ProviderInsight®

Nevada Edition
November 2025

Welcome!

Find medical and pharmacy information as well as program and plan updates for:

- Commercial
- Select Health Medicare

Select Health

In this Issue

Select Health News and Networks

Compliance Matters: Nevada Provider Surveys

Select Health provider surveys fall into two categories:

1. **Regulatory** — Required by state and federal agencies to ensure compliance with specific care standards, these surveys focus on aspects of health plan service (e.g., timely access, provider satisfaction, enrollee satisfaction).
2. **Accreditation** — Mandated by organizations such as the National Committee for Quality Assurance (NCQA). NCQA Health Plan Accreditation requires consistent monitoring of:
   - Practitioner availability and accessibility of services
   - Provider directory usability and accuracy
   - Efficient collection and analysis of member experience data.

To maintain certification, Select Health must demonstrate our ability to perform in alignment with NCQA standards for:

- Quality management and improvement
- Population health management
- Network management
- Utilization management
- Credentialing, recredentialing
- Member rights and responsibilities
- Member connections
- Provision of benefits

Use Figure 1 below to plan for upcoming Nevada provider surveys. **Survey timing can be subject to change as new surveys or timing requirements change.**

Questions about compliance? Contact your Provider Relations representative at nvproviderrelations@selecthealth.org.

Figure 1. Select Health Nevada Provider Survey Overview

Nevada Provider Survey Name (Cadence)	Required by:	Survey Timing
Quarterly Attestations for Provider Directory Info (Quarterly)	Various CMS, NCQA, and state mandates	Quarterly
Provider End-of-Year Experience Survey (Annual)	Select Health Business Practice for Improving Provider Experience	Q1
Clinic Manager End-of-Year Experience Survey (Annual)		
Appointment Wait Times Survey (Annual)	NCQA NET 2: Element A	Q2
QPP Experience Survey (participating clinics only) (Annual)	Select Health Business Practice for Improving Provider Experience	Q2
Appointment Wait Times Secret Shopper Survey[1] (Annual)	CMS 2023 Letters to Issuers Ch. 2, Sect. 3.ii.b	Q1-Q2
After-Hours Audit (Annual)	NCQA NET 2: Element A	Q4

[1] This survey is used to evaluate quality health plan issuers' compliance with appointment wait time standards through simulated patient calls performed by a third-party vendor.

Focus on Glycemic Control Monitoring

In 2024, the National Committee for Quality Assurance (NCQA) revised the name of the HEDIS measure, "Hemoglobin A1c Control for Patients With Diabetes (HBD)" to "Glycemic Status Assessment for Patients With Diabetes (GSD)." This change added the glucose management indicator (GMI), which calculates continuous glucose monitoring (CGM) data using average glucose levels.

Figure 2. Comparing HbA1c and GMI1

Hemoglobin A1c:	Glucose Management Indicator (GMI)
Lab test	CGM monitor reading
Reflects 2–3 months average glucose	Reflects estimated A1c from ≥14 days of CGM data
May be skewed by anemia, kidney disease, or hemoglobin variants	Can be more reflective of real-time glucose trends

Figure 2 at right provides an overview of the key differences in the two measurements. The GSD:

- Assesses the glycemic status control in patients aged 18–75 with type I & II diabetes
- Includes both hemoglobin (HbA1c) and glucose management indicator (GMI) values with targets of:
  - Good Control: HbA1c or GMI < 8.0%
  - Poor Control: HbA1c or GMI > 9.0%
- Uses medical and pharmacy claims data to identify patients

KEY UPDATES

- HbA1c in the HEDIS measure is now stated as "glycemic status" with a glycemic status goal <8%.
- Continuous glucose monitor GMI results can now be used in addition to HbA1c.
- **LOINC code 97506-0** is used to identify GMI values in the chart and must include:
  - Documentation of the continuous glucose monitoring including a result
  - Date range associated with the GMI. The end date of the range is used for the assessment date.
- Results from the most recent glycemic status assessment (HbA1c or GMI) performed during the measurement year will count towards compliance.

BEST PRACTICE TIPS:

- Test A1c 2 to 4 times annually and provide education on lab results, adjusting treatment plans as needed.
- Follow-up with patients whose A1c >8% for re-testing every 3 months.
- Use clinic gap reports to track patients with A1c > 8%, and recall those members for GMI or A1c checks every 3 months.
- Set care gap alerts in your electronic medical record when screenings are due.
- Outreach to patients who have not had their diabetic testing and eye exams completed.
- Document HbA1c or GMI result date and numeric value in the medical record. Ensure that:
  - A1c results include date collected **OR** reported **AND** numeric results.
  - CGM results include **EITHER**:
    - 14-day CGM date range (terminal date used as assessment date) **AND** GMI numeric result **OR**
    - An upload of 14-day CGM data report (for QPP participating clinics only).
- Incorporate a GMI workflow to assess blood sugar control for those who use a CGM.

Continued on page 4...

NOTE: Currently, there are no CPT II codes for GMI.

- Remember to include CPT II HbA1c codes to help reduce the burden of HEDIS medical record chart review.
- Use the codes shown in **Figure 3** (at right) on the date of service the HbA1c was drawn. If using an electronic health record (EHR) system, please consider electronic data sharing with Select Health to help us capture the glycemic status values. This will help reduce HEDIS chart requests and improve the quality of care we can provide our members. If interested, please email us at qualityimprovement@selecthealth.org.

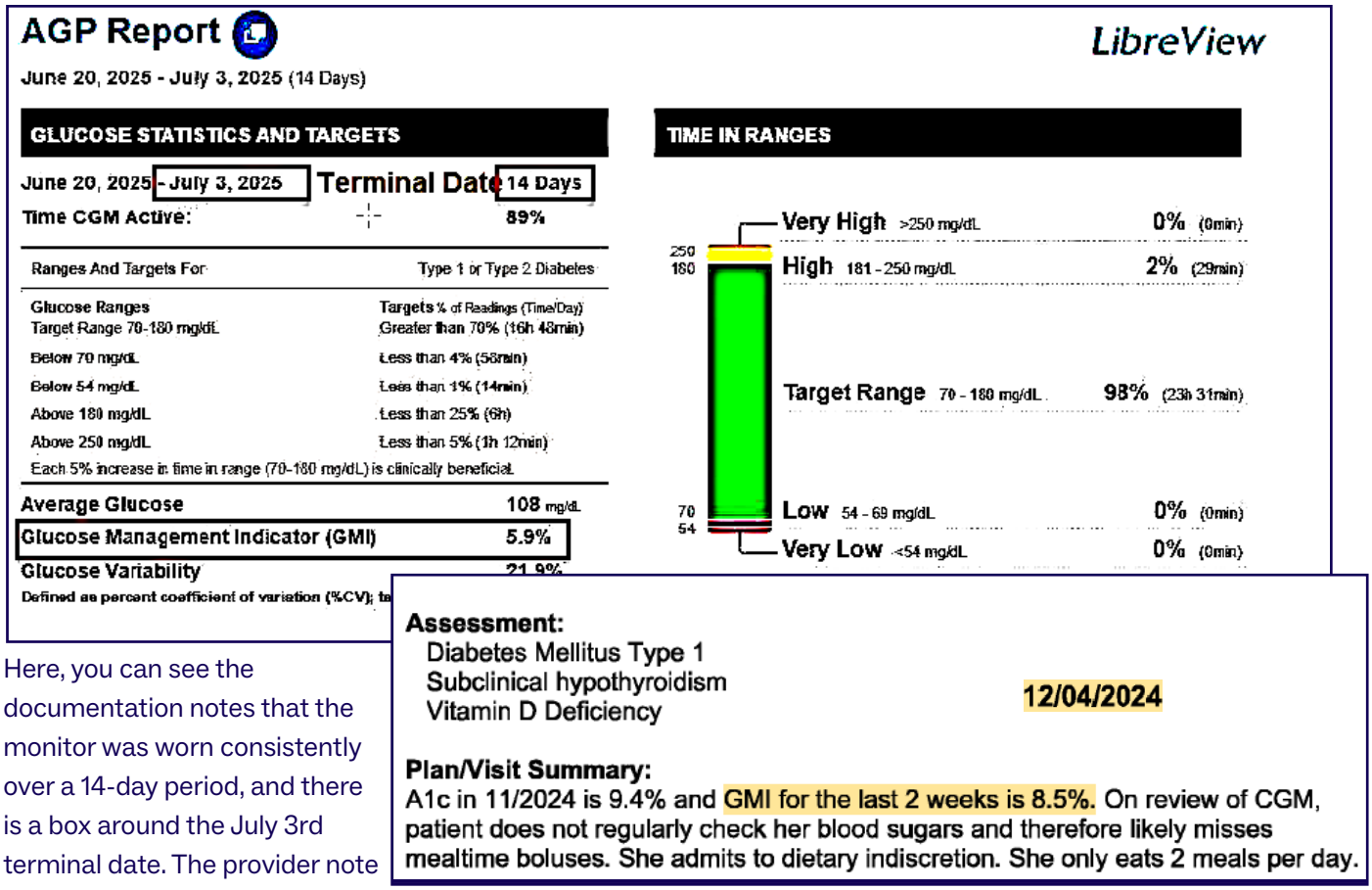
Figure 3. CPT II HbA1c Codes

CPT II Codes	Hemoglobin A1c Levels
3044F	<7.0%
3051F	≥7% and ≤8.0%
3052F	≥8.0% and ≤9.0%
3046F	>9.0%

WHAT DOES CORRECT DOCUMENTATION LOOK LIKE?

Figures 4 and 5 (below and on the next page) illustrate examples of correct documentation for the GMI measure.

Figure 4. CGM Example Report Data and Provider Note



AGP Report

LibreView

June 20, 2025 - July 3, 2025 (14 Days)

GLUCOSE STATISTICS AND TARGETS

June 20, 2025 - July 3, 2025 Terminal Date 14 Days

Time CGM Active: 89%

Ranges And Targets For	Type 1 or Type 2 Diabetes
Glucose Ranges	Targets % of Readings (Time/Day)
Target Range 70-180 mg/dL	Greater than 70% (16h 48min)
Below 70 mg/dL	Less than 4% (58min)
Below 54 mg/dL	Less than 1% (14min)
Above 180 mg/dL	Less than 25% (6h)
Above 250 mg/dL	Less than 5% (1h 12min)

Each 5% increase in time in range (70-180 mg/dL) is clinically beneficial.

Average Glucose	108 mg/dL
Glucose Management Indicator (GMI)	5.9%
Glucose Variability	21.9%

Defined as percent coefficient of variation (%CV); ta

TIME IN RANGES

Assessment:
Diabetes Mellitus Type 1
Subclinical hypothyroidism
Vitamin D Deficiency

12/04/2024

Plan/Visit Summary:
A1c in 11/2024 is 9.4% and GMI for the last 2 weeks is 8.5%. On review of CGM, patient does not regularly check her blood sugars and therefore likely misses mealtime boluses. She admits to dietary indiscretion. She only eats 2 meals per day.

Here, you can see the documentation notes that the monitor was worn consistently over a 14-day period, and there is a box around the July 3rd terminal date. The provider note says that the GMI for the "last 2 weeks" is 8.5%. In this case, we would use the office visit date as the GMI result date; the GMI is 5.9%.

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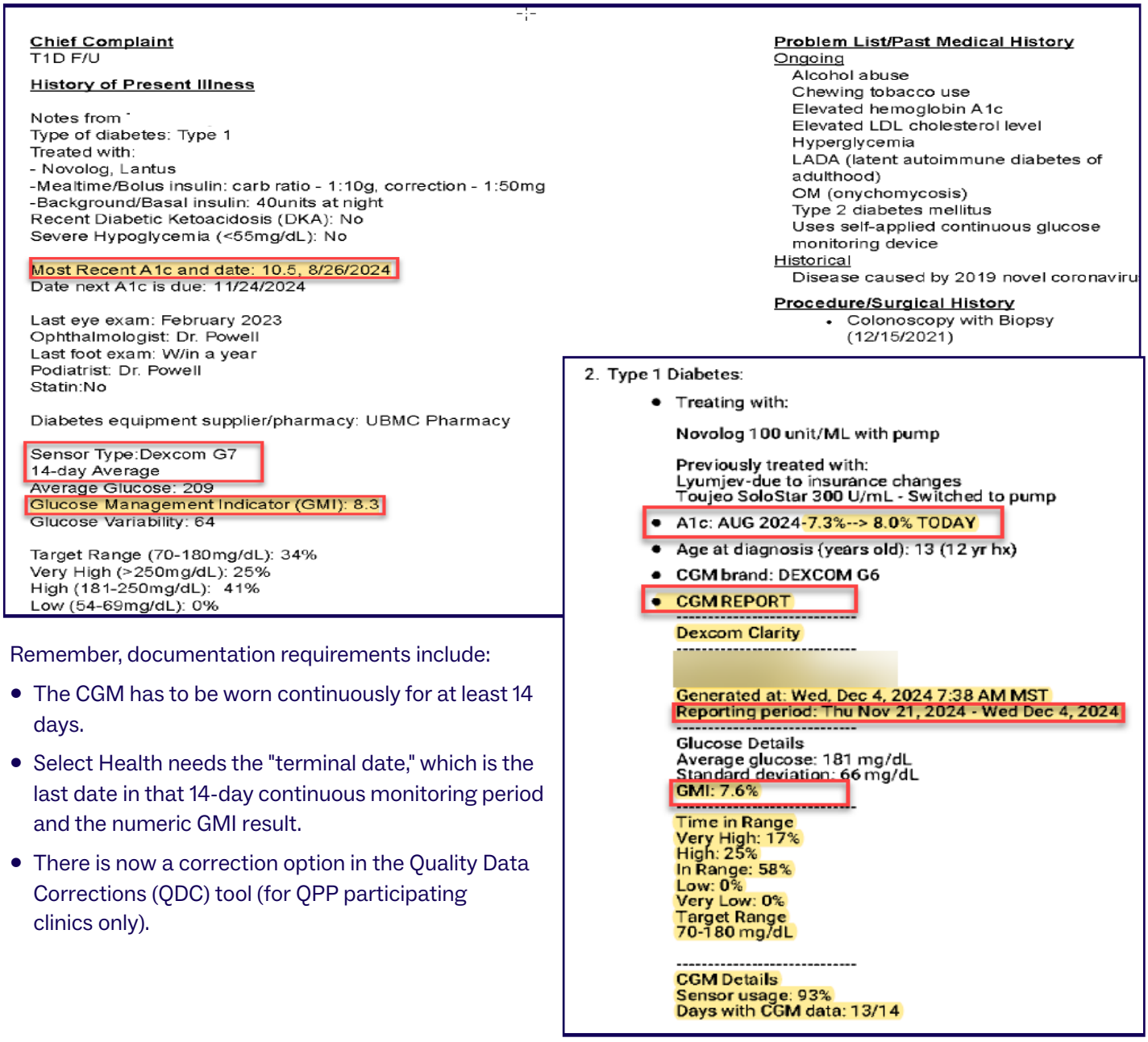
This example in **Figure 5** below has the 14-day date range in the note as well as the GMI result. The terminal date is the last date in that 14-day date range and is December 4. If there is an A1c and GMI on the same day, Select Health can accept the lower one. The latest one taken in the year is what will count towards the measure.

Figure 5. Other Provider Note Examples



Chief Complaint
T1D F/U

History of Present Illness

Notes from
Type of diabetes: Type 1
Treated with:
- Novolog, Lantus
-Mealtime/Bolus insulin: carb ratio - 1:10g, correction - 1:50mg
-Background/Basal insulin: 40units at night
Recent Diabetic Ketoacidosis (DKA): No
Severe Hypoglycemia (<55mg/dL): No

Most Recent A1c and date: 10.5, 8/26/2024
Date next A1c is due: 11/24/2024

Last eye exam: February 2023
Ophthalmologist: Dr. Powell
Last foot exam: W/in a year
Podiatrist: Dr. Powell
Statin:No

Diabetes equipment supplier/pharmacy: UBMC Pharmacy

Sensor Type:Dexcom G7
14-day Average
Average Glucose: 209
Glucose Management Indicator (GMI): 8.3
Glucose Variability: 64

Target Range (70-180mg/dL): 34%
Very High (>250mg/dL): 25%
High (181-250mg/dL): 41%
Low (54-69mg/dL): 0%

Problem List/Past Medical History
Ongoing
Alcohol abuse
Chewing tobacco use
Elevated hemoglobin A1c
Elevated LDL cholesterol level
Hyperglycemia
LADA (latent autoimmune diabetes of adulthood)
OM (onychomycosis)
Type 2 diabetes mellitus
Uses self-applied continuous glucose monitoring device
Historical
Disease caused by 2019 novel coronaviru

Procedure/Surgical History
- Colonoscopy with Biopsy (12/15/2021)

2. Type 1 Diabetes:
- Treating with:

Novolog 100 unit/ML with pump

Previously treated with:
Lyumjev-due to insurance changes
Toujeo SoloStar 300 U/mL - Switched to pump
- A1c: AUG 2024-7.3%--> 8.0% TODAY
- Age at diagnosis (years old): 13 (12 yr hx)
- CGM brand: DEXCOM G6
- CGM REPORT

Dexcom Clarity

Generated at: Wed, Dec 4, 2024 7:38 AM MST
Reporting period: Thu Nov 21, 2024 - Wed Dec 4, 2024

Glucose Details
Average glucose: 181 mg/dL
Standard deviation: 66 mg/dL
GMI: 7.6%

Time in Range
Very High: 17%
High: 25%
In Range: 58%
Low: 0%
Very Low: 0%
Target Range
70-180 mg/dL

CGM Details
Sensor usage: 93%
Days with CGM data: 13/14

Remember, documentation requirements include:

- The CGM has to be worn continuously for at least 14 days.
- Select Health needs the "terminal date," which is the last date in that 14-day continuous monitoring period and the numeric GMI result.
- There is now a correction option in the Quality Data Corrections (QDC) tool (for QPP participating clinics only).

REFERENCE:

1. Selvin E. The glucose management indicator: Time to change course? *Diabetes Care*, 2024. 47(6), 906-914.

Other HEDIS Measures Information

Follow-up After ED Visit for People with Multiple High-Risk Chronic Conditions (FMC)

The FMC measure looks at the percentage of members 18 years of age and older, who have had (all three):

- Multiple high-risk chronic conditions
- An emergency department (ED) visit
- A follow-up service within 7 days of the ED visit

These members are at higher risk of mortality and readmission than members without chronic conditions, so it's crucial to get them in for a follow-up visit as soon as possible after the ED visit.

WHAT ARE THE FMC HIGH-RISK CHRONIC CONDITIONS?

- Chronic obstructive pulmonary disease (COPD), asthma, or unspecified bronchitis
- Alzheimer's disease and related disorders
- Chronic kidney disease
- Depression
- Heart failure
- Acute myocardial infarction
- Atrial fibrillation
- Stroke and transient ischemic attack

HOW CAN YOU HELP CLOSE THIS OPEN GAP FOR YOUR PATIENTS?

- Encourage patients to schedule a follow-up visit within 7 days of an ED visit. You can remind them at their annual wellness visits.
- Encourage patients to utilize other follow-up services like telehealth or care management if unable to make an in-person visit within the 7-day timeframe.
- Remind members who may visit the ED often that they can utilize telehealth or their PCP instead.
- Consider receiving notifications from hospital systems when one of your patients has visited an ED so you can assist these patients with scheduling a follow-up visit.

Learn more by accessing NCQA's related online materials.

Questions about these HEDIS updates?
Contact Azure Gaskill, Quality Consultant RN, at azure.gaskill@selecthealth.org.

Kidney Health Evaluation for Patients with Diabetes

For the Kidney Health Evaluation (KED) measure, it is very important that providers know the changes necessary to be compliant. **Figure 6** indicates tests recommended to detect and manage kidney disease in patients with diabetes.

QUANTITATIVE URINE ALBUMIN ORDERS

Providers must order a **quantitative urine albumin** if ordering the urine albumin and urine creatinine separately. **NOTE**: A semi-quantitative urine albumin is **NOT** considered compliant for the KED measure.

Providers should continue ordering any tests necessary for their patient's care. The codes listed in **Figure 7** below are those that close an open care gap.

CODING CHANGES

For a quantitative urine albumin test, CPT code **82044** was removed from the acceptable codes, and now only **82043** is acceptable.

For measure compliance, both tests must be completed:

- **Urine test — urine albumin-creatinine ratio (uACR).** This can be ordered as a separate quantitative urine albumin test and a urine creatinine test as long as they have service dates four days or less apart.
- **Blood test — estimated glomerular filtration rate (eGFR).**

Learn more about the KED measure and coding changes, visit the National Committee for Quality Assurance (NCQA) website.

Questions? Contact Azure Gaskill, Quality Consultant RN at azure.gaskill@selecthealth.org.

Figure 6. Coding for KED in Patients with Diabetes

TEST	CPT CODES	LOINC CODES
Urine albumin creatinine ratio lab test	N/A	9318-7, 13705-9, 14958-3, 14959-1, 30000-4, 44292-1, 59159-4, 76401-9, 77253-3, 77254-1, 89998-9
Quantitative urine albumin lab test (**cannot** be semi-quantitative)	82043	1754-1, 14957-5, 21059-1, 30003-8, 43605-5, 53530-2, 53531-0, 57369-1, 89999-7, 100158-5
Urine creatinine lab test	82570	2161-8, 20624-3, 35674-1, 39982-4, 57344-4, 57346-9, 58951-5
Estimated glomerular filtration rate lab test	80047, 80048, 80050, 80053, 80069, 82565	50044-7, 50210-4, 50384-7, 62238-1, 69405-9, 70969-1, 77147-7, 94677-2, 98979-8, 98980-6, 102097-3

Pharmacy Compass: New Scripius Tool for Managing Prescription Costs

Help your Select Health patients access a new tool for saving on their prescriptions.

Most Select Health members and users of its Pharmacy Benefit Manager (PBM), Scripius, now have access to Pharmacy Compass, a powerful new tool for managing prescription costs. Your Select Health patients will love the upfront transparency with no surprises at the pharmacy counter, all through a user-friendly design that is easy to navigate.

WHAT IS PHARMACY COMPASS?

Pharmacy Compass is a digital tool for members to compare medication prices, explore lower-cost alternatives, and make informed decisions before heading to the pharmacy. It simplifies the process of finding the right drug at the right price.

Talk to your Select Health patients about Pharmacy Compass. With this new tool, they can:

- Compare prices across insurance, discount cards, and coupons.
- Discover generic or therapeutic equivalents that may offer additional savings.
- Choose the pharmacy that best fits their budget and convenience.

GETTING STARTED IS SIMPLE

Members can:

1. Log in to their Select Health member account.
2. Click on “Find Care.”
3. Select “Drug Lookup.”
4. Click the link to “Pharmacy Compass.”

MORE WAYS YOUR SELECT HEALTH PATIENTS CAN SAVE ON PRESCRIPTIONS

1. **Mail order and online pharmacies.** Scripius and Select Health also offer in-network online and mail-order pharmacies that may provide lower prices than traditional retail options.
   - — Intermountain Home Delivery Pharmacy: Ideal for maintenance medications, this service offers convenient 90-day supplies* — often at better rates than 30-day fills.
   - — Mark Cuban Cost Plus Drug Company: This online pharmacy offers transparent pricing and may provide significant savings on common medications.
   - — Amazon Pharmacy: A convenient delivery option with potential savings, especially for Amazon Prime members.
2. Rx Savings Solutions: Personalized prescription savings. Another way Scripius helps members cut costs is through **Rx Savings Solutions**, especially for members using long-term or maintenance medications. This service analyzes prescriptions and identifies potential savings strategies, such as:
   - — Switching to a lower-cost, equally effective medication
   - — Asking their doctor for a higher dosage and split pills to reduce costs
   - — Accessing discount cards and coupons directly through their member account

For identified savings opportunities, Rx Savings Solutions will coordinate with the member’s prescriber and pharmacy to update the prescription.

* Depending on the medication and a member's plan benefits, some Medicare members can receive 100-day supplies.

Based on article published in *Caregiver Insights*, an internal Intermountain Health publication. Author Brady Snyder.

Substance Use Disorders: Follow-up HEDIS Measures Drive Meaningful Change

The Healthcare Effectiveness Data and Information Set (HEDIS) is one of healthcare's most widely used performance improvement tools. Three HEDIS measures focus on follow-up care for substance use disorders. These measures are:

1. **FUI — Follow-Up After High-Intensity Care for Substance Use Disorder**, which measures the percentage of substance use disorders (SUD) patients who had a follow-up visit after an acute inpatient stay, residential treatment, or detoxification. This measure's goal is to ensure timely transition to outpatient or continuing care after intensive treatment at:
   - 7-Day Follow-Up (FUI-7)
   - 30-Day Follow-Up (FUI-30)
2. **IET — Initiation and Engagement of Substance Use Disorder Treatment, which measures:**
   - **Initiation**: A follow-up visit **within 14 days** of a new SUD diagnosis
   - **Engagement:** At least **2 additional visits** 34 days after initiation

   The goal of this measure is to promote early and sustained treatment engagement for newly diagnosed individuals.
3. **FUA —Follow-Up After Emergency Department (ED) Visit for Substance Use,** which measures the percentage of ED visits with a principal diagnosis of SUD, or any diagnosis of drug overdose that had a follow-up visit. Using the same time frames as FUI (see #1 above), this measure's goal is to reduce relapse and improve outcomes by ensuring timely outpatient care after ED discharge.

HOW CAN PROVIDERS ENSURE TIMELY FOLLOW UP?

Encourage providers and staff to:

- **Offer** telehealth and phone visits.
- **Schedule** the first visit within 7 days.
- **Code** substance-related diagnoses and visits correctly on claims.
- **Partner with the Select Health** and assess for peer support and care management referrals.
- **Coordinate care** between physical and mental health providers.
- **Educate** on relapse prevention and treatment options

WHAT ARE ELIGIBLE FOLLOW-UP CARE SETTINGS AND SERVICES FOR SUD?

Eligible care settings for SUD follow up include:

- Telehealth, telephone, or virtual visit
- Outpatient visit
- Observation visit
- Intensive outpatient encounter or partial hospitalization
- Nonresidential SUD facility
- Community mental health center visit
- Residential (BH) Treatment Center (**for FUI only**)
- Acute and Non-acute Inpatient (**for FUI and IET only**)

Eligible care services for follow-up SUD care include:

- Opioid Treatment
- Substance Use Service
- Medication-Assisted Treatment for Alcohol or Opioid
- Peer support (**for FUA only**)

Medicare News

Medicare Advantage Plan Availability Changes

Effective **January 1, 2026**, Select Health Medicare will no longer offer a PPO Medicare Advantage contract in Nevada. **Figure 7** indicates the Medicare plans offered for 2026.

Figure 7. Nevada Medicare Plans Offered in 2026

MEDICARE PLANS FOR 2026			
Select Health Medicare Essential (HMO)	Select Health Medicare + Kroger (HMO)	Select Health Medicare Wellness (HMO)	Select Health Medicare Dual-eligible Special Needs Plan (HMO-DSNP)

Since this change may affect some of your patients, please be aware that these members have been advised to enroll in a different Medicare plan prior to **January, 2026**.

We are working with these members to find suitable replacement plans to meet their ongoing needs. Members can also choose one of the Select Health Medicare HMO plans listed above.

Questions about these changes? Contact Select Health Member Services at **855-442-9900** weekdays from 7:00 a.m. to 8:00 p.m. and weekends from 8:00 a.m. to 8:00 p.m.

New Medical Savings Account

Select Health's new Group Medical Savings Account (MSA) is a unique and simple, employer-offered plan operating more like Original Medicare than other Medicare Advantage plans.

Select Health uses Fenyx Health, the nation's MSA leader, to administer our MSA plan.

WHY IS AN MSA BETTER FOR PROVIDERS?

- **Reduce billing and recovery efforts** — The Select Health Group MSA pays 100% of the Medicare-allowed amount, so no additional billing is required.
- **No additional prior authorizations or referrals** beyond those required by Medicare.
- **No contract required** to see patients or bill/receive payment from the MSA.
- **Simple reimbursement** — the Select Health Group MSA pays as Original Medicare pays, using Medicare's payment schedules and benefit/medical policies.
- **No credentialing hassles.**

HOW DO I GET MSA SUPPORT?

The Select Health Group MSA is supported exclusively by Fenyx Health, the nation's MSA leader. To get support, contact Select Health Group MSA directly using these channels:

- Call: **855-511-1514**
- Email: providers@selecthealthgroupmsa.org

HOW DO I LEARN MORE ABOUT THE SELECT HEALTH MSA?

Access online MSA information on claim submission, reimbursements, sample ID cards, and more.

Practice Management Resources

January 1, 2026 — Zelis Go Live!

On January 1, 2026, Select Health will manage all provider payments via the Zelis Payment Network. This change is being made to improve the speed, accuracy, and security of Select Health payments. If you have not done so already, we encourage your office to enroll in Zelis to enjoy maximum payment convenience.

HOW TO ENROLL IN THE ZELIS EPAYMENT CENTER

You will need:

- Federal tax identification number (TIN) or employer identification number (EIN)
- Your practice's corporate name and principal information
- Bank account routing transit number (RTN) or ABA routing number
- Bank account number

Steps to enroll:

1. Visit the Select Health ePayment Center.
2. Choose "No" when asked if you have a registration code. Complete the online form with information about your practice, and "Submit Request."
3. You will receive an email with a link; follow that link to complete your registration and set up your account.
4. Log in to the ePayment Center portal, and enter your bank account information.
5. Review and accept the ACH Agreement (if applicable to the payment type you choose; see below). Then, click "Submit."
6. Zelis will validate your bank account prior to beginning electronic fund transfer.

ZELIS PAYMENT TYPES

After enrolling, you can use any of the Zelis payment options. Contact Zelis using the information in **Figure 8** below to set up or change your payment type.

Figure 8. Zelis Payment Types

Payment Type	Basic Function	Provider Cost	Get Started or Change Type
ePayment Center	Direct settlement into provider bank account	None	• Register online. • Contact Zelis at: (855) 774-4392; or via email at help@epayment.center.
Paper Check	Cost-efficient paper check delivery		
Virtual Card	Virtual card processed via card terminal	Fee Required	Call: **(877) 828-8770**
ACH+	Direct settlement into provider bank account*		

* ACH+ Solution offers providers a unique payment experience over a traditional electronic funds transfer (EFT). With ACH+, provider payments, 835s delivery, and customer service are all managed under one seamless connection.

Now Available — Preauth & Care Plan Tool for Our Commercial Networks

On **September 15, 2025**, Select Health moved to a new online tool for **Commercial plan medical preauthorization requests**. The Preauth & Care Plan Tool brings a variety of updates and features to the online preauthorization process, including:

- Enhanced workflow automation
- Added care management functionality
- Improved dashboard experience

Register Now

GET UP TO SPEED QUICKLY

Whether you've already started using the Preauth & Care Plan tool or are just getting set up, check out these online resources to help make the transition smooth and simple:

- Sign up instructions
- Training videos
- FAQs
- **PDF guides**
  - — Quick Guide: Inpatient Requests
  - — Quick Guide: Outpatient Requests
  - — How to Check Authorization Status
  - — How to Access Letters
  - — How to Submit a Request for Auto-Approval

Reminder: You can view/monitor requests that were submitted in CareAffiliate® until **March 15, 2026**. All online medical preauthorization requests for members on Commercial plans, which are created on or after **September 15, 2025**, should be submitted through the Preauth & Care Plan tool. (This change does not apply to preauthorization requests submitted through PromptPA, email, or fax.)

Questions? Contact us at **web.preauth.support@selecthealth.org** with any questions or concerns.

Care Management Services: A Hidden Treasure for Providers & Patients

Select Health Care Management services (**available for Commercial plan members in Nevada**) are like a hidden treasure — full of support, guidance, and resources that many providers don't even know exist. That's why we're launching a new initiative to raise awareness. Care Management can make a meaningful difference, especially when patients' health journeys become challenging and extra support is needed.

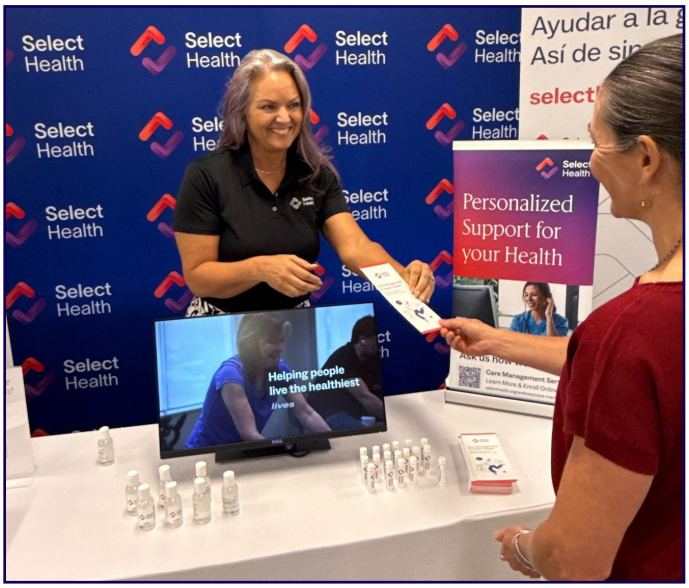
WHAT DO CARE MANAGERS DO?

- Help members understand how to successfully manage chronic conditions like diabetes, heart disease, or COPD
- Coordinate care between doctors, specialists, and community resources
- Address barriers, such as transportation, housing, and food security
- Provide education and encourage healthy habits
- Advocate for members within the healthcare system, and ensure they receive the care they need

A REAL-LIFE EXAMPLE

Meet Maria, a patient living with congestive heart failure. As her physician, you collaborate with a dedicated care manager at Select Health who serves as an extension of your clinical team. The Care Manager helps translate your treatment plan into actionable steps for Maria, ensuring she understands her medications and follows your recommendations. When Maria faces barriers, such as difficulty getting to appointments, her care manager helps arrange transportation. If she feels anxious about her condition, her care manager provides emotional support and connects her to counseling services.

By addressing Maria's social determinants of health, care management enables you to focus on clinical decision-making while knowing that she receives comprehensive support outside the exam room. This partnership not only improves patient outcomes but also reduces administrative burdens and ensures that care plans are followed between visits. Through ongoing guidance and advocacy, Maria feels empowered to manage her health and improve her quality of life.



HOW TO ACCESS CARE MANAGEMENT

If your Commercial Select Health patient could benefit from care management, contact us at: **800-442-5305**, or **submit a request form online**. Our care managers will contact your patient within seven business days to begin providing support. Expect to receive a letter from a Select Health care manager once your patient has enrolled in the program.

Let Care Management support your practice and patients. We offer more than outreach — a service listening, guiding, and empowering your patients to live their healthiest lives possible.

Treating a Select Health Commercial plan member where a care manager could help?
Contact our Care Management Department at **800-442-5305**, **option 2**.

Navigate! How can we help you today?

Start with Select Health online self-service solutions. Access our provider website (selecthealth.org/providers) for the quickest way to get your questions answered. Direct links are in purple type.

Do you need to:	Go to:
Find member ID card information?	https://selecthealth.org/providers/claims/id-guides
Access non-covered codes/ preauthorization requirements?	https://selecthealth.org/providers/preauthorization/forms-lists
Request preauthorization?	• **Commercial Networks:** https://selecthealth.org/providers/preauthorization • **Medicare:** Enter request in TapestryLink, or fax to **702-318-2404**. For help, call 855-866-8282 or email nv_networkcomms@imail.org.
Appeal a claim?	https://selecthealth.org/content/dam/selecthealth/Provider/PDFs/forms/Provider-Appeal-Form.pdf
Find pharmacy resources?	https://selecthealth.org/providers/programs/pharmacy
Access dental provider resources?	https://selecthealth.org/providers/programs/dental
Access Select Health policies (medical, dental, coding/reimbursement)?	https://selecthealth.org/providers/policies
Learn about secure provider tools (Provider Benefit Tool, Preauth & Care Plan)?	https://selecthealth.org/providers/provider-access-point

Contact us when you can't find answers online. We're here to help, Monday through Friday, 8:00 a.m. to 5:00 p.m. MST unless otherwise indicated below. Phone and email requests are answered in the order they are received.

When you need to:	Access:
Verify member benefits or get help with claims payment issues and information	Use the Provider Benefit Tool (see above), or call Member Services: **800-538-5038** (available 7:00 a.m. to 8:00 p.m. MST weekdays , 9:00 a.m. to 2:00 p.m. MST Saturdays).
Resolve issues with provider setup or directory listing	Provider Development: NVProviderRelations@selecthealth.org
Get help with access to online tools on our secure Provider Portal (e.g., Provider Benefit Tool, Preauth & Care Plan)	Provider Web Services: providerwebservices@selecthealth.org
Resolve claims appeals/preauth issues	• **For Commercial appeals**: **844-208-9012** • **For Medicare appeals: 702-253-2680** or nv_eobcheckinquiries@imail.org
Manage Electronic Funds Transfer (EFT)	• **For Commercial EFT**: EDI Department: **800-538-5099** (fax: **801-442-0372**); edi@selecthealth.org • **For Medicare EFT:** https://claimsportal.intermountainnv.org/Account/Login?ReturnUrl=%2F
Change passwords, reactivate accounts, resolve issues with 2-Step Authentication (PingID)	• **Commercial Account Help Desk**: **801-442-7979, Option 2** • **Medicare Portal**: Call **702-253-2680** for IT assistance; **801-442-5731** for help with PingID; and **702-318-2468** for all other issues.
Request fee schedules (contracted providers only)	Provider Development: SHFeeScheduleRequests@selecthealth.org

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