Hometown Health		Page 1 of 3	
		Effective Date:	1/1/2012
Policy Topic:	Selection Process for Case Management	Last Review Date:	11/1/2013
Policy Category:	Health Services	Last Revised Date:	11/1/2013
Policy Number:	HOMETOWN.HQH. 21		
Author:	Teri Howard, RN Health Services Director		

Scope:	All Hometown Health and Senior Care Plus members are routinely screened for case management intervention opportunities on a proactive basis to ensure quality care is delivered safely and in a timely manner in the environment of member (client) and family choice. The scope of this policy is not limited to health services, but allows for case management referrals from all sources to include, customer services, physicians, ancillary care providers, family, member and employer. The scope of this policy also includes the automated identification process embedded in case management software to include population management strategies.
Purpose:	Stewardship: Maximize the use of available, finite resources to meet the current and future needs of the community by ensuring member safety and quality of care in the environment of member (client) and family choice as well as proactively work to prevent transition to a higher level of care or inpatient admission.
Policy:	100% of commercial and senior membership will be screened for case management opportunities on an automated basis. In addition, screening will be completed on all referrals regardless of source.
Definitions:	Member (client) = recipient of case management services Case Management = a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost effective outcomes Case Manager = Registered Nurse or Social Worker performing primary functions of assessment, planning, facilitation and advocacy which are achieved through collaboration with the client and other health care professionals involved in the member (client) care.
Procedure:	Members (clients) are selected for case management services in several ways to include: ◦ MedHOK Case Management/Disease Management use of the John Hopkins ACG Model which predicts which members (clients) will be at risk for future high dollar, high risk incidents; ◦ Trigger Diagnosis to include but not limited to chronic diseases, catastrophic injuries, terminal illnesses, or potential for transplant; ◦ History of mental illness or substance abuse; ◦ Need for Home Health or Durable Medical Equipment, or member (client) is

scheduled for a potential procedure which would typically require home care or durable medical equipment during recovery;

- Multiple visits to the emergency room;
- More than 2 admissions within the last six months or one readmission within the last thirty days;
- Social barriers to compliance with the physician plan of care;
- Poor nutritional status;
- High dollar, high cost;
- Direct referral from member (client), family, physicians, ancillary providers, employer, or other providers of service.

Members (clients) meeting any of the above criteria will be identified for case management assessment and potential enrollment into a case management program.

References:

CMSA Standards of Practice for Case Management. Revised 2010.

Hometown Health		Effective Date:	1/1/2012
Policy Topic:	Selection Process for Case Management	Last Review Date:	11/1/2013
Policy Category:	Health Services	Last Revised Date:	11/1/2013
Policy Number:	HOMETOWN.HQH. 21		
Author:	Teri Howard, RN Health Services Director		

Approvals:	
	Date: 11/7/13 Ty Windefeldt Renown Health Vice President
	Date: 11/7/13 Linda Ash-Jackson, MD Medical Director
	Date: 11/4/13 Teri Howard, RN, BSN Health Services Director

Hometown Health		Page 1 of 3	
		Effective Date:	1/1/2012
Policy Topic:	Case Management Assessment of Need	Last Review Date:	11/1/2013
Policy Category:	Health Services	Last Revised Date:	11/1/2013
Policy Number:	HOMETOWN.HQH. 22		
Author:	Teri Howard, RN Health Services Director		

Scope:	All Hometown Health and Senior Care Plus members are routinely screened for case management intervention opportunities on a proactive basis to ensure quality care is delivered safely and in a timely manner in the environment of member (client) and family choice. The scope of this policy addresses the case management assessment process and entry into our case management programs. All members (clients) who have been identified through case management screening will be assessed for possible case management intervention using a standardized assessment tool. In addition to the standardized assessment tool, disease specific assessment tools are available as needed.
Purpose:	Stewardship: Maximize the use of available, finite resources to meet the current and future needs of the community by ensuring member safety and quality of care in the environment of member (client) and family choice as well as proactively work to prevent transition to a higher level of care or inpatient admission. Service: Anticipate customer needs and exceed expectations in a compassionate manner.
Policy:	100% of commercial and senior membership identified during the screening process will be assessed for case management opportunities using the standardized assessment tools available within the MedHOK case management/disease management programs.
Definitions:	Member (client) = recipient of case management services Case Management = a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost effective outcomes Case Manager = Registered Nurse or Social Worker performing primary functions of assessment, planning, facilitation and advocacy which are achieved through collaboration with the client and other health care professionals involved in the member (client) care. MedHOK = Hometown Health's Case Management/Disease Management system of record
Procedure:	Members (clients) identified with the potential need for case management services will be assessed for case management intervention in a systematic manner. Based on the assessment findings and barriers to care identified, case management services will be offered. Case Management procedure is as follows: ◦ Case Managers are assigned to manage lines of business and/or specific customers;

- Case managers will work the screening lists within MedHOK on a daily basis to determine which members would benefit from case management intervention.
- Case management screening is prioritized based on:

  Discharge from a recent hospitalization for transitional care planning;

  Physician/customer/utilization review nurse referral;

  John Hopkins ACG score;

  Need for end of life planning;

  Multiple co-morbidities; and

  Other opportunities as identified in MedHOK
- Case Management assessment is conducted in person or by phone depending on member (client) location at time of assessment.
- The Case Management assessment includes review of the member's (client's) health and psychosocial assessment, taking into consideration cultural and linguistic needs.
- The basic assessment tool includes:

  Medical health history

  Medication Review and compliance

  Psychosocial/Mental Health/Chemical Dependency/Cognitive issues

  Environmental and residential status/need

  Cultural/Spiritual/Language/Learning

  Caregiver capability

  Self Care capability

  Advanced care planning assistance

  Transportation needs

  Readiness to Change
- In addition, there are disease specific assessments available to enhance the basic assessment for:
  Diabetes
  Pulmonary/Asthma
  Cardiac Disease

- Based on the findings from the assessment, problems/barriers to care are identified and member (client) is offered case management assistance.

References:

CMSA Standards of Practice for Case Management. Revised 2010.

Approvals:

Ty Windefeldt
Renown Health Vice President
Date: 11/7/13

Linda Ash-Jackson, MD
Medical Director
Date: 11/7/13

Teri Howard, RN, BSN
Health Services Director
Date: 11/4/13

Hometown Health		Page 1 of 2	
		Effective Date:	1/1/2013
Policy Topic:	Catastrophic/Chronic Care Case Management Program	Last Review Date:	11/5/2013
Policy Category:	Health Services	Last Revised Date:	1/1/2013
Policy Number:	HOMETOWN.HQH. 21		
Author:	Teri Howard, RN Health Services Director		

Scope:	Program overview of Catastrophic/Chronic Care Case Management services
Purpose:	Identify processes for identifying members who may qualify for catastrophic/chronic care case management services, process, outcomes monitoring, and case closure.
Policy:	Commercial and Senior members with catastrophic or chronic illnesses may be eligible for participation in case management for coordination of care.
Definitions:	Case Management is a collaborative process of assessment, planning, facilitation, care coordination, advocacy for options and services to meet an individual's and family's comprehensive health care needs through communication and available health care resources to promote quality cost effective outcomes. CMSA Standards of Practice 20010
Procedure:	Case Management Team: The case management team will consist of the member and designated family members, primary nurse case manager, PCP, specialists and ancillary providers, pharmacist, and health plan medical director. Hours of Operation: Case Managers will be available Monday through Friday 8 am through 5 pm. Case Management Process: Once the triage/screening process has been completed and the member has verbally given consent to participate in case management, a case will be initiated. The case manager will complete a detailed assessment of the member's medical, psycho-social, financial, home safety and support and spiritual needs within the first thirty days following screening. The assessment is an ongoing process and may require several member contacts for completion. The assessment can be updated as needed during the case open period. The complete assessment will be completed annually if member is enrolled in case manager greater than one year. The case manager will be responsible for monitoring and coordinating a detailed annual health assessment by the primary care provider as well as any preventive care services while member is in case management. Once an assessment is initiated, the case manager will develop a member specific care plan with collaboration by the PCP and other team members. The PCP will receive a copy for their records.

Case Management savings will be identified and updated on a monthly basis.

Once all problems/barriers have been resolved or stable and the member is in agreement, the case management case may be closed.

At least one time per year and at time of case closure, the member will receive a member satisfaction survey for completion by mail.

If case management intervention is once again required after a case has been closed, a new file will be established.

All case management time spent in managing the case will be logged into MedHOK.

Approvals:

Ty Windfeldt
Renown Health Vice President
Date: 11/7/13

Linda Ash-Jackson, MD
Medical Director
Date: 11/7/13

Teri Howard, RN BSN
Health Services Director
Date: 11/4/13

Hometown Health		Page 1 of 2	
		Effective Date:	1/1/2012
Policy Topic:	Case Management Care Plan Development and Monitoring	Last Review Date:	11/1/2013
Policy Category:	Health Services	Last Revised Date:	11/1/2013
Policy Number:	HOMETOWN.HQH. 23		
Author:	Teri Howard, RN Health Services Director		

Scope:	All Hometown Health and Senior Care Plus members enrolled in case management will have a care plan in place outlining problems, barriers to care, goals, and interventions. All problems or barriers to care will have a start and end date for resolution. The care plan will be developed in coordination with the member (client), family, physicians, ancillary providers and case manager. The Care Plan is a working document and will be revised and/or added to based upon member (client) need.
Purpose:	Stewardship: Maximize the use of available, finite resources to meet the current and future needs of the community by ensuring member safety and quality of care in the environment of member (client) and family choice as well as proactively work to prevent transition to a higher level of care or inpatient admission. Service: Anticipate customer needs and exceed expectations in a compassionate manner.
Policy:	100% of commercial and senior membership enrolled in case management will have a care plan developed and shared with the member (client) and attending physician.
Definitions:	Member (client) = recipient of case management services Case Management = a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost effective outcomes Case Manager = Registered Nurse or Social Worker performing primary functions of assessment, planning, facilitation and advocacy which are achieved through collaboration with the client and other health care professionals involved in the member (client) care. Care Plan = working document which identifies problems/barriers to care for a member (client) with agreed upon long and short term goals accompanied by individualized interventions which are monitored and updated on an as needed basis. MedHOK = Hometown Health's Case Management/Disease Management system of record
Procedure:	Each member enrolled in Case Management will have a care plan established within seven (7) days of assessment completion. The careplan will be a working document housed within the MedHOK Case Management/Disease Management software and will be used as the basis for case management rounds.

- The careplan is automatically initiated based on positive responses to the assessment and is customized to meet the specific member (client) needs.
- The careplan will include evidence based guidelines for barriers/problems that are disease specific.
- The member will be in agreement with the problems/barriers and ready to change.
- The careplan is updated, monitored and progress towards goals is monitored at minimum monthly and updated on an as needed basis.
- Once all problems/barriers to care have been addressed and resolved, and member is in agreement, case management services may be terminated.

References:

CMSA Standards of Practice for Case Management. Revised 2010.

Approvals:

Date: 11/7/13
Ty Windefeldt
Renown Health Vice President

Date: 11/7/13
Linda Ash-Jackson, MD
Medical Director

Date: 11/4/13
Teri Howard, RN, BSN
Health Services Director

Hometown Health		Page 1 of 2	
		Effective Date:	1/1/2012
Policy Topic:	Case Management Termination of Services	Last Review Date:	11/1/2013
Policy Category:	Health Services	Last Revised Date:	11/1/2013
Policy Number:	HOMETOWN.HQH. 24		
Author:	Teri Howard, RN Health Services Director		

Scope:	All Hometown Health and Senior Care Plus members enrolled in case management will come to case closure based on the reasons listed below. Members (clients) coming to case management closure will be left with a final care plan as well as contact information for additional case management services if needed in the future.
Purpose:	Stewardship: Maximize the use of available, finite resources to meet the current and future needs of the community by ensuring member safety and quality of care in the environment of member (client) and family choice as well as proactively work to prevent transition to a higher level of care or inpatient admission. Service: Anticipate customer needs and exceed expectations in a compassionate manner.
Policy:	Case Management cases will be closed within seven days of completing all open interventions on the careplan and determination that the member is safe in current environment.
Definitions:	Member (client) = recipient of case management services Case Management = a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost effective outcomes Case Manager = Registered Nurse or Social Worker performing primary functions of assessment, planning, facilitation and advocacy which are achieved through collaboration with the client and other health care professionals involved in the member (client) care. Care Plan = working document which identifies problems/barriers to care for a member (client) with agreed upon long and short term goals accompanied by individualized interventions which are monitored and updated on an as needed basis. MedHOK = Hometown Health's Case Management/Disease Management system of record
Procedure:	◦ The Case Manager will terminate case management services based on the case closure guidelines listed below: All targeted problems/barriers to care have been resolved; Member (client) has moved to an alternate environment; Loss or change in health plan benefits; Member (client) refused further case management services;

Non-adherence or lack of willingness to change;
Death

- The member (client) will be notified by the case manager the reason for case closure by phone and in writing.
- The case manager will leave contact information with the member (client) in the event future needs arise.
- The reason for case closure will be documented in MedHOK;
- A closure date will be assigned to the file;

References:

CMSA Standards of Practice for Case Management. Revised 2010.

Approvals:

Ty Windefeldt
Renown Health Vice President
Date: 11/7/13

Linda Ash-Jackson, MD
Medical Director
Date: 11/7/13

Teri Howard, RN, BSN
Health Services Director
Date: 11/4/13

Hometown Health		Page 1 of 4	
		Effective Date:	1/1/2012
Policy Topic:	Case Management Return on Investment	Last Review Date:	11/1/2013
Policy Category:	Health Services	Last Revised Date:	11/1/2013
Policy Number:	HOMETOWN.HQH. 22		
Author:	Teri Howard, RN Health Services Director		

Scope:	Case Managers coordinate cares to ensure members are receiving quality care in a cost effective manner in the environment of choice based upon plan benefit design. At times, case managers are required to negotiate discounts, establish alternate levels of care, locations of care in order to ensure that health care services are delivered in a timely manner. Negotiations are reviewed and approved by the Director of Health Services and/or Medical Director. In addition, documentation is saved in order to ensure that claims pay the provider according to the negotiated rates. Based on customer need, negotiations are forwarded for approval. Summary reports of the above activities are provided as a part of the outcomes management reports on an as needed basis.
Purpose:	Stewardship: Maximize the use of available, finite resources to meet the current and future needs of the community by ensuring member safety and quality of care in the environment of member (client) and family choice as well as proactively work to prevent transition to a higher level of care or inpatient admission. Service: Anticipate customer needs and exceed expectations in a compassionate manner.
Policy:	All negotiations or established alternate plans of care will be documented in MedHOK, the case management system of record. Negotiated rates will be approved by the Medical Director and/or Director of Health Services or customer depending on requirements. Negotiated rates are forwarded to the claims team of record to ensure accurate payment.
Definitions:	Member (client) = recipient of case management services Case Management = a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost effective outcomes Case Manager = Registered Nurse or Social Worker performing primary functions of assessment, planning, facilitation and advocacy which are achieved through collaboration with the client and other health care professionals involved in the member (client) care. MedHOK = Hometown Health's Case Management/Disease Management system of record Negotiated Rate = rate established for reimbursement of services with non-contracted

provider of health care services.

Letter of agreement = document used to document that both parties agree to negotiated rate. This document will remain attached to the member file and will be shared with the claims department of record.

Averted Savings = dollars that have been saved due to channeling of health care services from a non-contracted provider to contracted provider.

Level of Care Savings = dollars that have been saved due to utilization review and management of acute inpatient stays to ensure that members (clients) are receiving services based on medical necessity. (i.e. Telemetry vs. cardiac intensive care)

Alternate Plan of Care Savings = dollars that have been saved due to coordination of an alternate level of care not presented by the direct medical care team. (i.e. SNF in lieu of acute rehabilitation, or partial hospitalization program in lieu of hospitalization)

List Price = standard rates for services obtained from the facility or vendor. This rate is used during the negotiation process.

Contracted rates = rates for in network services that are used during the negotiation process to ensure the negotiation is a win:win.

Procedure:	When indicated, case managers will negotiate rates for medically necessary services when the service cannot be provided within network, or at time of customer request to meet the needs of the member (client). Case Managers will: ◦ Identify medically necessary services; ◦ Research availability to deliver services in network if member is covered by an HMO plan; ◦ Offer PPO members the option of using an in network provider as well as educate member on differences in their out of pocket costs if we are unable to negotiate rates; ◦ Determine which return on investment category the savings for the negotiation will be managed in; ◦ Establish a letter of agreement with the vendor outlining the negotiated rates; ◦ Letter of agreement is approved by the Medical Director or Director of Health Services; ◦ Letter of agreement is forwarded to customer for approval if needed; ◦ Letter of agreement is forwarded to claims department or customer Third Party Administrator so claim is appropriately adjudicated; ◦ Letter of agreement is attached to the member file in MedHOK system.

Hometown Health		Effective Date:	1/1/2012
Policy Topic:	Case Management Return on Investment	Last Review Date:	11/1/2013
Policy Category:	Health Services	Last Revised Date:	11/1/2013
Policy Number:	HOMETOWN.HQH. 22		
Author:	Teri Howard, RN Health Services Director		

Approvals:	
	Ty Windefeldt Renown Health Vice President — Date: 11/7/13
	Linda Ash-Jackson, MD Medical Director — Date: 11/7/13
	Teri Howard, RN, BSN Health Services Director — Date: 11/4/13

NEVADA UNIVERSAL
PRIOR AUTHORIZATION AND REFERRAL FORM

Hometown Health 25TH ANNIVERSARY

HEALTH PLAN NAME & MEMBER HEALTH PLAN I.D. #:	Primary Care Provider Name / Address / Phone & Fax #:
Health Plan Phone #: 775-982-3700 Fax #: 775-982-3744	
Date of Request:	Requesting Provider Name:
Patient's Name & SS #: Insured Name & SS #	Requesting Provider's Address & Phone #: Requesting Provider's Fax #:
Patient's Address & Phone #:	Requesting Provider's Tax ID #: HIPAA Provider Identification #:
Patient's DOB:	Contact Person (Name, Phone & Fax #):
Employer Group's Name & Phone #:	Requesting Provider's Signature or Stamped Signature:
Other Insurance (s):	
Diagnosis (inc. ICD code):	Procedure / Treatment Request (inc. CPT code): Number of Treatments Requested: _____ Inpatient / Outpatient Service Requested by Patient *Yes* *No*
Service Provider / Address / Phone #:	Place of Service / Facility and Address: Requested Procedure Date / Start Treatment Date:

Current Clinical Findings and Management
All procedures/treatment requested require clinical information (may use this space - also see requirements below and attach to this form):

***Pertinent Attachments** = Any information to support the proposed diagnosis, treatment / procedure, such as current clinical findings (progress reports), results of laboratory testing, imaging studies (x-rays, etc.) must be submitted to prevent processing delays.*

Area for internal health plan use only	*Authorization:*		*Date of Authorization:*	*Pended / Denied: (Reason):*
Health plan contact name & phone #:	*Yes*	*No*	*Authorization Number:*	

**All sections of this form must be completed.*

***On adverse determinations a reconsideration / expedited appeal may be requested.*

This referral/authorization is not a guarantee of payment. Payment is contingent upon eligibility, benefits available at the time the service is rendered, contractual terms, limitations, exclusions, and coordination of benefits, and other terms and conditions set forth in the Member's Evidence of Coverage, Certificate of Coverage, or Self Insured Employer's Plan Documents.

The information contained in this form, including attachments, is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If this communication has been received in error, the reader shall notify sender immediately and shall destroy all information received.

Revised 8/2/04

3.11.1.16

Confidential Business Use 7/2013-6/2014

Date Created	Date Closed	Member	Case Type	Care Level Status	Case Seq #	Vendor Negotiations	Averted Adm Savings	Change in Level of Care	Proposed Alternative Plan
8/1/2013	Open	BS	LCM	Active	1	$ 58,992.00	$ -	$ -	$ -
7/1/2013	Open	EB	LCM	Active	2	$ 34,000.00	$ -	$ -	$ -
7/1/2013	Open	EB	LCM	Active	3	$ -	$ 5,600.00	$ -	$ -
9/27/2013	Open	JB	LCM	Active	4	$ -	$ -	$ 13,600.00	$ -
9/20/2013	Open	CF	Behavioral CM	Closed	5	$ -	$ -	$ 13,500.00	$ -
8/21/2013	Open	MG	LCM	Active	6	$ -	$ -	$ 11,480.00	$ -
7/1/2013	Open	JC	LCM	Active	7	$ 10,490.00	$ -	$ -	$ -
9/13/2013	Open	SW	Behavioral CM	Active	8	$ -	$ 3,600.00	$ -	$ -
8/20/2013	Open	DH	LCM	Active	9	$ 11,200.00	$ -	$ -	$ -
7/2/2013	Open	AV	Behavioral CM	Active	10	$ -	$ 3,000.00	$ -	$ -
7/1/2013	Open	JC	Behavioral CM	Active	11	$ -	$ 2,550.00	$ -	$ -
		Quarterly Savings by Type				**$ 114,682.00**	**$ 14,750.00**	**$ 38,580.00**	$ -
		Total Quarterly Savings				$ 114,682.00	$ 14,750.00	$ 38,580.00	$ -
		Q1 2014 Savings				$ 114,682.00	$ 14,750.00	$ 38,580.00	$ -
		Year to Date Savings (Q1 + Q2)				$ 114,682.00	$ 14,750.00	$ 38,580.00	$ -
		Year to Date ROI (Q1 + Q2 + Q3)				$ 114,682.00	$ 14,750.00	$ 38,580.00	$ -

Hometown Health		Page 1 of 2	
		Effective Date:	1/1/2012
Policy Topic:	Case Management of the Transplant Patient	Last Review Date:	11/1/2013
Policy Category:	Health Services	Last Revised Date:	11/1/2013
Policy Number:	HOMETOWN.HQH. 30		
Author:	Teri Howard, RN Health Services Director		

Scope:	All Hometown Health and Senior Care Plus members who are identified with a diagnosis which could lead to potential transplant are enrolled in Transplant Case Management.
Purpose:	Stewardship: Maximize the use of available, finite resources to meet the current and future needs of the community by ensuring member safety and quality of care in the environment of member (client) and family choice as well as proactively work to prevent transition to a higher level of care or inpatient admission. Service: Anticipate customer needs and exceed expectations in a compassionate manner.
Policy:	100% of commercial and senior membership identified with a diagnosis which could lead to transplant are enrolled in transplant case management to ensure we are managing potential high dollar, high cost cases.
Definitions:	Transplant Network – network identified by the customer or Hometown Health as having the capability of coordinating all of the medical care prior to transplant, during transplant and post transplant in a recognized center of excellence. The transplant network will use their contracted rates for the transplant as well as manage all claims processing. Low level monitoring – all precerts are triggered for transplant case manager review as well as any claims processed. The transplant case manager intervenes on an as needed basis or at member request. MedHOK = Hometown Health's Case Management/Disease Management system of record
Procedure:	Members with diagnosis which could potentially lead to transplant are enrolled in case management: • Identification of potential transplant candidates include: Diagnosis trigger report and high dollar claim report are reviewed monthly to identify potential members (client) who may lead to transplant in the future. MedHOK triage and precert modules reviewed for potential transplant cases All precerts for inpatient transition from lower level of care to higher level of care are reviewed for potential transplant evaluation.

- Pre-Transplant assessment is completed and if member is a candidate and treating provider requests a transplant consultation, the transplant case manager will assist the member in finding an approved center of excellence as outlined by the plan or Hometown Health.
- All costs related to the transplant evaluation and pre transplant monitoring are tracked.
- All services required by the member are coordinated by the transplant case manager
- Once the member is admitted into the hospital for the transplant, the utilization review is completed by the transplant case manager.
- Costs are also monitored in collaboration with the transplant network case manager.
- Once the member is stable and has exceeded the post transplant monitoring period, the member is placed on low level monitoring for identification of any future needs.
- The transplant case manager also collaborates and reports the member progression towards transplant and follow up with the transplant network case manager, reinsurance carrier as required, as well as Hometown Health finance committee.

Approvals:

Date: 12/2/13
Ty Windefeldt
Renown Health Vice President

Date: 12/2/13
Linda Ash-Jackson, MD
Medical Director

Date: 12/2/13
Teri Howard, RN, BSN
Health Services Director

Renown Health
Position Description

Position Title:	Case Manager - HTH		
Job Code Number:	640802		
Department:	500612, 510612, 510613		
Position Type:	02 – Registered Nurse		
Date Originated:	February 1995	**Date Reviewed / Revised:**	May 2013
HR Reviewed Date:	May 2013 LG		

Position Purpose:

Under the supervision of the Manager of Health Services, collaborates with their team members, and coordinates case management services to be provided for members with acute, chronic and/or catastrophic illness health needs for all age specific members.

Nature and Scope:

This position shall coordinate all components of case management to provide for individual member 's health care needs thorough the continuum of care. This includes: management in the setting of acute care (hospital), recovery care (Rehab/SNF), large case/chronic/ambulatory (seniors and commercial membership) and the pre-certification process.

The case manager collaborates with all medical team members throughout the continuum and educates the member/family on managed care issues, community resources and plan benefits. This collaboration promotes positive outcomes (quality) and the utilization of patient/member care resources in an efficient and cost-effective manner within the benefit structure.

The scope includes potential for cross training within the continuum, of the five case management roles to cover for departmental vacations, illness and vacancies.

Knowledge, Skills & Abilities

1. Strong interpersonal communication skills both verbal and written.
2. Able to facilitate, problem solve and negotiate with members, families, providers and other health care professionals to effectively resolve patient care management issues.
3. Understands the Case Management process of Assessment, Planning, Intervention, Evaluation and is able to utilize these components to provide for the individual health care needs and promote positive outcomes (quality).
4. Able to organize and correlate medical data and information; put into concise reports and graphs, and correspond with others by member and/or letter. Knowledge and understanding of financial components in determining access and placement of the appropriate level of care.
5. Knowledge of applicable regulatory requirements and community resources
6. Knowledge of continuous quality improvement process.
7. Philosophy consistent with the corporate culture of Renown Health

This position does provide patient care.

The foregoing description is not intended and should not be construed to be an exhaustive list of all responsibilities, skills and efforts or work conditions associated with the job. It is intended to be an accurate reflection of the general nature and level of the job.

Minimum Qualifications: Requirements - Required and/or Preferred

Education:	Must have working-level knowledge of the English language, including reading, writing and speaking English. English. Bachelor of Nursing Degree preferred.
Experience:	Applicants with 2-3 years previous managed care and/or case management experience including acute hospital case management is preferred. Minimum of one-year in hospital setting required.
License(s):	Ability to obtain and maintain a State of Nevada Registered Nurse license.

Certification(s):	Utilization or Case Management Certification desirable. Certification in Case Management (CCM), Professional Utilization Review (CPUR), Managed Care (NMCC) or ABQAUR is preferred.
Computer / Typing:	Must possess, or be able to obtain within 90 days, the computers skills necessary to complete online learning requirements for job-specific competencies, access online forms and policies, complete online benefits enrollment, etc.

Essential Physical Requirements

(The physical requirements section is used to identify the primary functions of the position for the purposes of determining Americans with Disabilities Act accommodations, Workers' Compensation return to work stipulations, ability to return to work following an accident or injury, etc. Please complete and check boxes as thoroughly and accurately as possible.)

It is common to encounter potential hazards in the healthcare environment. Some of these hazards could include, but are not limited to: radiation, toxic chemicals, biological hazards, heat, cold, noise, dust and stress. Renown Health has a Safety Management program in place addressing these issues.

Physical Activity

Percentage of time (equaling 100%) during the normal workday the employee is required to:

Sit:	60%	Stand:	10%	Walk:	20%	Run:	
Squat:		Bend:	Occ	Twist:		Lift:	Occ
Kneel:		Drive:	10%	Climb:		Crawl:	
Reach above shoulder:		Occ		Other:			

Tools and/or Equipment:	**Frequency**		
	Occasional (01-33%)	Frequent (34-66%)	Continuous (67-100%)
PC		x	
Telephone		x	
Office Equipment			x

Repetitive Use of Hands and Feet:

	Not Required	Occasional (01-33%)	Frequent (34-66%)	Continuous (67-100%)
Simple Grasping			X	
Pushing / Pulling		X		
Typing / Data Entry			X	
Fine Manipulation	X			
Repetitive use of foot/feet in operating machine controls	X			

Lifting and Carrying:

Weight to be manually lifted each normal workday. (Occasional 1 - 33%, Frequent 34 - 66%, Continuous 67 - 100%)

	Not Required	Occasional	Frequent	Continuous
Up to 10 lbs		X		
Up to 20 lbs		X		
Up to 35 lbs	X			
Up to 50 lbs	X			
Up to 75 lbs	X			
Up to 100 lbs	X			

Over 100 lbs	X			

Sensory Requirements:
Essential Functions
The ability to understand and resolve complex problems in a timely and effective manner using critical thinking skills.
The ability to keep current with new developments and acquire the needed knowledge for the position in order to keep skill sets up to date.
The ability to communicate clearly, timely and effectively.
The ability to come to work promptly and routinely.
The ability to routinely work under stress and to deadlines.
Must be able to direct (or receive direction) or supervise others, correctly assess patients' conditions, and determine when consultation is required.
The ability to work well with others
Must have the ability to maintain emotional stability to cope with human suffering, emergencies, and other stresses.
Ability to work with constant interruptions and prioritize emergency situations is required.
Ability to maneuver throughout halls, stairways, and patient rooms in response to hospital emergencies.
Must be able to perform various sensory requirements such as; vision, speech, smell, touch, manual dexterity, fine motor skills, and hearing in order to access and treat patient accurately.

Job Specific Duties and Responsibilities

This section will include the measures of success for the position. A percentage weight is given to each essential function. The percentages should total 100%. The only required job specific duty and responsibility is Standards of Conduct and it must carry a weight of 30%. Provide specific measures of success for each Essential Function listed. At least one essential function should be created for every fundamental (People, Service, Quality and Stewardship). To assist in developing measures, consider asking, "How will I know if the employee is meeting the requirements of job specific responsibilities?" Or consider adding the words, "as demonstrated by…" at the end of the stated job specific responsibility.

Weight		Score
30%	**Actively supports the Standards of Conduct (People)**	
	Total points divided by 9 = _____ x 30% =	
Comments:		
20%	**Collaborates with members, families, providers, Health Services Team, and other health care professionals to provide for individual's health needs throughout the continuum, utilizing patient care resources efficiently in a cost-effective manner.**	
	1. Serves as a Hometown Health Resource and contact to members, providers, and health care professionals in both contracted and non-contracted settings.	
	2. Assess plan of care and treatment interventions for appropriate utilization of patient care resources using Interqual/Milliman Guidelines.	
	3. Ongoing evaluation and monitoring of clinical requests recommendations, interventions utilizing Interqual/Milliman Guidelines.	
	4. Recommend interventions to meet discharge needs of clients to home, skilled and rehab settings.	
	5. Coordinate, review and discuss all clients admissions to facilities, both contracted and non-contracted, with the Medical Director.	
	6. Reviews requests for the needs of discharged patients in collaboration with Episodic Case Managers.	
	7. Act as a liaison representative for Hometown Health with community agencies and Renown Health committees.	
	Total points divided by 7 = _____ x 20% =	
Comments:		
20%	**Coordinate and manage the clinical case management process to promote positive outcomes for clients.**	

	1. Assess and evaluate referral requests from providers for appropriateness including DME, HH and other ancillary providers.
	2. Refer all Out of Plan services to Medical Director for authorization.
	3. Obtain approval from plan and/or employer if plan of care interventions require variance from available benefits.
	4. Conduct on-site or telephonic concurrent review in acute, skilled, rehab and OOA facilities.
	5. Conduct telephonic review of provider requests for elective, out patient or home based members needs.
	6. Initiate and participate in rounds with M.D.'s and team conferences with facility health care professionals.
	7. Coordinate discharge planning for skilled and rehab clients.
	8. Utilized criteria to evaluate clients for referral to Recovery or Ambulatory/Long Team Case Management.
	9. Assess client needs utilizing risk screens, re-admission data and home visits.
	10. Evaluate plan of care and develop alternative interventions that will promote positive outcomes.
	Total points divided by 10 = _____ x 20% =
Comments:	
10%	**Develop, organize and maintain processes to successfully collect data and document outcomes and utilization.**
	1. Documents accurately, per regulatory requirements, in a timely manner, in CSC system and generates response letters to providers and members within 48 hours timeframe.
	2. Meets standards for documentation of plan of care that identifies goals and expected outcomes.
	3. Recommends interventions and outcomes and provides periodic evaluation as to whether client's health care needs are being met throughout the continuum utilizing resources efficiently in a cost effective manner.
	4. Reports information to QI department. (i.e. adverse outcomes, OB stats) as well as concerns about quality.
	5. Develops and maintains reports which provided information about utilization of resources, client outcomes, care costs and savings.
	Total points divided by 5 = _____ x 10% =
Comments:	
10%	**Initiate and participate in Health Services case conferences in order to develop a plan of care, with interventions and expected goals and outcomes.**
	1. Demonstrates interpersonal skills which promote communication with members of the Health Services Team to better assess and identify client needs.
	2. Develop and/or participate in the plan of care that includes interventions, and evaluation of patient outcomes.
	3. Participate in development, review and revision, of case management procedures including care plan development and systems.
	Total points divided by 3 = _____ x 10% =
Comments:	
10%	**Demonstrates professional demeanor and commitment to continuous quality improvement processes.**
	1. Maintains RN licensure and accreditation from professional organizations if appropriate.
	2. Promotes healing environment for each client.
	3. Commits to philosophy of case management as defined by the Director of Health Services and which promotes efficient, effective quality care.
	4. Demonstrates respect for clients, families, visitor, and professional staff through personal appearance and dress.
	5. Communicates in a positive, open and direct manner.
	6. Handles conflict resolution and achieves positive outcomes.
	7. Initiates actions in an objective manner.
	8. Demonstrates a willingness to participate as a member of the Health Services team.

	9. Identifies problems and offers suggestions for resolution	
	10. Responsible and accountable for all direct and indirect actions.	
	11. Verbalizes understanding of need to manage patient care resources efficiently and in a cost effective manner.	
	12. Shows a willingness to "take a risk" and try new ideas.	
	13. Participates in the development of Renown Health.	
	14. Accepts other duties as assigned	
	Total points divided by 14 = _____ x 10% =	
Comments:		
	Total Points out of 400 =	

ACKNOWLEDGEMENT

I have read and understand the position description. I have reviewed all performance standards and understand that these standards will be used as criteria for evaluating my performance.

I hereby acknowledge that I currently hold, or will obtain within the amount of time specified, all required licensure and certifications listed in the minimum requirements section of the position description. I understand that it is my responsibility to maintain the required licensure and certifications (as applicable).

It is further understood that these requirements may be modified to reflect changes necessary in departmental and/or hospital needs.

Employee's Signature: _____ Date: _____

(Revised 3/09)

Renown Health
Position Description

Position Title:	Care Coordinator RN		
Job Code Number:	640602		
Department:	200766		
Position Type:	02 – Registered Nurse		
Date Originated:	November 2008	**Date Reviewed / Revised:**	May 2009
HR Reviewed Date:	May 2009 YJH		

Position Purpose:

A collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates options, services and alternative levels of care to meet an individual's needs. By assuming a leadership role with the interdisciplinary team, the Care Coordinator RN promotes appropriate utilization, high quality care and cost effective outcomes. The Care Coordinator RN, is responsible for Utilization Review, performs admission and concurrent reviews using Severity of Illness / Intensity of Service (SI/(S) criteria by reviewing the client's medical record and communicating with the physicians and payors regarding the medical necessity for services.

Nature and Scope:

The Care Coordinator RN has the responsibility to promote case management activities through the health continuum, beginning in the acute setting. Case management begins with the assessment of pre-morbid health status, current medical condition and post-acute needs. The Care Coordinator RN performs admission and concurrent continued stay reviews to ensure that services are being delivered at the most appropriate level of care to meet the client's needs and to secure reimbursement from payers.

Utilizing an interdisciplinary team approach, the Care Coordinator RN acts as a consultant and educator on matters referring to alternative levels of care, managed care issues, and community resources. In collaboration, to provide optimal patient care through, assessment, planning, implementation, and evaluation of neonatal, pediatric, adolescent, adult, and geriatric patients and families. This position also provides information such as certified LOS and reimbursement issues to physicians as needed to ensure the appropriate and timely disposition of the client to the next level of care. The Care Coordinator RN monitors and documents the progress of the plan, making revisions as needed, to assures a smooth transition to the next level of care at the time of discharge.

The Care Coordinator RN must respect beliefs and values while advocating for the client's right to self-determination and to make informed choices.

The Care Coordinator RN documents all chart and phone reviews, identifies and communicates potentially avoidable/non-reimbursed days, quality indicators (such as re-admissions) and core measures. As indicated, delivers non-coverage letters as set forth by payer and/or regulatory compliance.

The Care Coordinator RN acquires and maintains knowledge and competencies related to the expectations of their position including an extensive knowledge of post-acute admission criteria (Rehab, LTAC and SNF etc.). Practice is aligned with the mission, vision and goals of the Integrated Health System. She/he participates in Quality Improvement initiatives.

This position does not provide patient care.

The foregoing description is not intended and should not be construed to be an exhaustive list of all responsibilities, skills and efforts or work conditions associated with the job. It is intended to be an accurate reflection of the general nature and level of the job.

Minimum Qualifications: Requirements - Required and/or Preferred

Education:	Must have working-level knowledge of the English language, including reading, writing and speaking English. Appropriate education to obtain and maintain State of Nevada Registered Nurse licensure. Bachelor of Science in Nursing preferred.
Experience:	Minimum two years acute hospital experience, within the last 5 years required. Case Management, Post-Acute experience and/or UR/QA experience preferred.
License(s):	Ability to obtain and maintain a State of Nevada Registered Nurse license.
Certification(s):	National Certification (i.e. Case Management (CCM), Professional Utilization Reviewer (CPUR), or Managed Care (NMCC)) preferred. Current BLS/CPR certification required.

Computer / Typing:	Must be proficient with Microsoft Office Suite, including Outlook, PowerPoint, Excel and Word and have the ability to use the computer to complete online learning requirements for job-specific competencies, access online forms and policies, complete online benefits enrollment, etc.

Essential Physical Requirements

Temperature: Normal __X__ _____

Cold - Temperatures: From _____ To: _____
Heat - Temperatures: From _____ To: _____

Humidity: Normal __X__ Dry: _____

Other Hazards: Mechanical _____ Gas _____
Explosive _____ Poor Ventilation _____
Biological _____ Radiation _____
Electrical _____ Chemical _____
Fumes _____ Fire _____
Dust __X__ Other _____

Percent of time spent outside: Less than 10%

Protective Clothing Required: Standard precautions unless specific patient requires additional precautions.

It is common to encounter potential hazards in the healthcare environment. Some of these hazards could include, but are not limited to: radiation, toxic chemicals, biological hazards, heat, cold, noise, dust and stress. Renown Health has a Safety Management program in place addressing these issues.

Physical Activity

Percentage of time (equaling 100%) during the normal workday the employee is required to:

Sit:	50%	Stand: 25%		Walk: 25%		Run:	
Squat:	Occ.	Bend: Occ.		Twist: Occ.		Lift: Occ.	
Kneel:	Occ.	Drive: Occ.		Climb: Occ.		Crawl:	
Reach above shoulder: Occ.		Push: Occ.		Pull; Occ.			

Tools and/or Equipment:	**Frequency**		
	Occasional (01-33%)	Frequent (34-66%)	Continuous (67-100%)
Computer		X	
Phone/Voicemail		X	
Beeper		X	
Fax		X	
Copy Machine	X		

Repetitive Use of Hands and Feet:

	Not Required	Occasional (01-33%)	Frequent (34-66%)	Continuous (67-100%)
Simple Grasping			X	
Pushing / Pulling		X		
Typing / Data Entry			X	
		X		

Lifting and Carrying:

Weight to be manually lifted each normal workday. (Occasional 1 - 33%, Frequent 34 - 66%, Continuous 67 - 100%)

	Not Required	Occasional	Frequent	Continuous
Up to 10 lbs		X		
Up to 20 lbs	X			
Up to 35 lbs	X			

Up to 50 lbs	X			
Up to 75 lbs	X			
Up to 100 lbs	X			
Over 100 lbs	X			

Sensory Requirements:
Weight to be manually lifted each normal workday. (Occasional 1 - 33%, Frequent 34 - 66%, Continuous 67-100%)
Essential Functions
The ability to understand and resolve complex problems in a timely and effective manner using critical thinking skills.
The ability to keep current with new developments and acquire the needed knowledge for the position in order to keep skill sets up to date.
The ability to communicate clearly, timely and effectively.
The ability to come to work promptly and routinely.
The ability to routinely work under stress and to deadlines.
Must be able to direct (or receive direction) or supervise others, correctly assess patients' conditions, and determine when consultation is required.
The ability to work well with others
Must have the ability to maintain emotional stability to cope with human suffering, emergencies, and other stresses.
Ability to work with constant interruptions and prioritize emergency situations is required.
Ability to maneuver throughout halls, stairways, and patient rooms in response to hospital emergencies.
Must be able to perform various sensory requirements such as; vision, speech, smell, touch, manual dexterity, fine motor skills, and hearing in order to access and treat patient accurately.

Job Specific Duties and Responsibilities

This section will include the measures of success for the position. A percentage weight is given to each essential function. The percentages should total 100%. The only required job specific duty and responsibility is Standards of Conduct and it must carry a weight of 30%. Provide specific measures of success for each Essential Function listed. At least one essential function should be created for every fundamental (People, Service, Quality and Stewardship). To assist in developing measures, consider asking, "How will I know if the employee is meeting the requirements of job specific responsibilities?" Or consider adding the words, "as demonstrated by..." at the end of the stated job specific responsibility.

Weight		Score
30%	**Actively supports the Standards of Conduct (People)**	
	Total points divided by 9 = ____ x 30% =	
Comments:		
15%	**Coordinates the timely provision of cost effective care.**	
	1. Evaluates pro-active triggers (such as diagnosis, clinical condition, complications or costs) to identify potential clients suitable for care coordination intervention within one working day.	
	2. Completes a thorough and systematic evaluation of client's current status including: physical/functional, psychosocial, behavioral, support systems, legal and financial considerations within 48 hours.	
	3. Assesses prognosis, short and long-term goals and client/provider to meet post-acute needs.	
	4. Identifies and facilitates the discharge plan.	
	5. Identifies and documents aberrant/avoidable days.	
	Total points divided by 5 = ____ x 15% =	
Comments:		
15%	**Evaluates pre-morbid status, current medical condition and projected post-acute needs.**	
	1. Evaluates pro-active triggers (such as diagnosis, clinical condition, complications or costs) to identify potential clients suitable for care coordination intervention within one working day.	
	2. Completes a thorough and systematic evaluation of client's current status including: physical/functional, psychosocial, behavioral, support systems, legal and financial considerations within 48 hours.	
	3. Assesses prognosis, short and long-term goals and client/provider to meet post-acute needs.	

	4. Identifies and facilitates the discharge plan.	
	5. Identifies and documents aberrant/avoidable days.	
	Total points divided by 5 = ____ x 15% =	
Comments:		
10%	**Collaborates within Renown and the health care community to implement and appropriate and comprehensive discharge plan.**	
	1. Collaborates with client/family, physicians, the interdisciplinary health care team and payors to identify options to meet ongoing health care needs on a daily basis.	
	2. Initiates and participates in interdisciplinary team meetings, family conferences, medical director rounds, difficult discharge and staff meetings.	
	3. Proactively identify issues that are, or may become, barriers to the treatment plan.	
	4. Identifies funding and/or community resources available to implement the discharge plan and coordinates timely referrals.	
	5. Facilitates problem solving and resolution of conflicts.	
	6. Interacts effectively with outside review organizations, regulatory agencies, post acute providers and facilities.	
	7. Provides information on financial resources to the business office or admitting.	
	Total points divided by 7 = ____ x 10% =	
Comments:		
20%	**Demonstrates appropriate documentation and competencies.**	
	1. Within 24 hours of admission the Care Coordinator RN documents the initial review, assessment and customized discharge plan.	
	2. All phone and concurrent continued stay reviews documented daily.	
	3. The customized discharge plan will be initiated and printed for placement in the medical record within 48 hours.	
	4. Updates to the assessment and plan of care are ongoing and documented concurrently.	
	5. No less than weekly, the Care Coordinator RN will document on the Interdisciplinary Plan of Care (Care Map).	
	6. Documents and completes referral information including TARs, PARs and approved services forms.	
	7. Evaluates service delivery through collection of discharge and outcome date by providing monthly/quarterly data regarding admissions, discharges, aberrant/avoidable days, discharge disposition, services provided and customer satisfaction and outcomes.	
	8. Initiates and completes occurrence reports in an accurate and timely manner in accordance with policy. Evaluates and follows through as appropriate.	
	9. Demonstrates competency in area of employment as evidenced by satisfactory completion of Annual Competency Test.	
	10. Demonstrates ability to assist with complex cases.	
	11. Demonstrates knowledge of regulations effecting rehabilitation, skilled, long term and home health care.	
	12. Demonstrates competency in utilizing SI/IS criteria.	
	13. Demonstrates the knowledge and skills appropriate to the age of the patient served. (See Age Specific Grid)	
	14. Complete all In The Know posttests.	
	Total points divided by 14 = ____ x 20% =	
Comments:		
5%	**Meets financial and productivity goals.**	
	1. Meets departmental financial goals as determined by administration for the fiscal year based on a rolling 12-month period.	
	Total points divided by 1 = ____ x 5% =	
Comments:		
5%	**Customer Satisfaction**	

	1. Patient Satisfaction Survey: The average percentage of favorable responses for the department specific items on the patient Satisfaction Survey will be within the range established by Administration for the fiscal year.	
	2. Internal Customer Satisfaction Survey: The average percentage of favorable responses on the house-wide Internal Customer Satisfaction Survey will show improvement from the baseline survey by a percentage to be determined by Administration for the fiscal year.	
	3. Partner Satisfaction: The departmental average percentage of favorable responses for the department specific measurable goal, process or activity will be within the range established by the department manager/director for the fiscal year.	
	Total points divided by 3 = ____ x 5% =	
Comments:		
	Total Points out of 400 =	

ACKNOWLEDGEMENT

I have read and understand the position description. I have reviewed all performance standards and understand that these standards will be used as criteria for evaluating my performance.

I hereby acknowledge that I currently hold, or will obtain within the amount of time specified, all required licensure and certifications listed in the minimum requirements section of the position description. I understand that it is my responsibility to maintain the required licensure and certifications (as applicable).

It is further understood that these requirements may be modified to reflect changes necessary in departmental and/or hospital needs.

Employee's Signature: _____ Date: _____

(Revised 3/09)

Renown Health Position Description			
Position Title:	Hometown Health Social Worker		
Job Code Number:	730331		
Department:	500612, 510612		
Position Type:	01 – Techs/Specialists		
Date Originated:	July 2011	Date Reviewed / Revised:	July 2011
HR Reviewed Date:	July 2011		

Position Purpose:

This position is responsible under the supervision of the department manager for providing patients and families with emotional support, advocacy as appropriate, financial information, discharge planning, and social work services. This position also serves as a liaison between the medical staff and the patient/family and provides interventions designed to minimize patient stress and maximize coping skills to expedite recovery.

Nature and Scope:

This position provides psychosocial services to patients, families, and consultation to staff to assist in dealing with illness or injuries along the continuum of care. This position also provides educational information and referral services to community resources that may assist patients/families during and after hospitalization. This position provides clinical and complex discharge planning for patients requiring post acute services. Provides utilization management and discharge planning services for members with chemical dependency and behavioral health diagnosis.

The incumbent must provide optimal patient care through assessment, planning, implementation, and evaluation of neonatal, child, adolescent, adult, and geriatric patients and families.

The major challenge to this position is the ability to prioritize and assess critical situations while maintaining quality services under stressful conditions.

This position has the authority to review and evaluate each case; establish work priorities; and differentiate between services the health plan can provide and those services, which can be provided more appropriately by the community.

The position is primarily office based. Contact with members is primarily by phone, but can be in person as needed if member is hospitalized or schedules an office appointment.

This position will assist Senior Care Plus members in completion of Medicaid applications, advanced directives, and coordination of community resources.

Decisions referred to the manager include department policy, work and time off schedules, serious conflict with hospital staff, budget expenses, administrative policies, or legal matters.

KNOWLEDGE, SKILLS & ABILITIES

1. Knowledge of social work skills, theories, and intervention
2. Ability to make psychosocial assessments and implement treatment plans
3. Ability to participate in the development in collaboration with the case manager a discharge plan or care plan related to patient's condition, and coordinate in collaboration with the case management team. Requires knowledge and understanding of medical terms.
4. Ability to function in crisis situations, apply independent and mature judgment, and establish priorities
5. Ability to work as a member of an interdisciplinary team, and to facilitate close working relationships and cooperation within the Health System and community.
6. Ability to interact effectively with persons of differing ethnic and socio-economic backgrounds
7. Demonstrate the knowledge and skills necessary to provide care, based upon the physical, motor, sensory, psychosocial, and safety needs and development, to the age of the patient served- infant to geriatric.
8. Skills to assist patients and families in coping with crisis situations
9. Skills to assist insureds and their families in coping with crisis situations due to health events
10. Knowledge of community resources available to meet the psychosocial needs of patients.

This position does not provide patient care.

The foregoing description is not intended and should not be construed to be an exhaustive list of all responsibilities, skills and efforts or work conditions associated with the job. It is intended to be an accurate reflection of the general nature and level of the job.

Minimum Qualifications: Requirements - Required and/or Preferred	
Education:	Must have working-level knowledge of the English language, including reading, writing and speaking English. Master's degree in Social Work required.
Experience:	Requires minimum two years experience in the social service field. Applicants with experience in Healthcare settings will be given preference.
License(s):	Masters prepared social worker degree at minimum. Ability to obtain and maintain a State of Nevada Social Worker license. Requires valid Nevada license as an LSW, LISW, LCSW, LASW or is eligible for licensure in Nevada.
Certification(s):	
Computer / Typing:	Must possess, or be able to obtain within 90 days, the computers skills necessary to complete online learning requirements for job-specific competencies, access online forms and policies, complete online benefits enrollment, etc.

Essential Physical Requirements

It is common to encounter potential hazards in the healthcare environment. Some of these hazards could include, but are not limited to: radiation, toxic chemicals, biological hazards, heat, cold, noise, dust and stress. Renown Health has a Safety Management program in place addressing these issues.

Physical Activity

Percentage of time (equaling 100%) during the normal workday the employee is required to:

Sit:	75%	Stand:	105%	Walk:	15%	Run:	0%
Squat:	0%	Bend:	Occ.	Twist:	0%	Lift:	Occ.
Kneel:	0%	Drive:	0%	Climb:	0%	Crawl:	0%
Reach above shoulder:		0%		Other:	0%		

Tools and/or Equipment:	**Frequency**		
	Occasional (01-33%)	Frequent (34-66%)	Continuous (67-100%)
Computer Terminal			x
Telephone			x
Office Equipment		X	

Repetitive Use of Hands and Feet:

	Not Required	Occasional (01-33%)	Frequent (34-66%)	Continuous (67-100%)
Simple grasping			X	
Pushing/Pulling		X		
Typing/Data Entry			X	
Fine Manipulation	X			
Repetitive use of foot/feet in operating machine controls	X			

Lifting and Carrying:

Weight to be manually lifted each normal workday. (Occasional 1 - 33%, Frequent 34 - 66%, Continuous 67 - 100%)

	Not Required	Occasional	Frequent	Continuous
Up to 10 lbs		X		
Up to 20 lbs		X		
Up to 35 lbs	X			
Up to 50 lbs	X			
Up to 75 lbs	X			
Up to 100 lbs	X			
Over 100 lbs	X			

Sensory Requirements:
Speech for communication, vision for reading, hearing for communication.
Essential Functions
The ability to understand and resolve complex problems in a timely and effective manner using critical thinking skills.
The ability to keep current with new developments and acquire the needed knowledge for the position in order to keep skill sets up to date.
The ability to communicate clearly, timely and effectively.
The ability to develop and maintain an engaged workgroup.
The ability to ensure a quality work product is produced in the departments assigned.
The ability to come to work promptly and routinely, and to be on-premises on an unscheduled basis as required by the job functions and for problem resolution.
The ability to routinely work under stress and to deadlines.
The ability to manage and direct work of staff.
The ability to manage expenses to budget.
The ability to ensure service standards are met in the departments assigned.

Job Specific Duties and Responsibilities

This section will include the measures of success for the position. A percentage weight is given to each essential function. The percentages should total 100%. The only required job specific duty and responsibility is Standards of Conduct and it must carry a weight of 30%. Provide specific measures of success for each Essential Function listed. At least one essential function should be created for every fundamental (People, Service, Quality and Stewardship). To assist in developing measures, consider asking, "How will I know if the employee is meeting the requirements of job specific responsibilities?" Or consider adding the words, "as demonstrated by…" at the end of the stated job specific responsibility.

Weight		**Score**
30%	**Actively supports the Standards of Conduct (People)**	
	Total points divided by 9 = _____ x 30% =	
Comments:		
15%	**Provides crisis intervention for patients/families in emergency situations such as grief, trauma, cardiac emergencies, child abuse/neglect, end of life etc.**	
	1. Establishes good rapport through use of interviewing skills with patient/family in order to assess situation. **MEETS STANDARDS WHEN**: No more than 3 valid complaints received by department manager from patient/family during evaluation period.	
	2. Facilitates communication between patient/family and medical team to resolve crisis situation. **MEETS STANDARDS WHEN**: No more than 3 valid complaints are received by the department manager from the unit/medical team or community agency during the evaluation period.	

	3. Provides initial intervention to patient/family within departmental standards. **MEETS STANDARDS WHEN**: Initial intervention with patient/family within 1 working day of referral in 95 percent of the cases, as determined by peer chart review.	
	4. Completes final documentation in medical record within departmental standards. **MEETS STANDARDS WHEN:** Documentation in medical record within 1 working day of service provided as determined by peer review.	
	Total points divided by 4 = _____ x 15% =	
Comments:		
15%	**Provides psychosocial assessment and support to patients and families to assist them in dealing with the stress of illness/injury.**	
	1. Psychosocial assessment initiated per unit specific supplement and documentation within one working day of assessment. **MEETS STANDARDS WHEN:** Done within standards in 95 percent of the cases in chart review.	
	2. Advocates appropriately on behalf of the patient/family with the medical team to provide the opportunity to have questions addressed about illness. **MEETS STANDARDS WHEN:** No more than 3 valid complaints are received by department manager from medical team/patient/family during evaluation period.	
	3. Provides educational material and counseling around adjustment to illness. Demonstrates working knowledge of community resources by making appropriate referrals upon discharge. **MEETS STANDARDS WHEN:** Social Service charting indicates needs assessed for support/counseling in 95 percent of the cases as determined by peer chart review and educational materials provided to patient/family as appropriate.	
	Total points divided by 3 = _____ x 15% =	
Comments:		
10%	**Functions as a member of an interdisciplinary team.**	
	1. Participates in weekly Interdisciplinary and Medical Director rounds. **MEETS STANDARDS WHEN**: Attends scheduled IDR rounds at least once a week 95 percent of the time and attends 100 percent of staff meetings unless absence excused for emergency.	
	2. Maintains all OLA and Departmental competencies. **MEETS STANDARDS WHEN**: Completed within one month of presentation.	
	3. Develops effective working relationships with all members of the interdisciplinary team. **MEETS STANDARDS WHEN**: No more than 3 valid complaints received by department manager from patient/family during evaluation period.	
	Total points divided by 3 = _____ x 5% =	
Comments:		
15%	**Provides discharge planning with transitional care coordination of acute chemical dependency and behavioral health admissions..**	
	1. **MEETS STANDARDS WHEN**: Available telephonically during normal business hours.	
	2. **MEETS STANDARDS WHEN**:	
	3. Refers patients to appropriate staff for follow-up with written or verbal report. **MEETS STANDARDS WHEN:** Referral is made 100 percent of time.	
	Total points divided by 3 = _____ x 5% =	
Comments:		
5%	**Participates fully as a member of the Health Services Department .**	
	1. Attends staff meetings and departmental in-services 75 percent of the time unless excused.	
	2. Participates in special work assignments, health fairs, hospital projects, departmental projects, etc. At least two projects a year.	
	3. Orients new staff and social work interns to units. Exceeds if assigned a student.	
	4. Demonstrates a leadership role within the department and organization by participation in additional work assignments.	
	Total points divided by 4 = _____ x 5% =	
Comments:		

5%	**Supports Customer Satisfaction**	
	1. Patient Satisfaction Survey- the hospital wide patient satisfaction score within the range established by Administration for the fiscal year.	
	Total points divided by 4 = _____ x 5% =	
Comments:		
5%	**Participates in financial management and productivity goals.**	
	1. **MEETS STANDARDS WHEN:** as determined by Administration for the fiscal year based on a rolling 12-month period.	
	Total points divided by 1 = _____ x 5% =	
Comments:		
	Total Points out of 400 =	

ACKNOWLEDGEMENT

I have read and understand the position description. I have reviewed all performance standards and understand that these standards will be used as criteria for evaluating my performance.

I hereby acknowledge that I currently hold, or will obtain within the amount of time specified, all required licensure and certifications listed in the minimum requirements section of the position description. I understand that it is my responsibility to maintain the required licensure and certifications (as applicable).

It is further understood that these requirements may be modified to reflect changes necessary in departmental and/or hospital needs.

Employee's Signature: _____ Date: _____

(Revised 3/09)

Case Management – Saving Detail for Open & Closed Cases

Contract: PEBP/State of Nevada □/1/□013 to □/30/□013

Date Created	Date Closed	Member	Case Type	Care Level Status	Case Seq □	□endor Negotiations	Averted Adm Savings	Change in Level of Care	Proposed Alternative Plan	Total Savings
8/1/2013	Open	BS	LCM	Active	1	$ 58,992.00	$ -	$ -	$ -	$ 58,992.00
7/1/2013	Open	EB	LCM	Active	2	$ 34,000.00	$ -	$ -	$ -	$ 34,000.00
7/1/2013	Open	EB	LCM	Active	3	$ -	$ 5,600.00	$ -	$ -	$ 5,600.00
9/27/2013	Open	JB	LCM	Active	4	$ -	$ -	$ 13,600.00	$ -	$ 13,600.00
9/20/2013	Open	CF	Behavioral CM	Closed	5	$ -	$ -	$ 13,500.00	$ -	$ 13,500.00
8/21/2013	Open	MG	LCM	Active	6	$ -	$ -	$ 11,480.00	$ -	$ 11,480.00
7/1/2013	Open	JC	LCM	Active	7	$ 10,490.00	$ -	$ -	$ -	$ 10,490.00
9/13/2013	Open	SW	Behavioral CM	Active	8	$ -	$ 3,600.00	$ -	$ -	$ 3,600.00
8/20/2013	Open	DH	LCM	Active	9	$ 11,200.00	$ -	$ -	$ -	$ 11,200.00
7/2/2013	Open	AV	Behavioral CM	Active	10	$ -	$ 3,000.00	$ -	$ -	$ 3,000.00
7/1/2013	Open	JC	Behavioral CM	Active	11	$ -	$ 2,550.00	$ -	$ -	$ 2,550.00
7/12/2013	Closed	CY	LCM	Closed	12	$ -	$ 2,500.00	$ -	$ -	$ 2,500.00
9/27/2013	Open	GD	LCM	Active	13	$ -	$ -	$ -	$ 900.00	$ 900.00
7/1/2013	Open	RA	Behavioral CM	Active	14	$ -	$ 800.00	$ -	$ -	$ 800.00
8/19/2013	Open	RS	LCM	Active	15	$ -	$ -	$ -	$ 220.00	$ 220.00
8/19/2013	Open	JC	Behavioral CM	Closed	16	$ -	$ 200.00	$ -	$ -	$ 200.00
7/15/2013	Closed	DP	Behavioral CM	Closed	17	$ -	$ 200.00	$ -	$ -	$ 200.00
7/1/2013	Open	KC	Behavioral CM	Open	18	$ -	$ 175.00	$ -	$ -	$ 175.00
7/1/2013	Open	AG	Behavioral CM	Open	19	$ -	$150.00	$ -	$ -	$150.00
9/16/2013	Closed	MC	Behavioral CM	Closed	20	$ -	$100.00	$ -	$ -	$100.00
8/1/2013	Closed	GJ	Behavioral CM	Closed	21	$ -	$75.00	$ -	$ -	$75.00
		Quarterly Savings by Type				**□ 114,□□□.00**	**□ 1□,□50.00**	**□ 3□,5□0.00**	**□ 1,1□0.00**	
		Total Quarterly Savings								**□ 1□3,33□.00**
		Q1 □014 Savings								**□1□3,33□.00**
		□ear to Date Savings (Q1 □Q□)								
		□ear to Date RO1 (Q1 □Q□□Q3)								**□**

NEVADA UNIVERSAL
PRIOR AUTHORIZATION AND REFERRAL FORM

Hometown Health 25TH ANNIVERSARY

HEALTH PLAN NAME & MEMBER HEALTH PLAN I.D. #: **Health Plan Phone #: 775-982-3700 Fax #: 775-982-3744**	Primary Care Provider Name / Address / Phone & Fax #:
Date of Request:	Requesting Provider Name:
Patient's Name & SS #: Insured Name & SS #	Requesting Provider's Address & Phone #: Requesting Provider's Fax #:
Patient's Address & Phone #:	Requesting Provider's Tax ID #: HIPAA Provider Identification #:
Patient's DOB:	Contact Person (Name, Phone & Fax #):
Employer Group's Name & Phone #: Other Insurance (s):	Requesting Provider's Signature or Stamped Signature:
Diagnosis (inc. ICD code):	Procedure / Treatment Request (inc. CPT code): Number of Treatments Requested: _____ Inpatient / Outpatient Service Requested by Patient *Yes* *No*
Service Provider / Address / Phone #:	Place of Service / Facility and Address: Requested Procedure Date / Start Treatment Date:

Current Clinical Findings and Management
All procedures/treatment requested require clinical information (may use this space - also see requirements below and attach to this form):

***Pertinent Attachments* = Any information to support the proposed diagnosis, treatment / procedure, such as current clinical findings (progress reports), results of laboratory testing, imaging studies (x-rays, etc.) must be submitted to prevent processing delays.**

Area for internal health plan use only	***Authorization:***		***Date of Authorization:***	***Pended / Denied: (Reason):***
Health plan contact name & phone #:	***Yes***	***No***	***Authorization Number:***	

****All sections of this form must be completed.***

*****On adverse determinations a reconsideration / expedited appeal may be requested.***

This referral/authorization is not a guarantee of payment. Payment is contingent upon eligibility, benefits available at the time the service is rendered, contractual terms, limitations, exclusions, and coordination of benefits, and other terms and conditions set forth in the Member's Evidence of Coverage, Certificate of Coverage, or Self Insured Employer's Plan Documents.

The information contained in this form, including attachments, is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If this communication has been received in error, the reader shall notify sender immediately and shall destroy all information received.

Revised 8/2/04

Hometown Health Providers

08/29/2013

Mary Q.
Member 9999
First St
Las Vegas, NV 89135

Dear Mary Q. Member:

Hometown Health has contracted with your plan administrator to review services for medical necessity under the terms of your health plan coverage. We have authorized a request for referral to the provider indicated by 'Referred To' below. This referral is approved for the number of visits and date range specified below:

Referred By : Clark Provider, MD
Referred To : William Provider, MD
Phone Number : (702) 123-4567
Referral Number : 01-123456-789-99
Type of Referral: Outpatient-Other
Approved Visits/Days : 1 visit
Date Range : 08/29/2013 - 08/29/2014

If you cannot obtain these services within the date range indicated, please contact your referring provider to discuss your options.

This approval for referral does not guarantee payment. The plan administrator makes the final determination when the actual claim is submitted. Reimbursement is based on eligibility, deductibles and plan limits. For information on plan benefits, please contact your plan administrator.

If you have any questions or need further information regarding this letter, please contact Customer Service at one of the numbers below, Monday through Friday, 8:00 a.m. - 5:00 p.m.

Cc: Clark Provider, MD

Sincerely,

Health Services Department(202 A1 A132307)

Toll Free: 888-323-1461 TTY: 711

Hometown Health Providers

MARY Q. MEMBER
101 FIRST STREET
Sparks, NV 89999

Dear MARY Q. MEMBER:

Hometown Health has contracted with your plan administrator to review services for medical necessity under the terms of your health plan coverage. We have authorized a referral for the non-participating provider indicated by 'Referred To' below. This referral is approved for the number of visits and date range specified below:

Referred By : William Provider, MD
Referred To : Clark A. Provider, MD
Phone Number : (775) 329-4600
Referral Number: 01-123456-789-99
Type of Referral : Outpatient-Other
Approved Visits/Days : 6 visits
Date Range : 06/12/2009 - 12/09/2009

If you cannot obtain these services within the period indicated by the date range, please contact your referring provider to discuss your options.

This approval for a referral does not guarantee payment for services. Your plan benefit may require that you pay an out-of-pocket plan deductible, coinsurance, copayment, and/or expenses exceeding usual and customary charges when you receive services from a
non-participating provider. Your plan administrator makes the final determination regarding payment when the actual claim is submitted. Reimbursement is based on eligibility, deductibles, and plan limits. For information on plan benefits, please contact your plan administrator.

If you have any questions or need further information regarding this letter, please contact Customer Service at one of the numbers below, Monday through Friday, 8:00 a.m. -
5:00 p.m. regarding this letter

Cc: Clark A. Provider, MD

Sincerely,

Health Services Department (205 A4 A4831)

Toll Free: 888-323-1461 TTY: 711

Hometown Health Providers

Notice of Denial of Medical Coverage

11/12/2013

MARY Q. MEMBER
101 FIRST STREET
Sparks, NV 89999

Patient:	MARY Q. MEMBER
Policy Holder:	
ID No:	
Plan:	State of Nevada PEBP
DOB:	<N/A>
Facility:	Clark A. Provider, MD
Provider:	William Provider, MD
LOC:	Outpatient-Other
Authorization Number:	01-123456-789-99
DOS:	06/12/2009

Dear MARY Q. MEMBER:

Hometown Health has contracted with your plan administrator to review services for medical necessity under the terms of your health plan coverage. Your health plan benefit excludes services that are not medically necessary as defined in your plan.

We have completed a review of the level of care for date(s) of service (DOS) referenced above. It was determined that it did not meet the definition of medical necessity as a requirement of your plan for the following reason(s):

Because our records indicate you reached your maximum benefit.

Clinical criteria, in addition to an actively licensed board certified physician, were relied upon for the above determination. The clinical rationale and criteria are available without charge upon request by calling Hometown Health at 888-323-1461.

For certain types of determinations, the provider may request a “peer-to-peer conversation” within 30 calendar days of the non-certification decision, if one has not already occurred by calling 1-888-323-1461. Hometown Health offers providers, within one business day of a request, the opportunity to discuss the non-certification decision with the clinical peer reviewer who made the initial determination. If the original clinical peer reviewer cannot be available within one business day, a different clinical peer reviewer will be made available. If a peer-to-peer conversation has already occurred or if the determination does not qualify for a peer-to-peer conversation, the appeal process is available.

You have the right to appeal any adverse determination within 180 days of the denial. Contact Hometown Health at 888-323-1461 to submit your appeal request.

You may request an expedited appeal in a situation in which an enrollee's condition could be anticipated to deteriorate to the point of being at risk of harm to self or others if not evaluated/treated within 48 hours. Expedited appeals are completed with verbal notification of the determination within, seventy-two (72) hours receipt of the appeal request and written notification of the determination no later than seventy-two (72) hours after receipt of the appeal request.

If the enrollee's condition is non-urgent, a standard appeal is completed within the following timelines. For prospective service, a determination (including written notification) is completed within fifteen (15) business days of the appeal request. For retrospective review, a determination (including written notification) is completed within thirty (30) business days of the appeal request.

A finding of medical necessity is not a guarantee of claim payment. The plan administrator makes the final determination when the actual claim is submitted. Reimbursement is based on eligibility, deductibles and plan limits. If you receive services for unauthorized care, benefits may be reduced or denied under your health benefit plan. For information on plan benefits, please contact your plan administrator.

This letter contains individual health information from Hometown Health which may be confidential or privileged. The information is intended to be for the use of the individual(s)/facility named above. If you are not the intended recipient, please be aware that any disclosure, copying, distribution or use of the contents of this letter is prohibited and punishable under law. If you have received this letter in error, please notify us immediately by calling 888-323-1461.

Sincerely,
Health Services Department (215 A9 A4831)

cc: Clark A. Provider, MD
William Provider, MD

Toll Free: 888-323-1461 TTY: 711

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- Referral Management
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- Care Management Tools
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  - Endocrinology
  - Gastroenterology
  - General Surgery
  - Head and Neck Surgery
  - Hematology - Oncology
  - Infectious Disease
  - Nephrology
  - Neurology
  - Neurosurgery
  - Obstetrics and Gynecology
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- Summary of Changes

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    - Cystic Fibrosis: High Intensity
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    - Parkinson Disease: High Intensity
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    - High-Risk Pregnancy: Low Intensity
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    - Hypertension: Low Intensity
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    - Substance Use, Partial Hospital Behavioral Health Level of Care, Child or Adolescent
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- Therapeutic and Testing Procedures
  - Bright Light Therapy
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  - Transcranial Magnetic Stimulation
  - Vagus Nerve Stimulation (VNS)
- Care Guidelines for Behavioral Health
  - Anorexia Nervosa
  - Anxiety Disorders (excluding Posttraumatic Stress Disorder)
  - Attention-Deficit and Disruptive Behavior Disorders
  - Bipolar Disorders
  - Bulimia Nervosa and Eating Disorder not Otherwise Specified
  - Delirium
  - Dementia
  - Dysthymia and Minor Depression
  - Major Depressive Disorder
  - Other Psychiatric Disorders
  - Other Psychotic Disorders
  - Pervasive Developmental Disorders
  - Posttraumatic Stress Disorder
  - Schizophrenia Spectrum Disorders
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  - Dementia
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- Novel Tool for Measuring Clinical Outcomes in Colorectal Surgery
- Vagus Nerve Stimulation for Depression

Upcoming Topics

- External Iliac Atherectomy for Peripheral Vascular Disease
- Onyx Liquid Embolic System (Onyx® HD-500) For Treatment Of Cerebral Aneurysms
- Patient Compliance with Portable Pneumatic Compression Devices for the Prevention of Post-Operative Deep Vein Thrombosis (DVT)

News Service

- CMS Seeking Public Comments on Coverage for Transcatheter Mitral Valve Repair
- Does Pre-hospital Hypothermia Impact Outcomes Following Cardiac Arrest?
- Rethinking the Diagnosis and Treatment of Urinary Tract Infections
- Less Aggressive Treatment Effective for Early Lymphedema of Breast Cancer
- Reducing the Risk of Toxicity When Treating HER2-Positive Breast Cancer

Other Client Activity

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- Core Decompression for Atraumatic Avascular Necrosis of the Hip
- CollaRx® Gentamicin Surgical Implant
- Galectin-3 Testing for the Management of Patients with Chronic Heart Failure
- Core Decompression for Atraumatic Avascular Necrosis of the Hip
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Payer Registration
Provider Registration
Tutorials & FAQs

Education Center
On-Site Workshops
Upcoming Webinars
Webinar Library

Knowledge Center
Genetic Test Evaluation
GTE Algorithm
Health Technology Brief
Medical Technology Directory
News Service
Search & Summary
Technology Prognosis

Site Requirements
Remove Cookie

Requests & Suggestions
Clinical Research Support
Search & Summary Request
Topic Suggestion

Premier
Total Cost of Ownership Report
Average Acquisition Value Report

Contact Us

What's New
Media Center
Resource Center

Conflict of Interest
Terms & Conditions
Privacy Statement

Social Media
Blog

DATE

NAME
ADDRESS
ADDRESS

Dear Mr. or Ms. NAME:

As the Third Party Administrator for the Public Employees' Benefit Program, we have reviewed the facts surrounding your Standard Appeal received on DATE, regarding your non-certified prior authorization to PROVIDER for SERVICE.

After review of the information presented and the material we gathered during our investigation, it is our determination to uphold the original denial. We have reviewed this case, and while we understand your position, based on the information available to Hometown Health at this time, this is REASON. Please note, Hometown Health is not stating that you cannot receive this SERVICE. Rather, we are simply stating that any financial responsibility would be yours.

If you feel this determination is incorrect, you have the right to request a review by an external review board. The Executive Officer or his designee will use all resources available, including but not limited to, members of the staff of the Board, third party administrator,, prescription drug administrator, internet, and the PEBP Master Plan Document to determine if the authorization was denied correctly.

The request for Executive Officer review must be filed within (35) thirty-five days from the date of this letter. Please include any additional pertinent information, which may not have been provided in your Standard Appeal.

You will be provided, free of charge, reasonable access to, and copies of, all documents and records and other information relevant to the denial upon request. You can request a complete description of the Hometown Health's Appeals Procedures, free of charge. Requests must be in writing and sent to the Customer Services address above.

If you disagree with the determination of the 2nd Level Formal Appeal, you may have a right to bring a civil action under Section 502 of the Employee Retirement Income Security Act of 1974, as amended. If this is an Expedited Appeal, the 2nd Formal Level Appeal is voluntary.

If you have any questions or need further assistance, please do not hesitate to contact our Customer Services Department at 775-982-3232 or 800-336-0123. TTY users should call the State Relay at 711.

Sincerely,

NAME
Director of Customer Services
/encl.

DATE

NAME
ADDRESS
ADDRESS

Dear Mr / Ms NAME:

As the Third Party Administrator for the Public Employees' Benefits Program, we have reviewed the facts surrounding your Standard Appeal received on DATE. The appeal is in reference to your denied authorization with PROVIDER for SERVICE.

After review of the information presented and what we gathered during our investigation, a determination has been made to overturn the denial. The authorization number for the service is [insert number].

If you have any questions or need further assistance, please do not hesitate to contact our Customer Services Department at 775-982-3232 or 800-336-0123. TTY users should call the State Relay at 711.

Sincerely,

Name
Member Appeal Specialist
Hometown Health

Hometown Health

Case Management – Saving Detail for Open & Closed Cases

Contract: PEBP/State of Nevada **7/1/2013 to 9/30/2013**

Date Created	Date Closed	Member	Case Type	Care Level Status	Case Seq #	Vendor Negotiations	Averted Adm Savings	Change in Level of Care	Proposed Alternative Plan	Total Savings
8/1/2013	Open	BS	LCM	Active	1	$ 58,992.00	$ -	$ -	$ -	$ 58,992.00
7/1/2013	Open	EB	LCM	Active	2	$ 34,000.00	$ -	$ -	$ -	$ 34,000.00
7/1/2013	Open	EB	LCM	Active	3	$ -	$ 5,600.00	$ -	$ -	$ 5,600.00
9/27/2013	Open	JB	LCM	Active	4	$ -	$ -	$ 13,600.00	$ -	$ 13,600.00
9/20/2013	Open	CF	Behavioral CM	Closed	5	$ -	$ -	$ 13,500.00	$ -	$ 13,500.00
8/21/2013	Open	MG	LCM	Active	6	$ -	$ -	$ 11,480.00	$ -	$ 11,480.00
7/1/2013	Open	JC	LCM	Active	7	$ 10,490.00	$ -	$ -	$ -	$ 10,490.00
9/13/2013	Open	SW	Behavioral CM	Active	8	$ -	$ 3,600.00	$ -	$ -	$ 3,600.00
8/20/2013	Open	DH	LCM	Active	9	$ 11,200.00	$ -	$ -	$ -	$ 11,200.00
7/2/2013	Open	AV	Behavioral CM	Active	10	$ -	$ 3,000.00	$ -	$ -	$ 3,000.00
7/1/2013	Open	JC	Behavioral CM	Active	11	$ -	$ 2,550.00	$ -	$ -	$ 2,550.00
7/12/2013	Closed	CY	LCM	Closed	12	$ -	$ 2,500.00	$ -	$ -	$ 2,500.00
9/27/2013	Open	GD	LCM	Active	13	$ -	$ -	$ -	$ 900.00	$ 900.00
7/1/2013	Open	RA	Behavioral CM	Active	14	$ -	$ 800.00	$ -	$ -	$ 800.00
8/19/2013	Open	RS	LCM	Active	15	$ -	$ -	$ -	$ 220.00	$ 220.00
8/19/2013	Open	JC	Behavioral CM	Closed	16	$ -	$ 200.00	$ -	$ -	$ 200.00
7/15/2013	Closed	DP	Behavioral CM	Closed	17	$ -	$ 200.00	$ -	$ -	$ 200.00
7/1/2013	Open	KC	Behavioral CM	Open	18	$ -	$ 175.00	$ -	$ -	$ 175.00
7/1/2013	Open	AG	Behavioral CM	Open	19	$ -	$150.00	$ -	$ -	$150.00
9/16/2013	Closed	MC	Behavioral CM	Closed	20	$ -	$100.00	$ -	$ -	$100.00
8/1/2013	Closed	GJ	Behavioral CM	Closed	21	$ -	$75.00	$ -	$ -	$75.00
		Quarterly Savings by Type				**$ 114,682.00**	**$ 18,950.00**	**$ 38,580.00**	**$ 1,120.00**	
		Total Quarterly Savings								**$ 173,332.00**
		Q1 2014 Savings								**$173,332.00**
		Year to Date Savings (Q1 + Q2)								
		Year to Date ROI (Q1 + Q2 + Q3)								**$**

NEVADA UNIVERSAL
PRIOR AUTHORIZATION AND REFERRAL FORM

Hometown Health 25TH ANNIVERSARY

HEALTH PLAN NAME & MEMBER HEALTH PLAN I.D. #: **Health Plan Phone #: 775-982-3700 Fax #: 775-982-3744**	Primary Care Provider Name / Address / Phone & Fax #:
Date of Request:	Requesting Provider Name:
Patient's Name & SS #: Insured Name & SS #	Requesting Provider's Address & Phone #: Requesting Provider's Fax #:
Patient's Address & Phone #:	Requesting Provider's Tax ID #: HIPAA Provider Identification #:
Patient's DOB:	Contact Person (Name, Phone & Fax #):
Employer Group's Name & Phone #: Other Insurance (s):	Requesting Provider's Signature or Stamped Signature:
Diagnosis (inc. ICD code):	Procedure / Treatment Request (inc. CPT code): Number of Treatments Requested: _____ Inpatient / Outpatient Service Requested by Patient *Yes* *No*
Service Provider / Address / Phone #:	Place of Service / Facility and Address: Requested Procedure Date / Start Treatment Date:

Current Clinical Findings and Management
All procedures/treatment requested require clinical information (may use this space - also see requirements below and attach to this form):

***Pertinent Attachments* = Any information to support the proposed diagnosis, treatment / procedure, such as current clinical findings (progress reports), results of laboratory testing, imaging studies (x-rays, etc.) must be submitted to prevent processing delays.**

Area for internal health plan use only	***Authorization:***		***Date of Authorization:***	***Pended / Denied: (Reason):***
Health plan contact name & phone #:	***Yes***	***No***	***Authorization Number:***	

****All sections of this form must be completed.***

*****On adverse determinations a reconsideration / expedited appeal may be requested.***

This referral/authorization is not a guarantee of payment. Payment is contingent upon eligibility, benefits available at the time the service is rendered, contractual terms, limitations, exclusions, and coordination of benefits, and other terms and conditions set forth in the Member's Evidence of Coverage, Certificate of Coverage, or Self Insured Employer's Plan Documents.

The information contained in this form, including attachments, is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If this communication has been received in error, the reader shall notify sender immediately and shall destroy all information received.

Revised 8/2/04

RFP #3084
Attachment N

Business Associate Agreement

By and Between

State of Nevada

on its own behalf and on behalf of the

Public Employees' Benefits Program (PEBP)

and

{Vendor}

Business Associate Agreement

This Business Associate Agreement ("Agreement") is effective December 1, 2012 and made by and between the State of Nevada, acting by and through its **Public Employees' Benefits Program** (together "PEBP" or "Covered Entity"), **and** ("Business Associate"), (collectively, the "Parties"). Terms appearing below in the "Witnesseth" section with initial upper case letters shall have the respective meanings assigned to them in this introductory paragraph or in Section 1.02 of this Agreement, as applicable.

WITNESSETH:

WHEREAS, Business Associate has previously entered into an arrangement with the State of Nevada PEBP and/or the Covered Entity to provide Services to or on behalf of the Covered Entity;

WHEREAS, the Parties acknowledge and agree that in providing Services to or on behalf of the Covered Entity, Business Associate will create, receive, use or disclose Protected Health Information;

WHEREAS, the Parties intend to enter into this Agreement to address the requirements of HIPAA, HITECH, the Privacy Rule, and the Security Rule as they apply to "business associates", including the establishment of permitted and required uses and disclosures (and appropriate limitations and conditions on such uses and disclosures) of Protected Health Information by Business Associate that is created or received in the course of performing Services on behalf of the Covered Entity; and

WHEREAS, the objective of this Agreement is to provide the State of Nevada and the Covered Entity with reasonable assurances that Business Associate will appropriately safeguard the Protected Health Information that it creates or receives in the course of providing Services to the Covered Entity;

NOW, THEREFORE, in connection with Business Associate's creation, receipt, use or disclosure of Protected Health Information and in consideration for the mutual promises contained herein, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties hereby agree as follows:

ARTICLE I
Definitions

1.01 **General Definitions.** All terms appearing in this Agreement with initial upper case letters that are not otherwise defined in this Agreement shall have the same meaning as that provided for the respective terms in 45 C.F.R. §§ 160.103, 164.103, 164.304 and 164.501.

1.02 **Specific Definitions.** For purposes of this Agreement, the following terms shall have the indicated meanings whenever the term appears with initial upper case letters in this Agreement:

(a) **"Business Associate"** shall mean **Vendor.**

(b) **"Breach"** shall mean the acquisition, access, use or disclosure of Protected Health Information in a manner not permitted by HIPAA which compromises the security or privacy of the Protected Health Information unless such acquisition, access, use or disclosure is otherwise excluded under 45 C.F.R. § 164.402. For this purpose, Protected Health Information is "compromised" to the extent that the action poses a significant risk of financial, reputational or other harm to the Individual.

(c) **"Covered Entity"** shall mean the State of Nevada Public Employees Benefits Program (PEBP).

(d) **"Data Aggregation"** shall mean, with respect to Protected Health Information created or received by the Business Associate in its capacity as the Business Associate of the Covered Entity, the combining of such Protected Health Information by the Business Associate with the Protected Health Information received by the Business Associate in its capacity as business associate of another covered entity, to permit data analyses that relate to the health care operations of the respective entities.

(e) **"Designated Record Set"** shall mean a group of records maintained by or for the State of Nevada and/or the Covered Entity within the meaning of 45 C.F.R. § 164.501 that consists of: (i) the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or (ii) records that are used, in whole or in part, by or for the State of Nevada and/or the Covered Entity to make decisions about Individuals.

For purposes of this Section 1.02(e), the term "record" means any item, collection or grouping of information that includes Protected Health Information and is maintained, collected, used or disseminated by or for the Covered Entity.

(f) **"HHS-Approved Technology"** shall mean, with respect to data in motion, the encryption guidelines in Federal Information Processing Standard 140-2. For data at rest, HHS-Approved Technology shall mean the encryption guidelines in National Institutes of Standards and Technology (NIST) Special Publication 800-111. With respect to the destruction of data containing Protected Health Information, an HHS-Approved Technology requires the destruction of the media on which the Protected Health

Information is stored such that, for paper, film or other hard copy media, destruction requires shredding or otherwise destroying the media so that Protected Health Information cannot be read or reconstructed; for electronic media, destruction requires that the data be cleared, purged or destroyed consistent with NIST Special Publication 800-88 such that the information cannot be retrieved. HHS-Approved Technology may be updated from time to time based on guidance from the Secretary of HHS.

(g) **"HIPAA"** shall mean the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191.

(h) **"HITECH"** shall mean the Health Information Technology for Economic and Clinical Health Act, Pub. L. 111-5.

(i) **"Individual"** shall have the same meaning as the term "individual" in 45 C.F.R. § 160.103, and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

(j) **"Privacy Rule"** shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Part 160 and Part 164, Subparts A and E.

(k) **"Protected Health Information"** shall mean individually identifiable health information that is transmitted by electronic media (within the meaning of 45 C.F.R. § 160.103), maintained in electronic media, or maintained or transmitted in any form or medium including, without limitation, all information (including demographic, medical, and financial information), data, documentation, and materials that are created or received by Business Associate from or on behalf of the Covered Entity in connection with the performance of Services, and relates to:

(A) The past, present or future physical or mental health or condition of an Individual;

(B) The provision of health care to an Individual; or

(C) The past, present or future payment for the provision of health care to an Individual;

and that identifies or could reasonably be used to identify an Individual and shall otherwise have the meaning given to such term under the Privacy Rule including, but not limited to, 45 C.F.R. § 160.103. Protected Health Information does not include health information that has been de-identified in accordance with the standards for de-identification provided for in the Privacy Rule including, but not limited to, 45 C.F.R. § 164.514.

(l) **"Required By Law"** shall have the same meaning as the term "required by law" in 45 C.F.R. § 164.103.

(m) **"Secretary"** shall mean the Secretary of the United States Department of Health and Human Services ("HHS") or his designee.

(n) **"Secured Protected Health Information"** shall mean Protected Health Information to the extent that the information is protected by using an HHS-Approved Technology identified by HHS for rendering Protected Health Information unusable, unreadable or indecipherable to unauthorized individuals.

(o) **"Security Rule"** shall mean the Security Standards at 45 C.F.R. Part 160, Part 162, and Part 164.

(p) **"Services"** shall mean the functions, activities or services to be provided to the State of Nevada and/or the Covered Entity under the terms of an arrangement between the State of Nevada and/or the Covered Entity and Business Associate.

(q) **"Unsecured Protected Health Information"** shall mean Protected Health Information that is not rendered unusable, unreadable or indecipherable to unauthorized individuals through the use of an HHS-Approved Technology.

ARTICLE II
Obligations and Activities of Business Associate

2.01 **Non-Disclosure of Protected Health Information.** Business Associate agrees not to use or disclose Protected Health Information other than as permitted or required by this Agreement or as Required By Law.

2.02 **Safeguards.** Business Associate agrees to use appropriate safeguards to prevent use or disclosure of Protected Health Information other than as provided for by this Agreement or the Privacy Rule. Business Associate agrees to implement administrative, physical, and technical safeguards, along with policies and procedures, that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic Protected Health Information that it creates, receives, maintains or transmits on behalf of the Covered Entity and to utilize Secured Protected Health Information in connection with the performance of Services under this Agreement.

2.03 **Mitigation.** Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate relating to a use or disclosure

of Protected Health Information by Business Associate in violation of the requirements of this Agreement.

2.04 **Reporting of Violations.** Subject to Section 2.05, Business Associate agrees to report to the State of Nevada and the Covered Entity any use or disclosure of Protected Health Information not provided for by this Agreement within thirty (30) days of such disclosure or Business Associate's knowledge of such disclosure. Business Associate agrees to report to the State of Nevada and the Covered Entity any security incident (within the meaning of 45 C.F.R. § 164.304) of which Business Associate becomes aware.

2.05 **Breach of Unsecured Protected Health Information**. To the extent that the Business Associate knows or has reason to know that there has been a Breach or suspected Breach of Unsecured Protected Health Information, the Business Associate is required to identify the Individual whose Unsecured Protected Health Information has been acquired, accessed, used or disclosed and to notify the Covered Entity of such Breach without reasonable delay, but no later than five (5) days after discovery of the Breach. Upon discovering the Breach, the Business Associate is required to (a) identify the entity to which the information was impermissibly disclosed, (b) determine whether or not the entity is subject to the HIPAA and the Privacy Rule, (c) identify the type and amount of Protected Health Information disclosed, (d) determine whether the disclosure poses a significant risk of financial, reputational, or other harm to the Individual, and (e) if the improperly disclosed Unsecured Protected Health Information is returned, determine if the information was returned before being accessed for an improper purpose.

2.06 **Notice of a Breach of Unsecured Protected Health Information**. In the event of a Breach involving Unsecured Protected Health Information, the Business Associate, with the prior written approval of the Covered Entity, will notify the affected Individuals without unreasonable delay, but no later than sixty (60) days after discovery of the Breach ("notice date"). The notice will include (a) a brief description of the incident, (b) the date the Breach occurred, (c) the date the Breach was discovered, (d) the type of Protected Health Information involved, (e) steps the Individual should take to protect him/herself from potential harm resulting from the Breach, (f) a brief description of steps the Covered Entity has taken to investigate, mitigate losses and protect against further Breaches, and (g) contact information for Individuals to ask questions, including a toll-free number, e-mail address, website or postal address. To the extent that the Breach involves more than 500 residents of a single state or jurisdiction, the Business Associate shall provide to Covered Entity, no later than the notice date, the information necessary for the Covered Entity to prepare the notice to media outlets as set forth in 45 C.F.R. § 164.406. To the extent that the Breach involves 500 or more Individuals, the Business Associate shall provide to the Covered Entity, no later

than the notice date, the information necessary for the Covered Entity to prepare the notice to the Secretary of HHS, as set forth in 45 C.F.R. § 164.408. To the extent that the Breach involves less than 500 Individuals, the Business Associate shall maintain a log of such Breaches and provide such log to the Covered Entity for submission to HHS. The Breach log shall be provided by Business Associate to the Covered Entity on an annual basis, not later than sixty (60) days after the end of the calendar year.

2.07 **Audits.** Business Associate shall permit the State of Nevada and the Covered Entity to audit Business Associate's compliance with the Privacy Rule, Security Rule and this Agreement upon reasonable prior notice and in a reasonable manner. The State of Nevada and/or the Covered Entity shall pay for any such audits.

2.08 **Agents and Contractors.** Business Associate agrees to ensure that any Business Associate agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of the State of Nevada and/or the Covered Entity agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information. Business Associate also agrees to ensure that any Business Associate employee or agent, including any subcontractor to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of the State of Nevada and/or the Covered Entity agrees to implement reasonable and appropriate safeguards to protect such Protected Health Information. Business Associate, the State of Nevada, and the Covered Entity agree that the Business Associate is not the agent of the Covered Entity or the State of Nevada at any time under this Agreement.

2.09 **Sanctions.** Business Associate agrees to apply appropriate sanctions against any Business Associate employee or agent, including a subcontractor, with access to Individuals' Protected Health Information who fails to comply with the State of Nevada's, the Covered Entity's, or the Business Associate's health information privacy policies and procedures.

2.10 **Amendment of Protected Health Information.** Business Associate agrees to make appropriate amendments to Protected Health Information in a Designated Record Set that either the Covered Entity or an Individual requests pursuant to procedures established under 45 C.F.R. § 164.526. To the extent Business Associate is requested by an Individual to amend his or her Protected Health Information, Business Associate shall communicate its approval or denial of such request to the Individual pursuant to procedures to be mutually agreed upon in advance by the Parties.

2.11 **Disclosure of Internal Practices, Books, and Records.** Business Associate agrees to make internal practices, books, and records (including policies and procedures) relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of the State of Nevada or the Covered Entity, available to the Covered Entity or, at the request of the Covered Entity, to the Secretary, in a time and manner mutually agreed to by the Parties or designated by the Secretary, for purposes of the Secretary determining the Covered Entity's compliance with the Privacy Rule.

2.12 **Access to Protected Health Information.** To the extent that either the Covered Entity or an Individual requests to inspect or obtain a copy of Protected Health Information (as provided for in 45 C.F.R. § 164.524) that may be in the possession or control of the Business Associate or its agents or subcontractors, or that exists in a Designated Record Set, Business Associate shall respond within thirty (30) days of its receipt of the request by Business Associate, provided that compliance with the request would not result in a violation of HIPAA or the Privacy Rule.

2.13 **Documentation of Disclosures.** Business Associate agrees to document disclosures of Protected Health Information and information related to such disclosures as would be required for a Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528. At a minimum, such documentation shall include: (i) the date of each disclosure; (ii) the name of the entity or person who received Protected Health Information and, if known, the address of the entity or person; (iii) a brief description of the Protected Health Information disclosed; (iv) the disclosures of Protected Health Information that occurred during the six-year period prior to the date of the request for an accounting (or any shorter period of time requested by the Individual) and that are otherwise subject to the accounting requirement in 45 C.F.R. § 164.528; (v) a brief statement of the purpose of the disclosure that reasonably informs the Individual of the basis for the disclosure or, if applicable, in lieu of such a statement, a copy of the Individual's authorization and a copy of the written request for disclosure.

2.14 **Accounting for Disclosures.** Business Associate agrees to provide to the Covered Entity or an Individual, in a time and manner mutually determined by the Parties, information collected in accordance with Section 2.11 of this Agreement so as to permit the Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528, provided, however, that to the extent that the Covered Entity uses or maintains an electronic health record with respect to Protected Health Information, Business Associate shall provide such accounting to the Individual (or, upon the request of the Covered Entity, to the Covered Entity for delivery to the Individual) of the disclosures required for the three-year period immediately

preceding the date on which the accounting is requested. The accounting of disclosures through electronic health records shall not be required earlier than the earliest applicable date established by the Secretary of HHS.

2.15 **Facilitate the Exercise of Privacy Rights.** Business Associate agrees to establish procedures that allow Individuals to exercise their rights under the Privacy Rule, including the right to (i) inspect and obtain copies of records and documents within the possession or control of the Business Associate that contain the Individual's Protected Health Information; (ii) request amendments to their Protected Health Information; (iii) receive an accounting of disclosures of their Protected Health Information by Business Associate; (iv) request restrictions on the use or disclosure of Protected Health Information; and (v) receive communications regarding Protected Health Information at alternative locations or by alternative means. Business Associate agrees that, to the extent that an Individual requests restrictions with respect to the disclosure of Protected Health Information, and such restrictions relate to disclosure to the Covered Entity for purposes of carrying out payment or health care operations (but not treatment), and the Protected Health Information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full, such restriction shall be followed.

2.16 **No Waiver of Rights.** Business Associate agrees to not require Individuals to waive their health information privacy rights as a condition for treatment, payment or enrollment in the Covered Entity, or eligibility for its benefits.

2.17 **Responses to Subpoenas.** In the event that Business Associate receives a subpoena, discovery request or other lawful process, with or without an order from a court or administrative tribunal, arising out of or in connection with the Covered Entity or this Agreement including, but not limited to, any use or disclosure of Protected Health Information or any failure in Business Associate's health data security measures, Business Associate shall fully comply with the notice and protective action obligations set forth in 45 C.F.R. § 164.512(e) in accordance with Business Associate's standard policy and procedures regarding subpoenas, discovery requests, and other lawful processes which shall be communicated to the Covered Entity upon request.

2.18 **Electronic Transactions.** To the extent required under HIPAA (including the Standards for Electronic Transactions at 45 C.F.R. Parts 160 and 162), Business Associate agrees to use or conduct, in whole or part, standard transactions and utilize code sets or identifiers under the Privacy Rule for or on behalf of the State of Nevada or the Covered Entity as detailed under the Privacy Rule or HIPAA (including the Standards for Electronic Transactions at 45 C.F.R. Parts 160 and 162). Business Associate shall also require any subcontractor or agent to also

comply with such electronic transaction requirements under HIPAA (including the Standards for Electronic Transactions at 45 C.F.R. Parts 160 and 162).

2.19 **Security Standards.** Business Associate acknowledges that it may need to issue and change procedures from time to time to improve electronic data and file security, and agrees that such measures shall be at least as stringent as may be required by the Privacy Rule or the Security Rule, as applicable. Notwithstanding the foregoing, Business Associate agrees and acknowledges that it shall at all times use an HHS-Approved Technology for all Protected Health Information that is in motion, stored or to be destroyed.

2.20 **Disclosures to Designated Plan Sponsor Representatives.** The State of Nevada shall identify for Business Associate, in writing, certain the State of Nevada employees who are authorized to discuss Protected Health Information with Business Associate in connection with an Individual's claim for benefits from the Covered Entity. To the extent that Business Associate is contacted by any such designated the State of Nevada representative in connection with an Individual's claim for benefits from the Covered Entity, Business Associate shall treat such inquiry as relating to "treatment, payment or healthcare operations" within the meaning of the Privacy Rule and shall provide the information permitted under such Privacy Rule.

2.21 **Notice of Privacy Practices.** Covered Entity shall prepare and distribute a notice of privacy practices as required by the Privacy Rule. If Business Associate maintains a web site on behalf of the State of Nevada or the Covered Entity that provides information about the Covered Entity's participant services or benefits, Business Associate shall make the notice of privacy practices available electronically through the web site and shall make certain that the notice of privacy practices is prominently posted on the web site.

ARTICLE III
Permitted Uses and Disclosures By Business Associate

3.01 **General Uses and Disclosures.** Except as otherwise limited by this Agreement, Business Associate agrees to create, receive, use or disclose Protected Health Information only in a manner that is consistent with this Agreement, the Privacy Rule and the Security Rule, and only in connection with providing Services to the State of Nevada and/or the Covered Entity, provided that such creation, receipt, use or disclosure would not violate the Privacy Rule or Security Rule if done by the Covered Entity, or the minimum necessary policies and procedures of the Covered Entity.

3.02 **Use and Disclosure for Treatment, Payment and Health Care Operations.** In providing Services, Business Associate shall be permitted to use and disclose

Protected Health Information for purposes of "treatment, payment and health care operations" in accordance with the Privacy Rule, including, but not limited to, using or disclosing Protected Health Information (i) to investigate, pay, audit and otherwise administer and facilitate the payment of health plan claims; (ii) to enroll or disenroll participants and beneficiaries in and/or confirm or deny participant and beneficiary eligibility for participation in the Covered Entity; and (iii) to coordinate the payment of benefits from the Covered Entity when a participant or beneficiary is enrolled in another health plan which provides similar benefits, provided, however, that any communication by Business Associate that is about a product or service and that encourages recipients of the communication to purchase or use the product or service shall not be considered a health care operation for purposes of 45 C.F.R. Part 164, subpart E, unless the communication is made in accordance with 45 C.F.R. § 164.501 and is approved in writing by Covered Entity.

3.03 **Use and Disclosure for Public Health, Health Oversight and Law Enforcement Purposes.** In providing Services, Business Associate shall be permitted to use and disclose Protected Health Information, in accordance with the Privacy Rule, (i) to provide needed information to government agencies engaged in public health, health oversight, law enforcement, and otherwise as Required by Law; and (ii) to report violations of law to appropriate Federal and State authorities, consistent with 45 C.F.R. § 164.502(j)(1).

3.04 **Use for Management and Administration of Business Associate.** Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information for the proper management and administration of the Business Associate (defined as those uses arising in the ordinary course of its business and as is customary in its industry) or to carry out the legal responsibilities of the Business Associate. Any such use shall be in accordance with the uses and disclosures permitted by the Privacy Rule.

3.05 **Disclosure for Management and Administration of Business Associate.** Except as otherwise limited in this Agreement, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate provided that the disclosures are Required by Law, or Business Associate (i) obtains the prior written approval of the Covered Entity for such use or disclosure, and (ii) obtains reasonable assurances from the person to whom the information is to be disclosed that (A) the information shall remain confidential, (B) the information shall be used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person, and (C) the person shall notify the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

3.06 **Use for Data Aggregation Services.** Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information to provide Data Aggregation services relating to the health care operations of the Covered Entity as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B).

3.07 **Prohibition on Sale of Electronic Health Records or Protected Health Information.** Effective with respect to exchanges occurring after the date that is six (6) months after issuance of final regulations, and except as provided in this Agreement or otherwise excepted under HITECH, Business Associate shall not directly or indirectly receive remuneration in exchange for any Protected Health Information of an Individual unless the Covered Entity or Business Associate has received a valid authorization (within the meaning of 45 C.F.R. § 164.508) that includes a specification that the Protected Health Information can be further exchanged for remuneration by the entity receiving the Protected Health Information of that Individual.

ARTICLE IV
Obligations of the Covered Entity

4.01 **Obligations to Notify Business Associate.**

(a) **Limitations in Notice of Privacy Practices.** Covered Entity shall notify Business Associate of any limitations in the Covered Entity's notice of privacy practices provided in accordance with the requirements of 45 C.F.R. § 164.520, to the extent such limitations may affect Business Associate's use or disclosure of Protected Health Information.

(b) **Changes in Permission by Individual for Use of Disclosure.** Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose Protected Health Information, if and to the extent that such changes affect Business Associate's use or disclosure of Protected Health Information.

(c) **Agreements to Restrict Use or Disclosure.** Covered Entity shall notify Business Associate of any restrictions on the use or disclosure of Protected Health Information or a request for confidential communication that the Covered Entity has agreed to pursuant to and in accordance with the requirements of 45 C.F.R. § 164.522, or shall direct Individuals to make any such request directly to Business Associate if and to the extent that such restriction or request may affect Business Associate's use or disclosure of Protected Health Information.

4.02 **Permissible Requests by Covered Entity.** Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner

that would not be permissible under the Privacy Rule or Security Rule if done by the Covered Entity, except that the Covered Entity may request that Business Associate perform Data Aggregation services pursuant to the provisions of Section 3.06 of this Agreement.

ARTICLE V
Term and Termination

5.01 **Term.** This Agreement shall terminate when all of the Protected Health Information provided by the Covered Entity to Business Associate, or created or received by Business Associate on behalf of the Covered Entity, is destroyed or returned to the Covered Entity or, if it is infeasible to return or destroy Protected Health Information, protections shall be extended to such information, in accordance with the termination provisions in this Article VI.

5.02 **Termination for Cause.** Upon the Covered Entity's knowledge of a material breach of this Agreement by Business Associate, the Covered Entity shall either (i) provide an opportunity for Business Associate to cure the breach or end the violation, and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time agreed to by the Parties; or (ii) immediately terminate this Agreement if a cure is not possible.

5.03 **Effect of Termination.**

(a) **Return or Destruction of Protected Health Information.** Except as provided in Section 5.03(b) of this Agreement, upon termination of this Agreement for any reason, Business Associate shall return or destroy (in accordance with the HHS-Approved Technology) all Protected Health Information received from the Covered Entity, or created or received by Business Associate on behalf of the Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

(b) **Extension of Protections for Retained Protected Health Information.** In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to the Covered Entity notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the Parties that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected

Health Information. The obligations of the Business Associate under this Agreement shall survive termination of this Agreement with respect to that Protected Health Information that Business Associate is unable to return or destroy.

ARTICLE VI
Miscellaneous

6.01 **Regulatory References.** A reference in this Agreement to a section in the Privacy Rule or the Security Rule means the section in the respective regulations, as amended and in effect at the relevant time.

6.02 **Amendment.** The Parties agree to take such action as is necessary to amend this Agreement from time to time in order for the Covered Entity to comply with the requirements of the Privacy Rule, the Security Rule, and HIPAA. All references to "C.F.R." are to the Code of Federal Regulations as amended and in effect at the relevant time.

6.03 **Survival.** The respective rights and obligations of Business Associate under Article VI of this Agreement shall survive the termination of this Agreement.

6.04 **Interpretation.**

(a) **Ambiguity.** Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits the Covered Entity to comply with the Privacy Rule or the Security Rule, as applicable.

(b) **Inconsistency.** In the event of an inconsistency between the provisions of this Agreement and the Privacy Rule or the Security Rule, as may be amended from time to time, as a result of interpretations by HHS, a court or another regulatory agency with authority over the Parties, the interpretation of HHS, such other court or regulatory agency shall prevail.

(c) **Non-Mandatory Provisions.** In the event provisions of this Agreement are not the same as those mandated by the Privacy Rule or the Security Rule, but are nonetheless permitted by the Privacy Rule or the Security Rule, the provisions of this Agreement shall control.

6.05 **Complete Integration.** This Agreement constitutes the entire agreement between the Parties with respect to HIPAA, the Privacy Rule, and the Security Rule, and supersedes all prior negotiations, discussions, representations or proposals, whether oral or written, unless expressly incorporated herein, related to the subject matter of the Agreement. Unless expressly provided otherwise herein,

this Agreement may not be modified unless in writing signed by the duly authorized representatives of the Parties.

6.06 **Severability.** If any provision or part of this Agreement is found to be invalid, the remaining provisions of this Agreement shall remain in full force and effect.

6.07 **No Third-Party Beneficiaries.** Except as expressly provided for in the Privacy Rule, the Security Rule, and the Agreement, there are no third-party beneficiaries to this Agreement. Business Associate's obligations, unless expressly noted herein, are only to the State of Nevada and the Covered Entity.

6.08 **Successors and Assigns.** This Agreement shall inure to the benefit of and be binding upon the successors and assigns of the State of Nevada, the Covered Entity, and Business Associate. However, this Agreement is not assignable by any Party without the prior written consent of the other Parties, which shall not be unreasonably withheld, except that (i) Business Associate, the Covered Entity, and the State of Nevada may assign or transfer this Agreement to any entity owned or under common control with Business Associate, the Covered Entity or the State of Nevada, respectively; and (ii) this Agreement shall automatically be assigned to any entity to which the agreement for provision of Services is properly assigned.

6.09 **Confidentiality.** Except as otherwise provided for in the Privacy Rule, the Security Rule, or this Agreement, no Party shall disclose the terms of this Agreement to any third party without the remaining Parties' written consent.

6.10 **Counterparts.** This Agreement may be executed in two or more counterparts, each of which may be deemed an original.

6.11 **Applicable Laws.** Business Associate represents and warrants that it shall comply with all applicable laws and regulatory requirements in the performance of this Agreement. The Parties agree to enter into good faith discussions aimed at amending this Agreement from time to time to comply with the requirements of HIPAA, the Privacy Rule, the Standards for Electronic Transactions at 45 C.F.R. Parts 160 and 162, the Security Rule, and related regulations and technical pronouncements, provided, however, that Business Associate shall also be responsible for complying with any state privacy or data security rules that are not contrary (within the meaning of 45 C.F.R. § 160.202) to HIPAA, the Privacy Rule, the Security Rule and related regulations and technical pronouncements and, to the extent applicable, that are more stringent (within the meaning of 45 C.F.R. §§ 160.202 and 160.203(b)) than a standard, requirement or implementation specification adopted under 45 C.F.R. Part 164.

6.12 **Governing Law.** This Agreement shall be governed by and construed in accordance with the same internal laws governing the Services provided to the State of Nevada or the Covered Entity by Business Associate.

6.13 **Applicability to Separate Covered Entities.** If, and to the extent that this Agreement applies to two or more separate "covered entities" (as defined in the Privacy Rule), the provisions of this Agreement regarding the permitted and required uses and disclosures (and limitations and conditions on such uses and disclosures) of Protected Health Information shall apply separately and independently to each such "covered entity", except to the extent otherwise agreed to by the Parties.

6.14 **Indemnification.** The State of Nevada, Covered Entity and Business Associate agree to indemnify and hold each other harmless from any and all liability, damages, costs (including reasonable attorneys' fees and costs), fines, penalties and expenses imposed upon or asserted against the non-indemnifying party arising out of the indemnifying party's use or disclosure of Protected Health Information contrary to the provisions of HIPAA, the Privacy Rule, the Security Rule, HITECH, this Agreement or other applicable law.

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed by their duly authorized representatives.

THE PARTIES ACKNOWLEDGE THAT THEY HAVE READ THIS AGREEMENT, UNDERSTAND IT, AND AGREE TO BE BOUND BY ITS TERMS.

Vendor	**State of Nevada on behalf of the Public Employees Benefits Program (PEBP)**
By: _____ Signature	By: _____ Signature
Print Name: Ty Windfeldt	Print Name: _____
Title: Vice President	Title: _____
Date: 11-30-2013	Date: _____