OFFICE FOR CONSUMER HEALTH ASSISTANCE

Policy Manual, Chapter 2800

AGING AND DISABILITY SERVICES DIVISION

2801 INTRODUCTION

The Office for Consumer Health Assistance (OCHA) assists healthcare consumers and injured workers with understanding their rights and responsibilities under various health care plans and insurance policies. The following services are available to Nevada residents regardless of insured status.

- Education and advocacy on health plans and coverage through an employer, managed care, individual health plans, Employee Retirement Income Security Act (ERISA), Nevada Workers' Compensation, Medicare, or Medicaid.
- Assistance in accessing and/or enrolling in healthcare and prescription medication assistance programs.
- Resources and information to those uninsured or underinsured.
- Mediation, arbitration, and resolution of medical billing disputes.

2810 ELIGIBILITY AND INTAKE

Healthcare consumers can contact OCHA directly or to make a request for assistance or a report can be made by a person on behalf of the consumer. OCHA intake staff are responsible for providing consumers with information about OCHA services, gathering confidentiality forms, and providing referrals as needed. The intake staff process consumer complaints and submit them to the supervisor for review and assignment.

2820 CASE MANAGEMENT (RESERVED)

2821 MEDIATION, APPEALS, ARBITRATION

The Bureau of Hospital Patients (BHP) unit within OCHA provides mediation, arbitration, and resolution to medical billing disputes between patients and hospitals. OCHA assigns external review entities for consumers or physicians appealing an adverse determination from their health carrier.

OCHA provides neutral party arbitrators to resolve disputes between out-of-network providers and third parties involving claims of less than $5,000.

The out-of-network provider/facility is one of two parties disputing a claim for medically necessary emergency services provided out-of-network. The provider initiates the arbitration by submitting a Request for Arbitration to OCHA and submitting all required arbitration documents within the timeframes established in state law (NRS 439B.754).

The third party, otherwise known as the health carrier, is the other party involved in arbitration. The third party is the payor of the claim (meeting arbitration limits and

criteria), for which the out-of-network provider is seeking additional reimbursement. The third party is responsible for submitting relevant information to OCHA within the timeframes established in state law (NRS 439B.754). If the third party is the non-prevailing party in the arbitration, they have the responsibility of paying the costs of the arbitrator (See Manual Section 2871).

OCHA staff working on arbitration are responsible for documenting their time spent on the same day the activity occurs and ensuring that all tracking is entered before the arbitration determination is complete. Time spent must be tracked for following activities performed:

- Arbitrator review of the arbitration records and entering arbitration determinations and decisions into the designated electronic system of record.
- Administration time spent on arbitration which cannot be attributed to an individual arbitration (e.g., meeting to discuss processes, preparing and validating arbitration reports, and communicating with arbitration parties).
- Correspondence process of preparing and filing arbitration documents.
- Entering arbitration data into the designated electronic system of record to include new applications, correspondence, and receipt of relevant documentation/information.
- Document process of preparing documents received from arbitration parties (e.g., date stamping, sorting, filing, and naming documents for upload).
- Screening/reviewing each request for arbitration application for completeness and eligibility to continue the arbitration process.
- Once the arbitration determination has been made and approved by the Arbitration manager, a Notice of Determination letter created by the designated electronic system of record will be issued to the provider and their third party.

2830 INDIVIDUAL RIGHTS AND APPEALS (RESERVED)

2840 ELECTRONIC RECORDS (RESERVED)

2841 QUALITY ASSURANCE & COMPLIANCE (RESERVED)

2860 PROVIDER INFORMATION (RESERVED)

2870 BILLING/FISCAL MANAGEMENT (RESERVED)

2871 ARBITRATION COSTS

Pursuant to NRS 439B.754 (7), OCHA will recover arbitrator costs from the non-prevailing party for the arbitrators time to complete an arbitration, which may vary depending on the relevant information provided and the complexity of the arbitration. The arbitrator's hourly cost is established by OCHA and subject to change.

Upon issuance of the Notice of Determination, created by the designated electronic system of record the time tracking will be calculated on an invoice and issued to the non-prevailing party. Payment from the non-prevailing party is due within 30 days of the invoice mail date. Any invoice not paid timely will receive a 2nd invoice after day 30, and a 3rd and final notice at 60 days along with a call to the appropriate party to inquire about the past due invoice. Any unpaid invoices after the 3rd and final notice will be sent to State Collections. See OCHA Arbitration Internal Invoice Process Job Aid (OCHA-BF-JA-01).

June invoices will be processed in June to allow for end of State Fiscal Year deadlines.

2880 RESERVED

2890 RESERVED

2898 AUTHORITY

NRS 232.459

NRS 232.462

NRS 439B.754-439B.760

NRS 695G.241-695G.310

2899 ACRONYMS & DEFINITIONS

Arbitrator: Employees of the Office for Consumer Health Assistance of the Department who are qualified to arbitrate a dispute of a claim under $5,000 for medically necessary emergency services provided out-of-network.

Arbitration: The process of resolving disputes outside the courts by using an impartial party who makes a decision or an award after hearing both sides.

Bureau for Hospital Patients (BHP): Program within the Office for Consumer Health Assistance that mediates, arbitrates, or resolves medical billing disputes between patients and hospitals.

Consumer: State of Nevada healthcare consumers and injured workers with issues or concerns involving their health plans including appeals, grievances, external review requests, eligibility, billing, benefit and/or claim denial.

Employee Retirement Income Security Act (ERISA): A federal law that sets minimum standards for most voluntarily established retirement and health plans in private industry to provide protections for individuals in these plans.

External Review Organization (ERO): An entity that conducts independent external reviews of adverse determinations and final adverse determinations of a health carrier regarding medical necessity, appropriateness, healthcare setting, level of care or effectiveness of a healthcare service or treatment, or healthcare provider compensation.

Health Benefit Plan: A policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

Health Carrier: An entity subject to insurance laws and regulations of this State, or subject to the jurisdiction of the Commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for reimbursement any of the costs of health care services, including, without limitation, a sickness and accident health insurance company, a health maintenance organization, a nonprofit hospital and health services corporation or any other entity providing a plan of health insurance, health benefits or health care services.

Ombudsman (OMB): An employee of the Office for Consumer Health Assistance who assists consumers and insured employees with understanding their rights and responsibilities under various health care plans and policies of industrial insurance. AKA Consumer Health Advocate.

Out-of-Network Emergency Facility: Means a hospital or independent center for emergency medical care that is an out-of-network provider.

Out-of-Network Provider: A provider of health care that has not entered into a provider contract with a third party for the provision of health care to the covered person. (NRS 439B.721)

Reporter: The person who contacts OCHA on behalf of a consumer. The role and responsibility of the reporter ends once the request for assistance has been made to OCHA.

Third Party: Also referred to as the health carrier. The issuer of a health benefit plan which provides coverage for medically necessary emergency services; the Public Employees Benefits Program; any other entity or organization that elects to apply the

provisions of medically necessary emergency services by out-of-network providers to covered persons (e.g., ERISA plans). (NRS 439B.736)