all past and current diagnoses
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, NKA or NKDA are documented
- An up-to-date immunization record is established for pediatric members or an appropriate history is made in chart for adults
- Evidence that preventive screening and services are offered in accordance with SilverSummit Healthplan' practice guidelines

- Appropriate subjective and objective information pertinent to the member's presenting complaints is documented in the history and physicalPast medical history (for members seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters
- For children and adolescents (18 years and younger) past medical history relating to prenatal care, birth, any operations and/or childhood illnesses
- Working diagnosis is consistent with findings
- Treatment plan is appropriate for diagnosis
- Documented treatment prescribed, therapy prescribed, and drug administered or dispensed including instructions to the member
- Documentation of prenatal risk assessment for pregnant women or infant risk assessment for newborns
- Signed and dated required consent forms
- Unresolved problems from previous visits are addressed in subsequent visits
- Laboratory and other studies ordered as appropriate
- Abnormal lab and imaging study results have explicit notations in the record for follow up plans; all entries should be initialed by the primary care provider (PCP) to signify review
- Referrals to specialists and ancillary providers are documented including follow up of outcomes and summaries of treatment rendered elsewhere including family planning services, preventive services and services for the treatment of sexually transmitted diseases
- Health teaching and/or counseling is documented.
- For members 10 years and over, appropriate notations concerning use of tobacco, alcohol and substance use (for members seen three or more times substance abuse history should be queried)
- Documentation of failure to keep an appointment
- Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months or as needed
- Evidence that the member is not placed at inappropriate risk by a diagnostic or therapeutic problem
- Confidentiality of member information and records protected.
- Evidence that an advance directive has been offered to adults 18 years of age and older

SilverSummit Healthplan also conducts Medical Record Review (MRR) Audits to assess provider compliance with documentation, including required EPSDT components. Providers that do not meet the 80% compliance standard on any one component, or who miss required elements, are placed on a corrective action plan (CAP). SilverSummit Healthplan will educate all non-compliant providers during the review about what they need to do to become compliant

Medical Records Release

All member medical records shall be confidential and shall not be released without the written authorization of the covered person or a responsible covered person's legal guardian. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need-to-know basis.

As a reminder, protected health information (PHI) that is used or disclosed for purposes of treatment, payment or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member/patient. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with SilverSummit Healthplan which allows them to collect PHI on our behalf.

SilverSummit Healthplan acknowledge that all eligible Indians may access and receive covered medically necessary services at Indian Health Service (IHS) facilities and/or Tribal Clinics. The Plan will reach out to the IHS staff to request and receive medical records regarding those covered services/treatments provided by IHS to the eligible Indian members. SilverSummit Healthplan will incorporate this information into the member's record in our health management and clinical documentation system to ensure the member's Care Manager and other vendor staff on the member's care team has access to the information. This information will also be available to the member, PCP and treating network providers, as well as any authorized caregiver(s) via our secure online web portals, ensuring all parties involved in the member's care are aware of all care and services received both in and out of our network.

Medical Records Transfer for New Members

All PCPs are required to document in the member's medical record attempts to obtain historical medical records for all newly assigned SilverSummit Healthplan members. If the member or member's guardian is unable to remember where they obtained medical care, or they are unable to provide addresses of the previous providers then this should also be noted in the medical record.

Federal and State Laws Govern the Release of Information

The release of certain information is governed by a myriad of federal and/or state laws. These laws often place restrictions on how specific types of information may be disclosed, including, but not limited to, mental health, alcohol /substance abuse treatment and communicable disease records.

For example, the federal Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities, such as health plans and providers, release protected health information only when permitted under the law, such as for treatment, payment and operations activities, including care management and coordination.

However, a different set of federal rules place more stringent restrictions on the use and disclosure of alcohol and substance abuse treatment records (42 CFR Part 2 or "Part 2").

These records generally may not be released without consent from the individual whose information is subject to the release.

Still other laws at the state level place further restrictions on the release of certain information such as mental health, communicable disease, etc.

For more information about any of these laws, refer to following:

- HIPAA - please visit the Centers for Medicare & Medicaid Services (CMS) website at: **www.cms.gov** and then select "Regulations and Guidance" and "HIPAA – General Information"

- Part 2 regulations - please visit the Substance Abuse and Mental Health Services Administration (within the U.S. Department of Health and Human Services) at: http://www.samhsa.gov/
- State laws - consult applicable statutes to determine how they may impact the release of information on patients whose care you provide

Contracted providers within our network are independently obligated to know, understand and comply with these laws.

We take privacy and confidentiality seriously. We have established processes, policies and procedures to comply with HIPAA and other applicable federal and/or State confidentiality and privacy laws.

Please contact the SilverSummit Healthplan Privacy Officer at 1-844-366-2880 or in writing (refer to the address below) with any questions about our privacy practices.

SilverSummit Healthplan
Attn: Compliance Department
2500 N. Buffalo Drive, Suite 250
Las Vegas, NV 89128

Section 1557 of the Patient Protection and Affordable Care Act

Section 1557 is the nondiscrimination provision of the Affordable Care Act (ACA). The law prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities. Section 1557 builds on long-standing and familiar Federal civil rights laws: Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975. Section 1557 extends nondiscrimination protections to individuals participating in:

- Any health program or activity any part of which received funding from HHS
- Any health program or activity that HHS itself administers
- Health Insurance Marketplaces and all plans offered by issuers that participate in those Marketplaces

For more information please visit: www.hhs.gov/civil-rights/for-individuals/section-1557/index.html

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