Provider Manual - Combined

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Provider Manual

The Exclusive Provider Organization (EPO) Operations Manual offers Health Net participating providers access to important plan benefits, limitations and administration processes to make sure members enrolled in the EPO plan receive covered services when needed. The Health Net EPO plan is underwritten by Health Net Life Insurance Company and regulated by the California Department of Insurance. Benefits and policies listed in the EPO Operations Manual apply to all EPO plans, unless specified otherwise in the Provider Participation Agreement (PPA), *Schedule of Benefits* or member's *Explanation of Coverage* (EOC).

The four providers types - Physicians, Participating Physician Groups (PPGs), Hospitals, and Ancillary - are listed at the top of every page. Refer to the *Provider Type* listed at the top of the page to see if the content applies to you.

As a Health Net participating provider, you are required to comply with applicable state laws and regulations and Health Net policies and procedures.

The contents of Health Net's operations manuals are in addition to your PPA and its addendums. When the contents of Health Net's operations manuals conflict with the PPA, the PPA takes precedence.

Adverse Childhood Experiences (ACEs)

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

The following information is intended to provide a general guide to help you implement screening for adverse childhood experiences (ACEs) and better determine the likelihood a patient is at increased health risk due to a toxic stress response. Screening for ACEs helps inform patient treatment and encourage the use of trauma-informed care. For more information, visit ACEs Aware.

Note: While ACE's Aware billing and payment information is specific to Medi-Cal providers, funded by Proposition 56, the ACE's Aware training materials and resources still apply to non Medi-Cal Providers. Non Medi-Cal providers can still get trained and use the workflows and tools. This article outlines how non Medi-Cal providers (that are trained and attest to training) can receive the $29 payment.

Prevent

Addressing trauma in primary care pediatrics can help patient remove discomfort for discussion of trauma histories. It can help connect patients and families and provide a way to prevent future trauma experiences from one generation to the next. Click here to learn more on Preventing Childhood Toxic Stress.

Trauma Informed Care

ACEs are stressful or traumatic experiences people have by age 18, such as abuse, neglect and household dysfunction. By screening for ACEs, providers can better determine the likelihood a patient is at increased health risk due to a toxic stress response. This is a critical step in advancing to trauma-informed care.

Follow the principles of trauma-informed care. Use these key principles as a guideline:

- Establish the physical and emotional safety of patients and staff.
- Build trust between providers and patients.
- Recognize the signs and symptoms of trauma exposure on physical, psychological and behavioral health.
- Promote patient-centered, evidence-based care.
- Train leadership, providers and staff on trauma-informed care.
- Ensure provider and patient collaboration by bringing patients into the treatment process and discussing mutually agreed-upon goals for treatment.
- Provide care that is sensitive to the racial, ethnic, cultural and gender identity of patients.

References

For more information, refer to:

- ACEs Aware
- Health Care Toolbox

Toxic Stress

Everyone experiences stress. Stress can show up in our bodies, emotions and behavior in many different ways. Too much of the wrong kind of stress can be unhealthy and, over time, become “toxic” stress and harm physical and mental health. An adult who has experienced significant adversity in the past, especially during the critical years of childhood, may be at higher risk of experiencing health and behavioral problems during times of stress.

References

For more information, refer to:

- ACEs Aware
- California All
- CFAP
- Healthy Children

Positive Parenting and Resilience Building

Parents and caregivers look to providers for reliable resources, information and help to address childhood trauma. Providers can offer help by assessing parental ACE’s, practicing trauma informed care to address childhood trauma and toxic stress and offer the following resources, focused on development and positive parenting skills.

- ACEs Connection: News and information on ACEs and how to become more trauma-informed in practice.
- The Center for Youth Wellness: Led by Nadine Burke-Harris, MD, the Center for Youth Wellness is an international leader in addressing ACEs in practice.
- Centers for Disease Control and Prevention (CDC): Helpful tip sheets for positive parenting at different ages.

- ZERO to THREE: This organization works to ensure that babies and toddlers benefit from the early connections that are critical to their well-being and development.
- Parenting Beyond Punishment: No cost parenting webinars for positive discipline in everyday parenting.
- Build resilience to cope with trauma
  - Mind Yeti: A research-based digital library designed to help kids and their adults calm their minds, focus their attention, and connect better to the world around them.
  - Stress Health: Learn how the stress that humans live with can have adverse effects if there is too much for too long.
  - American Academy of Pediatrics: A presentation on Identifying Toxic Stress in Pediatric Practices at the 2015 American Academy of Pediatrics Event.

Screen for ACEs

Screening for ACEs can help determine if a patient is at increased health risk due to a toxic stress response and provide trauma-informed care. Identifying and treating cases of trauma in children and adults can lower long-term health costs and support the well-being of individuals and families.

The California Department of Health Care Services (DHCS) has identified and approved specific screening tools for children and adults for the 10 categories of ACEs grouped under three sub-categories: abuse, neglect and household dysfunction.

For children and adolescents, use PEARLS.

PEARLS is designed and licensed by the Center for Youth Wellness and are available in additional languages. There are three versions of the tool based on age:

- PEARLS for children ages 0–11, to be completed by a caregiver
- PEARLS for teenagers ages 12–19, to be completed by a caregiver
- PEARLS for teenagers ages 12–19, self-reported

For adults, use the ACE assessment tool.

The ACE assessment tool is adapted from the work of Kaiser Permanente and the Centers for Disease Control and Prevention (CDC). Other versions of the ACEs questionnaires can be used, but to qualify, questions must contain the 10 categories mentioned above.

Use of tools

AGES	USE THIS TOOL	TO RECEIVE DIRECTED PAYMENT
0-17	PEARLS	Not given more than once during a 12-month period, per provider, per member

AGES	USE THIS TOOL	TO RECEIVE DIRECTED PAYMENT
18 or 19	ACEs or PEARLS	Not given more than once during a 12-month period, per provider, per member
20-64	ACEs screening portion of the PEARLS tool (Part 1) can also be used.	Not given more than once during a 12-month period, per provider, per member under age 21. Not given more than once per lifetime, per provider, per member ages 21 and older.

The approved tools are available in two formats:

- **De-identified screening tool:** Patients have the option to choose a de-identified screening, which counts the numbers of experiences from a list without specifying which adverse experience happened.
- **Identified screening tool:** Patients can opt in for an identified screening in which respondents specify the experience(s) that happened to their child or themselves.

Providers are encouraged to use the de-identified format to reduce the fear and anxiety patients may have.

Administering the screening

There are several ways to administer the screening. Providers are encouraged to use the tools appropriate for their patient population and clinical workflow. Before administering, providers should consider the following:

- Identify which screening tools and format to use for adults, caregivers of children and adolescents, and adolescents.
- Determine who should administer the tool, and how.
- Determine which patients should be screened.

It is recommended that the screening be conducted at the beginning of an appointment. Providers or office staff will provide an overview of the questionnaire and encourage the patients (adolescent, adults or caregivers) to complete the form themselves in a private space to allow members to disclose their ACEs without having to explain their answers. Patients may take up to five minutes to complete the screening tool.

References

For more information, refer to:

- ACEs Aware screening tools
- ACE Screening Clinical Workflows and Assessment Algorithm (PDF)
- ACE Screening Tools in Multiple Languages

Treat and Heal

The ACE score determines the total reported exposure to the 10 ACE categories indicated in the adult ACE assessment tool or the top box of the pediatric PEARLS tool. ACE scores range from 0 to 10 based on the number of adversities, protective factors and the level of negative experience(s) that have impacted the patient. Providers will obtain a sum total of the number of ACEs reported on the screening tool.

For children and adults, two toxic stress risk assessment algorithms based on the score were developed to determine the level of risk and referral needs. According to the algorithm, risk and scores are determined as follows:

RISK	SCORE	ACTION
Low	0	If a patient is at low risk, providers should offer education on the impact of ACEs, anticipatory guidance on ACEs, toxic stress and buffering factors.
Intermediate	1 – 3	A patient who scores 1–3 has disclosed at least one ACE-associated condition and should be offered educational resources.
High	1 – 3 with associated health conditions, or a score of 4 higher	The higher the score, the more likely the patient has experienced toxic stress during the first 18 years of life and has a greater chance of experiencing mental health conditions, such as depression, post-traumatic disorder, anxiety and engaging in risky behaviors.

Referral and Resources

As part of the clinical workflow, providers should be prepared with a treatment plan and referral process so patients who have identified behavioral, social or trauma can be connected to trained professionals and resources. Building a strong referral network and conducting warm hand-offs to partners and services are vital

to the treatment plan. In addition, it is critical to build a follow-up plan to effectively track the patient's process to ensure they get connected to the support needed.

ACEs resources

Free ACEs resources for providers on screening and clinical response.

Behavioral Health Services

For Health Net:

Health Net members can obtain individual and group mental health evaluation and treatment. Providers can call Behavioral Health Provider Services. It is recommended providers call the member services number on the back of the members ID card with the member to facilitate the referral and obtain member consent for treatment. Crisis support is available 24 hours a day, 7 days a week. Members can call the number on the back of their ID card to talk to someone right away.

Case Management

If your patient is uncertain about next steps or would like to learn more, please refer them to the health plan's behavioral health Case Management Department.

Health Net Community Connect

Health Net Community Connect is powered by Findhelp formerly known as Aunt Bertha, which is the largest online search and referral platform that provides results customized for the communities you and your health care staff serve or where members live.

To use the tool, Health Net members should go to healthnet.findhelp.com, enter a ZIP code and click Search.

myStrength

For members with ACEs, the myStrength program can provide an additional resource. Providers should call Health Net if a member needs emergent or routine treatment services. To refer a member to the myStrength program, members can visit myStrength.com to sign up online or download the myStrength app at Google Play or the Apple Store.

To join online, visit my Strength, then click Sign Up and complete the myStrength sign-up process with a brief wellness assessment and personal profile.

Health Education Materials

You can request materials on many key topics from Health Net's Health Education Department utilizing the form located in the Provider Library under Forms and References.

Consider ordering the below materials to support your ACEs treatment plan:

- Exercise
- Nutrition
- Parenting (stress reduction)
- Lower toxic stress
- Parenting Prevent ACEs
- Understanding ACEs
- Stress Management

References

For more information, refer to:

- ACEs Screening Sample Scripts for Pediatric Clinical Teams
- ACEs Aware treatment
- ACEs Screening Clinical Workflows and Assessment Algorithm
- ACEs Aware resources

ACE Training and Self-Attestation Requirement for Billing

Effective July 1, 2022, Medi-Cal providers who have completed the two-hour online ACE training and submitted their self-attestation to DHCS can continue or begin billing for ACE screenings. Providers who missed the July 1 deadline can still complete the training, self-attest and begin billing the month of completing the attestation.

You must attest with a valid NPI number, or you will not be eligible to receive payment. Our support teams at Provider Services and Provider Relations Department will have the latest DHCS Prop 56 ACEs Provider Training Attestation List and be able to look up the customer/provider to see if DHCS has received their ACEs training attestation online form.

How to receive payments for ACE screenings

Providers will need to complete the ACEs Aware training and must self-attest to receive payment. To get started, you must:

- Register for the "Becoming ACEs Aware in California" core training.
- Self-attest. Complete the ACEs Provider Training Attestation form.
    - Note. The ACEs Aware provider directory is optional for commercial providers.
- Submit claims for ACEs screening with dates of service on or after January 1, 2022, and proof of completion certificate. Claims eligible for payment must be submitted within one year from the date of service.
- Use CPT codes 96160 and 96161 when billing for ACE screenings.
- Claims must also include an ICD-10 code (e.g., T and Z codes around child maltreatment). In California, some ICD-10 codes have been identified as being related to ACEs screening in the state. Examples are:
    - Z59.4: Lack of adequate food or safe drinking water
    - Z63.0: Relationship problem between spouse or partners
    - Z62.819: History of abuse in childhood
    - Z63.5: Family disruption due to divorce or legal separation
    - Z63.32: Absence of family member
    - Z81.9: Family history of mental and behavioral disorder
    - Z63.72: Alcoholism and drug addiction in family
    - Z63.9: Problem related to primary support group
- Providers must document the following information and ensure the documents remain in the member's medical record and available upon request:
    - The screening tool that was used.
    - Date the completed screen was reviewed.
    - Results of the screen.
    - Interpretation of the results.
    - What was discussed with member and/or family.
    - Include any appropriate action taken.

Existing and future trainings on ACEs

ACEs Aware offers a variety of trainings on ACEs and Trauma Informed Care. To access and view existing trainings or register for future trainings to support your work with ACEs, visit the ACEs Aware site.

Appeals, Grievances and Disputes

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

This section describes initial organization determinations, member and provider appeals and dispute resolution processes.

Select any subject below:

- Member Appeals Overview
- Provider Appeals and Dispute Resolution
- Grievances

Grievances

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Members may submit grievances orally or in writing to the Member Appeals and Grievance Department.

Health Net acknowledges receipt of the grievance within five calendar days, and sends a final resolution/ disposition letter to the member within 15 calendar days for PPO members and 30 calendar days for HMO. If the case exceeds the 15 day PPO time limit or the 30-day HMO time limit, an interim letter of explanation is sent to the member by the 30th calendar day indicating the reason for the delay and providing an estimated resolution date. The written resolution is made as soon as possible and not to exceed 15 additional calendar days.

If the grievance involves an imminent and serious threat to the member's health, including but not limited to severe pain, potential loss of life, limb or major bodily function, the member or the provider may request that Health Net expedite its grievance review. When Health Net evaluates and determines the expedited grievance request to be urgent, the grievance is resolved within 72 hours from receipt of the request.

Members may obtain additional information about member grievance procedures in the member's Evidence of Coverage (EOC) or Certificate of Insurance (COI).

DMHC Notices of Translation Assistance, Forms and Applications

DMHC Notices of Translation Assistance

Participating providers are required to insert a notice of translation assistance when corresponding with applicable members. Health Net-specific, DMHC notices of translation assistance are available on the Health Industry and Collaboration Effort (ICE) website at www.ICEforhealth.org > Library > Approved ICE Documents > Cultural & Linguistics Team folder. For additional information, providers can contact the Cultural and Linguistic Services Department.

Translated DMHC Complaint (Grievance) Forms

Physicians and ancillary providers must know how to locate and provide translated DMHC complaint (grievance) forms to members upon request. These forms are available in English, Chinese and Spanish on the DMHC website at www.dmhc.ca.gov.

Translated DMHC IMR Applications

Physicians and ancillary providers must know how to locate and provide translated DMHC IMR applications to members upon request. These applications are available in English, Chinese and Spanish on the DMHC website at www.dmhc.ca.gov.

Ancillary Providers and Notice of Language Assistance

Ancillary providers are required to include a notice of language assistance services when sending vital documents to applicable Health Net members. For assistance in determining if a document being sent to a Health Net member meets the vital document criteria, contact the Cultural and Linguistic Services Department.

Provider Appeals and Dispute Resolution

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section includes general information on provider dispute resolution and appeals processes.

Select any subject below:

- Overview
- Acknowledgement and Resolution
- Dispute Submission
- Inquiry Submission

Overview

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net's provider dispute resolution process ensures correct routing and timely consideration of provider disputes (or appeals). Participating providers use this process to:

- Appeal, challenge or request reconsideration of a claim (including a bundled group of similar claims) that has been denied or adjusted by Health Net
- Respond to a contested claim that the participating provider does not agree requires additional information for adjudication. A contested claim is one for which Health Net needs more information in order to process the claim
- Challenge a request by Health Net for reimbursement for an overpayment of a claim
- Seek resolution of a billing determination or other contractual dispute with Health Net
- Appeal a written determination when the dispute involves an issue of medical necessity or utilization review, to Health Net for a de novo review, provided the appeal is made within 60 business days of the written determination

Health Net does not charge providers of service who submit disputes to the Health Net Provider Dispute - Commercial Appeals Unit (PDF), the Health Net Provider Appeals Unit - IFP for processing provider disputes and does not discriminate or retaliate against a participating provider who uses the provider dispute process.

Disputes regarding the denial of a referral or a prior authorization request are considered member appeals. Although participating providers may appeal such a denial on a member's behalf, the member appeal process must be followed. Refer to the Dispute Resolution and Appeals topic for additional information.

In addition to the provider dispute process, a provider inquiry process is available for routine claim follow-up when a participating provider wants to:

- Inquire about the status of a claim or obtain payment calculation clarification
- Resubmit contested claims with the missing information requested by Health Net
- Submit a corrected claim (additional charges previously not submitted)
- Clarify member responsibility

To check the status of an appeal or dispute, contact the applicable Health Net Provider Services Center.

Acknowledgement and Resolution

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net acknowledges receipt of each provider dispute, in writing and within 15 business days of receipt. If the provider dispute submission does not include all pertinent details of the dispute, it is returned to the provider with a request detailing the additional information required to resolve the issue. The amended dispute must be submitted with the missing information within 30 business days from the date of receipt of the request for additional information.

Providers are not asked to resubmit claim information or supporting documentation that was previously submitted to Health Net as part of the claims adjudication process, unless Health Net returned the information to the provider.

Health Net resolves each provider dispute within 45 business days following receipt and sends the provider a written determination stating the reasons for the determination.

If the provider dispute involving a claim for a provider's services is resolved in favor of the provider, Health Net pays any outstanding money due, including any required interest or penalties, within five business days of the decision. Accrual of the interest and penalties, if any, commences on the day following the date by which the claim or dispute should have been processed.

Participating providers who contract directly with Health Net and disagree with Health Net's determination may refer to their Provider Participation Agreement (PPA) for other available resolution mechanisms.

Dispute Submission

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net accepts disputes, including appeals, from participating providers if they are submitted within 365 days of receipt of Health Net's decision (for example, denial or adjustment), except as described below. If the participating provider does not receive a decision from Health Net, the dispute must be submitted within 365 days after the deadline for contesting or denying the claim has expired. If the participating provider's Provider Participation Agreement (PPA) provides for a dispute-filing deadline that is greater than 365 calendar days, this longer time frame continues to apply until the contract is amended.

When submitting a provider dispute, a provider should use the Provider Dispute Resolution Request form - Provider Dispute Resolution Request form - Health Net (PDF), Provider Dispute Resolution Request form – Community Health Plan of Imperial Valley (PDF) or Provider Dispute Resolution Request form - CalViva Health (PDF). If the dispute is for multiple, substantially similar claims, the Provider Dispute Resolution Request spreadsheet (page two of the request form above and up to 12 claims) or the Claims Project Submission Universal Template spreadsheet (used for more than 12 claims) should be submitted with the Provider Dispute Resolution Request form. The Claims Project Submission Universal Template spreadsheet should be requested from your Provider Network Management contact. Provider Network Management will email you a copy of the spreadsheet template to complete and submit along with the Provider Dispute Resolution Form.

The provider dispute must include:

- The provider's name; identification (ID) number; contact information, including phone number; and the original claim number.
- If the dispute is regarding a claim or a request for reimbursement of an overpayment of a claim, the dispute must include: a clear identification of the disputed item; the date of service; and a clear explanation as to why the provider believes the payment amount, request for additional information, request for reimbursement of an overpayment, or other action is incorrect.
- If the dispute is not about a claim, the provider must include a clear explanation of the reason for the dispute, including, if applicable, relevant references to the PPA.

Providers who participate under a capitated agreement with a participating physician group (PPG) must submit disputes to the PPG that processed the claim.

Inquiry Submission

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

For routine claim follow-up, contact the appropriate Provider Services Center.

Provider dispute requests are submitted to the Health Net Provider Dispute and Inquiry Resolution Unit.

Member Appeals

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section includes information on the member appeals process, including procedures and requirements.

Select any subject below:

- Member Appeals Overview
- Appeal Process
- Investigational or Experimental Treatment

Member Appeals Overview

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net members are entitled to have their appeals or grievances addressed by Health Net and have a contractual right to claims arbitration for claims that are not resolved to their satisfaction. Health Net does not delegate appeals or grievances to participating providers. If the participating provider becomes aware of a member appeal, the participating provider must fax the appeal to the Health Net Member Appeals and Grievance Department within one business day. Health Net's process includes peer-review-protected evaluations on the matters raised. A copy of the denial and relevant clinical information needs to be submitted with appeal requests. Health Net's grievance and appeal process includes peer-review-protected evaluation of the matters raised.

Grievances are a verbal or written statement, other than one that is an organization determination, expressing dissatisfaction regarding any aspect of an organization's or participating provider's operations, contractual issues, activities, or behavior. A grievance is generally further classified as either a quality-of-care or quality-of-service issue.

An appeal or request for reconsideration is a verbal or written request to change a previous service decision or adverse determination. The request can be from a member, a participating provider or a member representative and is categorized as either a pre-service, post-service, expedited, or external review.

The fact that a member submits an appeal or grievance to Health Net or the participating provider should not affect in any way the manner in which the member is treated by the participating provider. If Health Net discovers that any improper action has been taken against such a member by the participating provider, Health Net takes immediate steps to prevent such conduct in the future. These steps involve appropriate sanctions, including possible termination of the applicable Provider Participation Agreement (PPA).

Health Net requires that all participating providers provide all pertinent appeal or grievance documentation to the Health Net Member Appeals and Grievance Department by fax or mail within five calendar days of the participating providers' receipt of Health Net's request for information. Health Net expects the participating provider to review the matter promptly and work with Health Net on corrective actions needed as part of the overall quality improvement process. If the participating provider does not provide the necessary documentation, Health Net may be obligated to make a determination in the member's favor.

Refer to Appeal, Grievance, Complaint, or Inquiry as applicable for additional information.

Expedited

An expedited appeal is warranted if there is a time-sensitive situation where an adverse decision could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, defined as cases involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function.

Expedited appeals includes pre-service appeals, a terminally ill appeal for a request for reconsideration of treatment, services or supplies deemed experimental as recommended by a participating provider, or a life-threatening or seriously debilitating condition appeal.

All expedited appeals that meet the above definition are processed within 72 hours from the time the request is received by the participating provider or Health Net.

Financial Responsibility

Financial responsibility determinations are made consistent with the terms of the Provider Participation Agreement (PPA) and Health Net policy. If, during an appeal, Health Net or the independent medical review (IMR) overturns a denial, the responsible participating provider provides the service and pays the claim as stated in the PPA.

Binding Arbitration Process

Sometimes disputes may arise between a member and Health Net regarding the construction, interpretation, performance, or breach of the member's Evidence of Coverage (EOC) or Certificate of Insurance (COI), or regarding other matters relating to or arising out of membership. Typically such disputes are handled and resolved through the Health Net appeal, grievance or independent medical review (IMR) processes. However, in the event that a dispute is not resolved, Health Net uses binding arbitration as the final method for resolving all such disputes, whether stated in tort, contract or otherwise, and whether or not other parties, such as employer groups, health care providers, or their agents or employees, are also involved. In addition, disputes with Health Net involving alleged professional liability or medical malpractice (that is, whether any medical

services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) also must be submitted to binding arbitration.

As a condition of membership, Health Net members agree to submit all disputes against Health Net, except those described later, to final and binding arbitration. Health Net agrees to arbitrate all of these disputes. This mutual agreement to arbitrate disputes means that both the member and Health Net use binding arbitration as the final means of resolving disputes that may arise between them, and forego any right they may have to a jury trial on such disputes. However, no remedies that otherwise would be available to either party in a court of law are forfeited by virtue of this agreement to use and be bound by Health Net's binding arbitration process. This agreement to arbitrate is enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter.

Health Net's binding arbitration process is conducted by mutually acceptable arbitrators selected by Health Net and the member. The Federal Arbitration Act, 9 U.S.C.1, et sea., governs arbitrations under this process. If the total amount of damages claimed is $200,000 or less, Health Net and the member must, within 30 days of submission of the demand for arbitration to Health Net, appoint a mutually acceptable single neutral arbitrator who hears and decides the case and who cannot award more than $200,000. In the event that the total amount of damages is more than $200,000, Health Net and the member must, within 30 days of submission of the demand for arbitration to Health Net, appoint a mutually acceptable panel of three neutral arbitrators (unless they mutually agree to one arbitrator), who hears and decides the case.

If Health Net and the member fail to reach an agreement during this time frame, then either may apply to a Court of Competent Jurisdiction for appointment of the arbitrators to hear and decide the matter.

Arbitration can be initiated by submitting a demand for arbitration to Health Net's litigation administrator. The demand must have a clear statement of the facts, the relief sought and a dollar amount.

The arbitrator is required to follow applicable state or federal law. The arbitrator may interpret the Health Net member's EOC or COI, but does not have any power to change, modify or refuse to enforce any of its terms, nor can the arbitrator have the authority to make any award that would not be available in a court of law. At the conclusion of the arbitration, the arbitrator issues a written opinion and award providing findings of fact and conclusions of law. The award is final and binding on Health Net and the member, except to the extent that state or federal law provides for judicial review of arbitration proceedings.

Health Net and the member share equally the arbitrator's fees and expenses of administration involved in the arbitration. Each is also responsible for their own attorneys' fees. In cases of extreme hardship to a member, Health Net may assume all or a portion of a member's share of the fees and expenses of the arbitration. Upon written notice by the member requesting a hardship application, Health Net forwards the request for hardship to an independent professional dispute resolution organization for a determination. Such request for hardship should be submitted to the litigation administrator.

Members enrolled in an employer-sponsored health plan that is subject to ERISA, 29 U.S.C. 1001 et seq. are not required to submit disputes about certain adverse benefit determinations to binding arbitration. However, the member and Health Net may voluntarily agree to resolve adverse benefit determinations through the arbitration process.

Appeal Process

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

A participating provider has five calendar days from receipt of a request for information from Health Net to submit to Health Net the case file information requested for a member appeal. Case file information includes medical records, the rationale for denial and an alternative treatment plan. Participating providers must follow Health Net's provider information request process when submitting pertinent case file documentation to Health Net.

Health Net is responsible for reviewing the case file, requesting any additional information needed from the participating provider, and upholding or overturning the denial. In addition, Health Net is responsible for informing members of their right to appeal to the Department of Insurance (DOI). This includes sending members an application form and addressed envelope so they can request an independent medical review (IMR) through the DOI for member appeals that have been denied for lack of medical necessity or for investigational or experimental treatment. The IMR organization reviews the case, prepares a written decision, including its rationale, and submits the decision to the DOI, member and Health Net. Health Net accepts the IMR recommendation, then sends the IMR decision and rationale to the participating provider and notifies the member in writing whether the denial was upheld or overturned. If the denial is upheld, the member has the right to request arbitration.

Investigational or Experimental Treatment

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

A member with a life-threatening or seriously debilitating condition who disagrees with a Health Net denial of coverage for a service, medication, device, or procedure because it is investigational or experimental may request an appeal review. If the denial is sustained, the member can request an independent medical review (IMR) from the Department of Insurance (DOI).

Participating providers are to forward immediately to Health Net any requests they receive for investigational or experimental treatment for a Health Net member. These requests cannot be reviewed by the participating provider.

Services, medications, devices, or procedures that have not been accepted under standard medical practice for treatment of a condition, symptom, illness, or injury are excluded from coverage by Health Net. If a question arises as to whether a service, medication, device, or procedure is investigational or experimental, the Health Net Medical Management Department reviews the information and makes a coverage determination.

Benefits

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information.

Benefits in Alphabetical Order

Select any subject below:

A | B | C | D | E | F | G | H | I | J | K | L | M | N | O | P | Q | R | S | T | U | V | W | X | Y | Z

A

- Acupuncture
- Alcohol and Drug Abuse
- Allergy Treatment
- Ambulance
- Autism Spectrum Disorders

B

- Bariatric Surgery
- Blood
- Behavioral Health

C

- Chemotherapy
- Chiropractic
- Clinical Trials
- Cosmetic and Reconstructive Surgery

D

- Dental Services
- Dialysis
- Durable Medical Equipment

E

- Essential Health Benefits

F

- Family Planning

G

- General Benefit Exclusions and Limitations
- Genetic Testing

H

- Hearing
- Home Health Care
- Hospice Care

- Hospital and Skilled Nursing

I

- Immunizations
- Injectables

J

K

L

M

- Maternity
- Medical Social Services

N

- Nuclear Medicine

O

- Obesity
- Outpatient Services

P

- Periodic Health Evaluations
- Physicians Visit
- Preventive Services
- Prosthesis

Q

R

- Rehabilitation Therapy
- Routine Physical Exam

S

- Seciond Opinion by a Physician
- Support for Disabled Members
- Surgery, Surgical Supplies and Anesthesia

T

- TMJ
- Transgender Services
- Transplants

U

V

- Vision

W

X

- X-Ray and Laboratory Services

Y

Z

Acupuncture

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information on acupuncture services, including coverage exclusions and limitations.

Select any subject below:

- Acupuncture Services
- Covered Services

Acupuncture Services

Provider Type: Physicians | Ancillary | Participating Physician Groups (PPG)

The following information applies to HSP, HMO, Ambetter HMO and Ambetter PPO members.

Acupuncture services for treatment or diagnosis of musculoskeletal and related disorders, nausea, and pain are a covered benefit for some members. Refer to the member's Evidence of Coverage (EOC) to confirm if the member is eligible for acupuncture services.

Acupuncture services are administered by the American Specialty Health Plans, Inc. (ASH Plans) network of participating acupuncturists without a referral from the member's primary care physician (PCP) as stated in the EOC.

Refer the member to ASH Plans or the Member Services Department for more information about acupuncture services.

Coverage Criteria

Acupuncture services for treatment or diagnosis of musculoskeletal and related disorders, nausea, and pain are a covered benefit, subject to medical benefits exclusions, limitations and authorization protocols listed in the EOC. Subsequent visits are authorized by ASH when medically necessary as stated in the EOC.

Additional services in subsequent visits may include:

- Adjunctive therapies or modalities such as acupressure, moxibustion or breathing techniques are covered only when provided during the same course of treatment and in support of acupuncture services.

The following information applies to PPO members.

Acupuncture services for treatment or diagnosis of musculoskeletal and related disorders, nausea, and pain are a covered benefit for some members. Refer to the member's EOC to confirm if the member is eligible for acupuncture services.

Coverage Criteria

Acupuncture services for treatment or diagnosis of musculoskeletal and related disorders, nausea, and pain are a covered benefit, subject to medical benefits exclusions, limitations and authorization protocols listed in the EOC. Subsequent visits are authorized when medically necessary as stated in the EOC.

Additional services in subsequent visits may include:

- Adjunctive therapies or modalities such as acupressure, moxibustion or breathing techniques are covered only when provided during the same course of treatment and in support of acupuncture services.

Exclusions and Limitations

- Hypnotherapy, behavior training, sleep therapy, and weight programs.
- Services, examinations and/or treatments for asthma or addiction, such as nicotine addiction.
- Thermography, magnets used for diagnostic or therapeutic use, ion cord devices, manipulation or adjustments of the joints, physical therapy services, iridology, hormone replacement products, acupuncture point or trigger-point injections (including injectable substances), laser/laser BioStim®, colorpuncture, nambudripad's allergy elimination techniques (NAET) diagnosis and/or treatment, and direct moxibustion.

- Services and other treatments that are classified as experimental or investigational.
- Radiological X-rays (plain film studies), magnetic resonance imaging, CAT scans, bone scans, nuclear radiology, diagnostic radiology, and laboratory services.
- Transportation costs, including local ambulance charges.
- Education programs, non-medical lifestyle or self-help, or self-help physical exercise training or any related diagnostic testing.
- Air conditioners/purifiers, therapeutic mattresses, supplies or any other similar devices or appliances or durable medical equipment.
- Adjunctive therapy not associated with acupuncture.
- Dietary and nutritional supplements, including vitamins, minerals, herbs, and herbal products, injectable supplements and injection services, or other similar products.
- Massage therapy.
- Services provided by a practitioner of acupuncture services practicing outside of the service area, except for urgent or emergency services.

Covered Services

Provider Type: Physicians |Hospitals | Participating Physician Groups (PPG) | Ancillary

The following are covered acupuncture services when the member's plan includes optional acupuncture coverage under Health Net's arrangement with American Specialty Health Plans, Inc. (ASH Plans).

- Examination - initial examination and re-examinations
- Treatment - acupuncture/office visit, and adjunctive therapy
- X-ray and lab tests are payable in full by ASH Plans when referred by a participating acupuncturist and authorized by ASH Plans. Radiological consultations are a covered benefit when authorized by ASH Plans as medically/clinically necessary services

Acupuncture services under this benefit are obtained through self-referral; however, acupuncture for certain conditions, illnesses or injuries are only covered if the services are provided in conjunction with services from a medical doctor (for example, chronic pain or nausea related to chemotherapy).

Alcohol and Drug Abuse

Provider Type: Physicians |Hospitals | Participating Physician Groups (PPG) | Ancillary

This section contains general member benefit information and provider referral information on alcohol and drug abuse services.

Select any subject below:

- Overview
- Substance Abuse Facilities
- Substance Abuse Rehabilitation Services

Overview

Provider Type: Participating Physician Groups (PPG) | Ancillary | Hospitals

Health Net covers acute care (detoxification) services for alcohol and drug abuse based on medical necessity. Services include diagnosis, medical evaluation, treatment, detoxification services, and referrals for further assistance. Coverage for acute care does not have a maximum number of admissions and must be provided even if the problem is determined to be chronic.

Plans also cover alcohol and drug or substance abuse rehabilitation on an outpatient and/or inpatient basis. Outpatient treatment can include partial hospital programs (PHP) day treatment, intensive outpatient (IOP) treatment, or just outpatient sessions. Coverage may include treatment on an inpatient basis in a residential substance abuse facility or on an outpatient basis for day care substance abuse treatment programs. Refer to the member's Evidence of Coverage (EOC) or Certificate of Insurance (COI) for specific plan coverage.

Exclusions and Limitations

For plans that cover acute medical care (detoxification) only, non-medical ancillary services and substance abuse rehabilitation services are not covered. This exclusion does not apply to Individual Family Plan (IFP) Ambetter HMO and Ambetter PPO members.

Substance Abuse Facilities

Provider Type: Participating Physician Groups (PPG) | Ancillary | Hospitals

Inpatient substance abuse facilities must be certified and provide medical and other services to inpatient residents. On admission to an inpatient substance abuse facility, the member is entitled to coverage for the following services:

- Detoxification, if necessary (days used for detoxification are not deducted from the calendar year maximum for rehabilitation).
- Laboratory tests.
- Medications, biologicals and solutions dispensed by the facility and used while the patient is in the facility.
- Supplies and use of equipment required for detoxification or rehabilitation.
- Professional and other trained staff and ancillary services provided in the facility that are necessary for patient care and treatment.
- Individual and group therapy or counseling.
- Psychological testing by an individual who is legally qualified to administer and interpret such tests (subject to prior review for medical necessity).
- Family counseling.

Substance Abuse Facilities - Outpatient

Health Net uses intensive outpatient (IOP) treatment prior to using partial hospital programs (PHP) for substance abuse. IOP can be from 24 to 32 sessions over six to eight weeks.

Health Net defines half-day PHP (HD-PHP) as facilities providing ambulatory care, and having the requisite credentialing to provide up to 20 hours per week, but no more than four hours a day, of skilled treatment interventions. During the course of treatment, the member returns home or to a sober living environment (after each session) in order to facilitate a smooth transition to lower levels of care. These consist of diversified treatment modalities to address the problems of substance abuse. Health Net requires that each staff person, from chemical dependency (CD) counselor to addictionologist, be certified or licensed in their particular level of expertise.

Treatment strategies are diversified, and individually fitted to the needs of the member. HD-PHP may be utilized for substance abuse treatment alone, or as a dual substance abuse/behavioral health program. The duration of the program is not pre-established but individually determined, according to the needs and current status of the member. The HD-PHP may be part of a full-day program where treatment has been adjusted to the member's needs and the structure of the full day is no longer required. The program can be part of a medical setting, or a freestanding facility. If the latter, it must have access to a medical center within a reasonable period of time, to treat any emergencies that may arise.

Outpatient substance abuse facilities must be certified (Medicare-certified for Medicare Advantage plans) and provide medical and other services on a daily basis during designated hours and on certain specified days, usually Monday through Friday, and occasionally half-days on Saturday. Health Net must also approve the facility in order for services to be covered.

Members receiving treatment in a Health Net-approved outpatient facility are entitled to coverage for the following services:

- Professional and other trained staff and ancillary services provided in the facility that are necessary for treatment of the ambulatory patient.
- Individual and group therapy or counseling.
- Family counseling, with each visit by one or more family members of the Health Net member being deducted from the member's outpatient behavioral health consultation benefit for the calendar year.
- Laboratory tests required in connection with the treatment received at the facility.
- Medications, biologicals, solutions, and supplies dispensed by the facility in connection with treatment received at the facility, including medications to be taken home.
- Psychological testing by a person legally qualified to administer and interpret such tests. Where there are no licensure laws, the psychologist must be certified for psychological testing by the appropriate professional body (subject to prior review for medical necessity).

Substance Abuse Rehabilitation Services

Provider Type: Participating Physician Groups (PPG) | Ancillary | Hospitals

Refer to the specific plan chart in the Schedule of Benefits and Summary of Benefits for inpatient or outpatient rehabilitation services for substance abuse. The facility may be an acute care general hospital that provides all of the usual treatments and services as well as a substance abuse rehabilitation center that specializes in providing care for chemical dependency. The facility must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or Rehabilitation Accreditation Commission. For MA members, the rehabilitation facility must also be Medicare-certified.

Substance Abuse Rehabilitation Exclusions and Limitations

The following are exclusions and limitations for substance abuse rehabilitation services:

- Personal or convenience items, such as phones, television or services of a hairdresser.
- Health services for disorders other than alcoholism or drug dependence as classified in categories 303.0-304.7 of the Ninth Revision, International Classification of Diseases, adopted for use by the U.S. Department of Health, Education and Welfare.
- Diversional therapy.
- Aversion therapies.

Allergy Treatment

Provider Type: Physicians | Participating Physician Groups (PPG)

Allergy testing and allergy immunotherapy (allergy injection services) are covered under all plans when medically necessary for the treatment of members with clinically significant allergic symptoms. Some plans also cover allergy serum. Allergy treatment is subject to scheduled copayments.

Ambulance

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

This section contains general member benefit information on ambulance services.

Select any subject below:

- Ambulance (Air or Ground)
- Transfer of Members Hospitalized Out of Area

Ambulance (Air or Ground)

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

Non-emergency air and ground ambulance services are covered if ordered and approved by a Non-emergency air and ground ambulance services are covered if ordered and approved by a participating provider. All emergency air and ground ambulance services are covered regardless of whether the services were obtained in or out of the service area. Emergency air and ground ambulance services do not require prior authorization.

Transfer of Members Hospitalized Out of Area

Provider Type: Physicians |Hospitals | Participating Physician Groups (PPG) | Ancillary

Occasionally, a Health Net member is hospitalized at a participating or non-participating out-of-area facility. This type of hospitalization is covered if the member requires emergency care. If an emergency requires admission or long-term care, the member must notify Health Net or the participating physician group (PPG) as soon as possible. Health Net or the PPG monitors the member's treatment and transfers the member, when possible, to a participating facility in the Health Net or PPG's service area. Transfer is usually by ground or air ambulance, although some members may be safely transported by other less costly means.

Autism Spectrum Disorders

Provider Type: Physicians | Ancillary

Autism is the most common of a group of conditions collectively referred to as autism spectrum disorders (ASDs). Autism, a behavioral illness that can range on the spectrum from mild to severe, is a developmental disorder. Severe forms of autism present in the first few years of life and profoundly interfere with the individual's lifelong functioning.

Health Net has developed a medical policy, Applied Behavioral Analysis (ABA), which provides more detailed information about the screening, diagnosis and treatment of ASD. This medical policy is available on the Health Net website.

Screening

Autism is typically characterized by impairment in three core areas:

1. Social interactions
2. Verbal and nonverbal communication
3. Restricted activities or interests and/or unusual, repetitive behaviors

The degree of impairment in these areas varies widely from child to child.

The American Academy of Pediatrics (AAP) has added screening for autism at ages 18 and 24 months to their recommendations for preventive pediatric care. Additional follow-up in six months for borderline development of autism screening results, such as a 30-month visit, is the clinical decision of the provider.

Screenings may include:

- Assessing vision and hearing
- Directly observing the child in structured and unstructured settings
- Evaluating cognitive functioning (verbal and nonverbal)
- Assessing adaptive functioning
- Discussing with parents any concerns they have and asking specific questions regarding the child's functioning

AAP guidelines for Autism Spectrum Disorders are available online at https://brightfutures.aap.org. Additional AAP autism resources are available at www.healthychildren.org/English/health-issues/conditions/Autism/Pages/Autism-Spectrum-Disorder.aspx.

Diagnostic Evaluation

Typically, the child's medical services provider or a behavioral pediatrician, a child psychiatrist, a speech and language pathologist, and other ancillary clinical specialists, as needed, provide input for a diagnosis of ASD. A thorough evaluation for ASD may include the following:

- Parents and/or caregiver interview, including siblings of the child with suspected autism.
- Comprehensive medical evaluation.
- Direct observation of the child.
- Evaluation by a speech-language pathologist.
- Formal hearing evaluation, including frequency-specific brainstem auditory evoked response.
- Evaluation of the child's cognitive and adaptive functioning.
- Evaluation of academic achievement for children ages six and older.

There are a number of assessment tools that are used by clinicians to assist in the diagnosis of autism. A list of some of the assessment tools is included in the Health Net medical policy on the Health Net website.

Medical and Behavioral Health Services

Health Net provides coverage for medical and behavioral health services, subject to limitations, copayments, coinsurance, and deductibles of the member's benefit plan. Members may access services through Health Net's participating providers, or through out-of-network providers if out-of-network provider services are covered under the member's benefit plan. Some covered expenses are subject to precertification. A provider or member should request precertification, when required, before services are rendered to verify benefit coverage and ensure that the member receives full benefits. All precertifications are performed by Health Net.

Medical services for the treatment of ASD may include speech and language therapy, physical therapy, occupational therapy, and specialty management for seizure disorders and other appropriate services. Parents (or legal guardians) of the member with ASD can request a medical home with one provider or ask one provider to lead the care plan and coordinate medical services with other providers and specialists.

Behavioral health services may include psychiatric services, such as medication management of specific symptoms related to ASD, and any comorbid psychiatric conditions; family therapy to help parents and siblings cope with the diagnosis and the member with ASD behaviors; brief psychotherapy to teach behavior modification techniques to parents to assist them in managing their child; and individual psychotherapy for adolescents and young adults with an ASD. Inpatient hospitalization may also be necessary if the child with ASD becomes an acute danger to self or others, or is behaviorally disruptive requiring intensive intervention to restabilize the individual. Inpatient services do require precertification.

Qualified Autism Professionals

Every health care service plan subject to Section 1374.73 of the Health and Safety Code shall maintain an adequate network that includes qualified autism service providers who supervise or employ qualified autism service professionals or paraprofessionals who provide and administer behavioral health treatment. A health care service plan is not prevented from selectively contracting with providers within these requirements.

A “qualified autism service professional” is a person who meets specified educational, training, and other requirements and is supervised and employed by a qualified autism service provider. These professionals can be a psychological associate, an associate marriage and family therapist, an associate clinical social worker, or an associate professional clinical counselor as long as these types meet the criteria for a Behavioral Health Professional as defined and regulated by the Board of Behavioral Sciences or the Board of Psychology.

A “qualified autism service paraprofessional” is an unlicensed and uncertified individual who meets specified educational, training, and other criteria, is supervised by a qualified autism service provider or a qualified autism service professional, and is employed by the qualified autism service provider. A qualified autism service paraprofessional can include a behavioral health paraprofessional.

Definitions of qualified autism service providers, professionals and paraprofessionals:

A “qualified autism service provider” means either of the following:

- A person who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person who is nationally certified.
- A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.
- Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.

A “qualified autism service professiona” means an individual who meets all of the following criteria:

- Provides behavioral health treatment, which may include clinical case management and case supervision under the direction and supervision of a qualified autism service provider.
- Is supervised by a qualified autism service provider.
- Provides treatment pursuant to a treatment plan developed and approved by the qualified autism service provider.
- Is either of the following:
    - A behavioral service provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program, or meets the criteria set forth in the regulations adopted pursuant to subdivision (a) of Section 4686.4 of the Welfare and Institutions Code for a behavioral health professional.
    - A psychology associate, an associate marriage and family therapist, an associate clinical social worker, or an associate professional clinical counselor, as defined and regulated by the Board of Behavioral Sciences or the Board of Psychology.

A “qualified autism service paraprofessional” means an unlicensed and uncertified individual who meets all of the following criteria:

- Is supervised by a qualified autism service provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice.
- Provides treatment and implements services pursuant to a treatment plan developed and approved by the qualified autism service provider.
- Meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations for a behavior management technician (paraprofessional) Behavior Management Technician (Paraprofessional) or meets the criteria set forth in the regulations adopted pursuant to subdivision (b) of Section 4686.4 of the Welfare and Institutions Code for a Behavioral Health Paraprofessional.
- Has adequate education, training, and experience, as certified by a qualified autism service provider or an entity or group that employs qualified autism service providers.
- Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.

Educational Services

Health Net is not responsible for and does not provide coverage for educational services. An important potential source of help for educational services for children with autism is the public school system. Under Federal Public Law 94-142 (the Individuals with Disabilities Education Acts of 1990 and 1997), each school is required to provide handicapped children with free, appropriate education through age 21. The school is required to evaluate each child and, with the parents, develop an individual education plan (IEP). The IEP determines the educational setting that is most appropriate for the child, establishing goals for each child that are academic and behavioral/social. The local public school system may provide for or refer the child for educational interventions, such as Lovaas therapy, intensive behavioral intervention (BI), discrete trials training, early intensive behavioral intervention (EIBI), intensive intervention programs, Picture Exchange Communication Systems (PECS), facilitated communication, Treatment and Education of Autistic and Related Communication of Handicapped Children (TEACCH), or floor time.

The local school system is responsible for education services once the child reaches age three. California's Early Start Program (for children under age three) or the local regional center (for children ages three and up) provides other services, such as in-home services.

Health Net is not responsible for and does not provide coverage for educational services (except for medically necessary ABA services for Health Net PPO members diagnosed with ASDs when coverage is mandated by the state).

Case Management/Comanagement

At the provider's request, Health Net provides a case manager who is knowledgeable about plan benefits to assist in the coordination of health care treatment services, including behavioral health services.

Coordination of Care

Health Net expects all providers involved in the treatment of a member with ASD to coordinate the care and treatment they are providing through appropriate communication. Communication helps prevent duplication of tests and contraindicated medications and treatment, and allows providers the opportunity to modify the member's treatment plan based on more thorough information.

Coordination with the school system, Early Start Program, and regional centers regarding educational services helps ensure the ASD member receives the full range of service options.

Nurse Advice Line

The Nurse Advice Line offers highly trained registered nurses for condition-specific support, 24 hours a day, seven days a week to members. Refer to the Nurse Advice Line to discuss health concerns of ASD for Health Net members.

Resources

The following online resources are available to assist providers in the screening, diagnosis and treatment of ASD and other services.

- AAP recommendations for preventive care
- Early Start Program
- Health Net national medical policy
- Individuals with Disabilities Education Act
- Other AAP resources
- Regional Centers contact information

Bariatric Surgery

Provider Type: Physicians || Hospitals Participating Physician Groups (PPG)

Bariatric surgery provided for the treatment of morbid obesity is covered when medically necessary, authorized by Health Net or a delegated participating physician group (PPG), and performed at a Health Net Bariatric Surgery Performance Center (PDF) by a participating surgeon.

Direct network physicians and non-delegated PPGs may submit prior authorization requests for bariatric surgery to Health Net Medical Management Department.

Compliance for Bariatric Hospitals and Surgeons

Health Net's standardized review process monitors and evaluates bariatric surgery participating providers' quality and outcomes to ensure access to high-quality bariatric surgical care for Health Net members. Health Net bariatric performance centers must be accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) or currently in the accreditation application process. Hospitals and surgeons must continuously be in good standing through MBSAQIP and other industry-accepted oversight organizations.

Health Net's bariatric surgery participating providers are evaluated at least every calendar year to ensure each hospital and surgeon meets Health Net criteria. This evaluation is based on data reported each calendar year by the participating provider using Health Net's data submission process. Health Net may conduct off-cycle reviews upon discovery of substandard clinical care practices, as evidenced by changes in the participating provider's MBSAQIP designation level.

Evaluation Criteria

Health Net's bariatric surgery participating providers are evaluated annually based on the following criteria.

Hospitals:

- Volume must meet a minimum of 125 bariatric surgery procedures every two calendar years
- 30-day mortality must be equal to or less than one percent
- One-year mortality must be equal to or less than one percent

Surgeons:

- Volume must meet a minimum of 50 bariatric surgery procedures every two calendar years
- 30-day mortality must be equal to or less than one percent
- One-year mortality must be equal to or less than one percent

Data Monitoring

Health Net identifies regularly monitored measures based on the above criteria or when a new industry standard is set. Health Net may request an explanation from the hospital or surgeon when results fall below standards. Additionally, each year, Health Net collects and reviews data to adhere to the following specifications:

- The percentage of readmissions must be equal to or less than five percent
- Average length of stay (ALOS) must be equal to or less than the current Milliman Benchmarks for surgical procedures

- The percentage of complications must be equal to or less than three percent

Letter of Deficiency Process

If a bariatric surgeon does not comply with evaluation criteria, Health Net sends a letter of deficiency and indicates if a response is required within 21 days. If the provider does not respond by the deadline and a response is required, Health Net sends a certified letter with a two-week extension. If the provider still does not respond after the second deadline has expired, Health Net sends a third and final notice to the participating provider regarding the deficiency. This notice informs the participating provider of Health Net's decision including potential termination of the bariatric surgery program due to non-response.

Corrective Action Plan Submission and Implementation

If a bariatric surgery participating provider does not comply with all of the evaluation criteria or results are deficient for three consecutive periods, a corrective action process may be initiated and a corrective action plan (CAP) requested. Health Net may request that the provider submit explanations prior to the request for a formal CAP. Additionally, if a program does not meet the criteria standards required for bariatric surgery performance centers or is under investigation by MBSAQIP or any other industry-accepted oversight organizations, Health Net requests that the bariatric surgery program share the oversight organization's findings and recommendations.

When requested, based on non-compliance with bariatric surgery criteria, the bariatric surgery participating hospital or surgeon must submit the CAP within 21 calendar days. Health Net reviews it to ensure it is appropriate and complete. If Health Net does not approve the CAP, a second notice is sent to the bariatric surgery participating provider allowing an additional 15 calendar days to revise the CAP and resubmit it to Health Net.

Health Net sends a third and final notice to the bariatric surgery participating provider upon continued non-responsiveness requests for a CAP or insufficient progress towards correcting the deficiencies. This notice informs the participating provider of Health Net's decision, including potential termination of the bariatric surgery program. Bariatric surgery participating providers may avoid these actions if both of the following occur:

- The provider submits an acceptable CAP to Health Net within 15 calendar days of receipt of the final notice
- The provider completes and demonstrates substantial progress toward completing the correction within 30 calendar days

The bariatric surgery provider must submit updates six months and one year after the original CAP submission date, or until completion of the CAP. If volume or outcome criteria are not met for two sequential data collection periods, Health Net may suspend new patient referrals for that participating provider. If criteria are not met for three sequential data collection periods, Health Net may take a remedial action, up to and including termination of the participating provider's contract.

Onsite Visits

At any time, either Health Net or a bariatric surgery provider may request, with reasonable advance notice, a meeting at the provider's office to discuss bariatric surgery program issues or concerns. Both parties must agree to attend.

Adding Bariatric Surgeons or Performance Centers

Existing Health Net bariatric surgeons who are interested in adding bariatric surgeons to their practice must have the surgeons undergo the request for information (RFI) process. Hospitals interested in becoming a Health Net performance center must be accredited by MBSAQIP and undergo an RFI process. Providers may request and RFI via email at cqi_dsm@healthnet.com

Behavioral Health

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

This section contains general member benefit information and provider referral information on behavioral health and substance abuse care services.

Select any subject below:

- Overview
- 5150 Holds
- Behavioral Health Customer Service
- Coordination of Care
- Day Care Treatment
- Dual Diagnosis
- Employee Assistance Program
- Exclusions
- General Guidelines for Referrals
- Obtaining Behavioral Health and Substance Abuse Care
- Out-of-Area Cases Involving an Acute Medical Diagnosis

Overview

Provider Type: Physicians | Hospitals |Participating Physician Groups (PPG) | Ancillary

Health Net manages inpatient and outpatient treatment for behavioral health and substance abuse care. Health Net has an extensive network of qualified practitioners and facilities. The network includes psychiatrists, psychologists, clinical social workers, psychiatric nurse specialists, marriage and family therapists, and licensed professional counselors, as well as psychiatric and substance abuse facilities and programs. All practitioners and facilities meet strict credentialing requirements. Members with behavioral health benefits have access to its network of behavioral health practitioners and providers. Health Net's behavioral health program

provides inpatient care, including detoxification; outpatient care; day treatment; residential treatment; and structured outpatient treatment programs.

In addition, Health Net provides members with a single source for all the necessary components of a comprehensive behavioral health and substance abuse programs, including:

- Claims administration
- Customer service
- Provider services and contracting
- 24-hour phone access for clinical screening information and referral
- Care management and quality improvement

Copayment

A copayment may be collected from the member at the time services are rendered for some covered behavioral health and substance abuse services. The Schedule of Benefits located in the member's Evidence of Coverage (EOC) provides copayment information. Any required copayment should be collected by the Health Net provider or facility rendering the services.

Criteria for Behavioral Health and Substance Abuse Treatment

All eligible members who call Health Net for a referral are screened by a customer service representative. If the member is in distress or appears to require treatment at a higher level than standard outpatient, they are transferred to a licensed clinical care manager for more complete assessment and referral to treatment. If the member is requesting a routine outpatient referral, the customer service representative provides them with names and contact information for several providers in their area. Outpatient office-based psychotherapy and medication evaluation/management does not require prior authorization. However, requests for facility-based care (with the exception of life-threatening emergencies), and psychological/neuropsychological testing, must be evaluated for medical necessity and prior authorized by Health Net. Members who present with conditions not related to a behavioral health disorder may be referred to community resources or the primary medical provider as appropriate.

Participating providers may also refer members for routine behavioral health services by advising the member to contact the Member Services number listed on the back of their ID card.

5150 Holds

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

Under Section 5150 of the California Welfare and Institutions Code, a person who may be dangerous to self or others can be taken into custody and placed in an approved facility for a 72-hour treatment and evaluation. This is commonly referred to as a "5150 hold." Inpatient psychiatric coverage applies. 5150 holds are considered emergencies and should be handled like any other emergency inpatient hospitalization where the member

cannot be immediately transferred. If the member is admitted to a non-participating facility and cannot be transferred until the 72-hour hold has expired, the situation should be monitored by Health Net. If continued inpatient care is required, the member should be transferred to a participating facility when it is safe to do so. Prior authorization is not required for emergency care; however, providers are encouraged to contact Health Net to report emergency encounters and admissions, and to coordinate post-stabilization care.

Coordination of Care

Provider Type: Physicians | Participating Physician Groups (PPG)

Behavioral health providers and the member's primary care physician (PCP) need to be able to contact each other in the event that the behavioral health provider discovers a medical condition or the PCP identifies a psychiatric or substance abuse problem during a medical examination.

After the behavioral health provider conducts an initial assessment, the behavioral health provider or clinical care manager should coordinate care with the member's PCP if a medical condition is discovered. Behavioral health providers can contact Behavioral Health Provider Services for help in coordinating care for members who require specialized assistance in managing co-occurring medical and behavioral health conditions.

Although the Health Insurance Portability and Accountability Act (HIPAA) allows for communication between clinical practitioners for purposes of treatment coordination without member authorization, behavioral health practitioners are encouraged to discuss this with each member. In order to maintain member confidentiality, a written release form signed by the member is necessary for release of psychotherapy notes (session notes in the medical record consisting of the content of conversation during a private, group, joint, or family counseling session).

Coordination of care between the member's medical and behavioral providers is encouraged in the following situations:

- When a behavioral health practitioner begins prescribing psychotropic medications or makes significant changes to the regimen.
- A new member reports a concurrent medical condition, a substance abuse disorder and/or a major mental illness (for example, a condition other than an adjustment disorder) or when there is a change in condition for an established member.
- A behavioral health practitioner is considering treatment that requires a medical evaluation (for example, electroconvulsive therapy).
- A PCP or other medical provider refers a member to a behavioral health practitioner.

If there is any indication during a medical evaluation that a psychiatric or substance abuse problem is present, the PCP may contact Behavioral Health Provider Services. Participating providers may also refer members for routine behavioral health services by advising members to contact the Member Services number listed on the back of their ID card.

Day Care Treatment

Provider Type: Physicians | | Hospitals Participating Physician Groups (PPG)

When a member requires day care mental health treatment for four to eight hours per day in a mental health facility, any partial day treatment applies toward the outpatient mental health coverage. Verify that the member has outpatient mental health coverage by reviewing the Schedule of Benefits.

Dual Diagnosis

Provider Type: Physicians | Ancillary | Participating Physician Groups (PPG)

For cases requiring both behavioral health and medical treatment services, the behavioral health clinician and medical provider determine a mutually acceptable treatment plan. This makes both treatments more effective. Conversations between the behavioral health provider and the member's health care providers should occur as necessary to ensure the treatment plans are managed together and the member's coverage is correctly applied between the two delivery systems.

Severe Mental Illness

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Severe mental illness (SMI) includes conditions such as schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.

Employee Assistance Program

Provider Type: Physicians | Participating Physician Groups (PPG)

The primary focus of the Employee Assistance Program (EAP) is to resolve short-term issues. If a member needs ongoing assistance with behavioral health needs, the EAP clinician can conduct an assessment and furnish referrals to appropriate treatment resources, such as those covered by the employee's health insurance plan, or to community resources.

Many members accessing EAP services are not looking for or are not in need of psychotherapy. Members can access services for a range of reasons. The most common presenting problem is marital and family concerns. However, members also use EAP for problems in the workplace; stress, anxiety and sadness; alcohol and drug dependency; grief and loss; and other emotional health concerns.

In addition, EAP offers eligible members and their family members an array of non-clinical services. EAP experts provide telephonic guidance and referrals to help with financial and legal matters, identity theft recovery, childcare, elder care, and pre-retirement planning.

EAP providers can refer members to the Health Net behavioral health provider network and, when needed, coordinate care with the member's primary care physician (PCP) or participating physician group (PPG). Clinical care managers are available to work with EAP providers on referrals to behavioral health providers and programs.

Exclusions

Provider Type: Physicians |Hospitals | Participating Physician Groups (PPG) | Ancillary

The following are general exclusions that are not covered under the behavioral health program:

- Non-treatable disorders: Mental disorders or substance abuse conditions that Health Net determines are not likely to improve with generally accepted methods of treatment or conditions excluded from coverage.
- State hospital treatment: Treatment or confinement in a state hospital are limited to treatment or confinement as the result of an emergency or urgent care.
- Non-standard therapies: Services that do not meet national standards for professional mental health practice, such as Erhard/The Forum, primal therapy, bioenergetics therapy, crystal healing therapy and therapies deemed experimental or investigational by medical policies.
- Psychological testing: Psychological testing for learning disabilities, academic difficulties, and educational achievement testing are not covered. Testing for attention deficit hyperactivity disorder (ADHD) as a single diagnosis, or not part of diagnostic clarification is also not a covered benefit. Psychological testing must be conducted by a licensed psychologist or psychiatrist, and must be medically necessary to diagnose or treat a mental health disorder.

- Prescription medications: Outpatient prescription medications or over-the-counter medications.
- Private-duty nursing: Private-duty nursing services in the home or in a hospital
- Insurance: Services for obtaining or maintaining insurance.
- Aversion therapy: Therapy intended to change behavior by inducing a dislike for the behavior through association with a noxious stimulus.
- Treatment for co-dependency: Treatment for co-dependency services, unless they are provided for a treatable mental disorder.
- Wilderness programs or therapeutic boarding schools not licensed as residential treatment centers.
- Non-participating providers: Services provided by mental health professionals or facilities not contracting with Health Net, except in those cases where Health Net refers a member to a non-participating provider or authorizes emergency or urgently needed care.
- Treatment by a relative: Treatment or consultation provided by the member's parents, siblings, children, current or former spouse, or any adults who live in the member's household.

- Education and employment services: Services related to educational, vocational and professional purposes, including:
  - Treatment of learning disabilities, borderline intellectual functioning and mental retardation.
  - Vocational rehabilitative education.
  - Investigations required for employment.
  - Education for maintaining employment or for professional certification.
  - Education for personal or professional growth, development or training, including vocational counseling.
  - Academic education during residential treatment.
- Testing, screening or treatment for learning disabilities.
- Specialized treatment program for smoking cessation, weight reduction, obesity, stammering, stuttering, or sexual addiction.

The following types of treatment, except when provided in connection with covered treatment for a behavioral disorder or substance abuse condition:

- Treatment ordered by a court or treatment related to judicial/legal proceedings, including child custody, driving under the influence (DUI), driving while intoxicated (DWI), divorce, or child/elder/spousal abuse or neglect.
- Treatment of chronic pain.
- Treatment for co-dependency.
- Treatment for psychological stress.
- Relational problems, such as marital dysfunction, parent/child dysfunction, sibling dysfunction, spousal abuse, and work-related conflicts.
- Problems of daily living, such as stress, work, unemployment, uncomplicated bereavement, homelessness, poverty, phase of life, acculturation/discrimination, victim of crime/terrorism, incarceration, religious/spirituality problems, unwanted or conflicted pregnancy, lifestyle conflicts, and malingering.

For additional list of exclusions, providers must refer to the member Evidence of Coverage (EOC).

General Guidelines for Referrals

Provider Type: Physicians |Hospitals | Participating Physician Groups (PPG) | Ancillary

The following situations warrant referring a member to a behavioral health provider:

- Moderate to severe symptoms of depression that are not responding to treatment with first-line antidepressant medications.
- Suicidal ideation.
- Schizophrenic disorders where Clozaril® or risperidone or similar psychopharmaceuticals are being considered.
- Bipolar disorder where lithium, valproic acid, carbamazepine, or similar psychopharmaceuticals may be needed.
- Eating disorders.
- Psychological issues for outpatient referral, such as anxiety, phobias, stress, and depression.
- Transition of care from psychological to medical facility, such as a skilled nursing facility (SNF), or vice versa.

- Member is inpatient and a behavioral health provider is consulted or behavioral health services are ordered as part of the discharge plan.
- Alcohol or other substance abuse or dependence that is not responsive to brief interventions to reduce intake, motivational enhancement therapies and self-help programs, or those in need of detoxification.
- Transition from detoxification to medical bed.
- Psychiatric consultation, psychological/neuropsychological testing or psychiatric evaluation requested at a facility.
- Catastrophic illness requiring behavioral health support.
- Difficult placement due to medical and behavioral health problems.
- Pain management with substance abuse issues.
- Frequent emergency visits for behavioral health diagnoses or pain issues.
- Autism spectrum disorder.

Behavioral Health Customer Service

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

Customer service is available 24 hours a day, seven days a week through the phone number listed on the back of the member's identification (ID) card. The following services are available to members:

- Claims inquiry
- Clinical referral
- Eligibility inquiry
- Explanation of behavioral health benefits, including exclusions and limitations
- Referral for crisis triage/evaluation and referral

Obtaining Behavioral Health and Substance Abuse Care

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

A member who needs a behavioral health referral may contact Health Net directly, without a referral from their primary care physician (PCP) or participating physician group (PPG). Members should refer to their identification card for the phone number. The member's PPG or employer group Employee Assistance Program (EAP) counselor may also make the referral to behavioral health services advising the member to contact the Member Services number listed on the back of the member’s ID card.

Member Services is available 24 hours a day, seven days a week. Licensed clinical care managers and customer service representatives are always available for referrals, benefit inquiries and crisis intervention.

- Crisis intervention: A clinical crisis is defined as when a member presents a situation involving imminent danger to self or others, or suspected grave disability. A grave disability is when a

member demonstrates severely impaired judgment as a result of psychosis or other psychiatric condition leading to inability to manage self-care safely. The clinical care manager is responsible for assuring that the crisis evaluation is arranged and must make follow-up contact to confirm that the emergency face-to-face evaluation was conducted and the disposition is in place according to Health Net's accessibility and follow-up standards. Health Net has licensed behavioral health clinicians available for phone crisis intervention, stabilization and referrals.
- Routine: If the situation is not defined as emergency or urgent, the customer service representative assesses the member's needs, geographic area, benefit plan and scheduling requirements to determine the type and location of providers available to meet those needs. The customer service specialist then conducts a provider search and furnishes the member with several referrals from which to choose. Member preferences and needs, such as gender, linguistic and cultural experience, are seriously considered. After receiving referrals, the member calls providers directly in order to schedule an appointment.

When medication or quality of care is in question, the clinical care manager may arrange for a second opinion by another psychiatrist.

- Urgent: After assessing the situation, the clinical care manager either provides referral information to the member or, as necessary, may assist with scheduling an appointment.

Out-of-Area Cases Involving an Acute Medical Diagnosis

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

In cases where there is an acute medical diagnosis during inpatient psychiatric care and the member is out of the service area, Health Net takes steps to transfer the member into the service area. The Plan's behavioral health case manager assists in coordinating the member's transfer and in connecting the behavioral health provider with the member's primary care physician (PCP). The treating psychiatrist and the member's PCP decide whether the member will be transferred and the level of the facility to which the member will be transferred. The PCP is responsible for locating the medical facility for treatment of the acute medical diagnosis.

Blood

Provider Type: Physicians | Participating Physician Groups (PPG)

Blood and blood plasma, and derivatives are covered.

This coverage includes all of the following:

1. Community blood
2. Designated donor blood

3. Autologous blood (including collection and storage, is covered only for a scheduled surgery that has been authorized, even if the anticipated surgery is not performed)

Blood factors are covered under the Specialty Drug tier under the pharmacy benefit.

Any participating provider can provide antihemophilic factors (for example, Factors VIII and IX) for Food and Drug Administration (FDA)-approved indications.

Chemotherapy

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information on chemotherapy.

Select any subject below:

- Overview
- Off-Label Use

Overview

Provider Type: Physicians | Ancillary | Participating Physician Groups (PPG)

Chemotherapy is covered when it is provided by a participating provider in an inpatient hospital setting, at the participating physician group (PPG) or other outpatient setting, or in the member's home. Visits for treatment are not considered office visits.

Health Net's capitated home infusion provider must be used for home chemotherapy services for Health Net members. If a delegated PPG does not use the capitated home infusion provider to provide home chemotherapy, the services are the PPG's responsibility.

Off-Label Use

Provider Type: Physicians | Ancillary | Participating Physician Groups (PPG)

Food and Drug Administration (FDA)-approved chemotherapy and oncology medications used for an off-label malignancy or indication are covered if approved by the Health Net National Pharmacy and Therapeutics (P&T) Committee or Medical Advisory Council (MAC), or if evidence is presented that the medication used in treatment for a particular cancer is indicated under a professionally recognized standard of care. Providers may contact their medical program manager (MPM) to determine whether the Health Net P&T or MAC approves a chemotherapy or oncology medication.

Chiropractic

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information on chiropractic services.

Select any subject below:

- Coverage Explanation

Coverage Explanation

Provider Type: Physicians | Participating Physician Groups (PPG)

The following information does not apply to Individual Family Plan (IFP) members.

Chiropractic services for treatment of neuromusculosketetal disorders of the spine, neck and joints are a covered benefit, under the member's medical plan through the participating physician group (PPG) or as purchased by the employer group through American Specialty Health Plans, Inc. (ASH Plans). ASH Plans is a specialized health care service plan that provides and arranges for delivery of chiropractic services through a network of ASH Plans-participating chiropractors. A referral from the PPG or primary care physician (PCP) is not required. A member requesting chiropractic services should be referred to their employer group or the Health Net Member Services Department.

Coverage Criteria

Chiropractic services provided through a member's PPG are subject to the applicable copayment for either the specialist consultation or rehabilitation therapy, based on the diagnosis and procedure code. The member must adhere to referral and authorization protocol through their PPG and PCP and chiropractic services are subject to the medical benefits exclusions and limitations listed as in the Evidence of Coverage (EOC) or Certificate of Insurance (COI).The PPG is financially responsible through capitation, if the PPG has financial risk under the Division of Financial Responsibility (DOFR) for outpatient professional and/or rehabilitation services. X-ray services are covered when prescribed by a participating chiropractor and performed by the PPG's participating provider for verification of suspected tumors or fractures, not for routine care.

For plans with chiropractic coverage through ASH Plans, the member may self-refer to an ASH Plans-participating chiropractor located in California for an initial examination and development of a treatment plan. Subsequent visits are authorized by ASH Plans and the member is covered up to a maximum number of visits as stated in the Schedule of Benefits or the EOC. Additional services in subsequent visits may include:

- Manipulations, adjustments, therapy, X-ray procedures, and laboratory tests in various combinations
- Adjunctive therapy, as set forth in a treatment plan approved by ASH Plans, which may involve therapies such as hot packs, cold packs, electrical muscle stimulation, and other therapies

Medically Necessary Services

Medically necessary chiropractic care is covered through the member's medical benefit in the same manner as any other specialist care when determined medically appropriate for the member's condition and authorized by the provider. The applicable specialist copayment applies.

Providers can refer to the member's Schedule of Benefits and Evidence of Coverage (EOC) for additional information on copayments, benefit coverage, exclusions and limitations.

Exclusions and Limitations

Chiropractic care through the member's medical benefits is subject to the exclusions and limitations for medical benefits listed in the member's EOC or COI. The following services or supplies are not covered:

- Examinations or treatments for conditions other than those related to neuromusculoskeletal disorders and physical therapy not associated with spinal, muscle or joint manipulation
- Laboratory services
- Surgical procedures
- Durable medical equipment (DME)
- Medications (prescription or non-prescription)
- Hypnotherapy, behavior training, sleep therapy, and weight programs
- Thermography
- MRI and any types of diagnostic radiology, other than X-rays
- Transportation costs, including local ambulance charges
- Education programs, non-medical self-care, self-help training, or any related diagnostic testing
- Vitamins, minerals, nutritional supplements, or other similar products
- Anesthesia
- Chiropractic care that is investigatory or an unproven chiropractic service that does not meet generally accepted and professionally recognized standards of practice in the chiropractic provider community
- Charges for hospital confinement and related services

Chiropractic Appliances

The following information does not apply to Individual Family Plan (IFP) members.

Coverage is limited to employer group plans that include chiropractic care through American Specialty Health Plans, Inc. (ASH Plans) and may be subject to the maximum allowable amount as listed in the member's Evidence of Coverage (EOC) or Certificate of Insurance (COI). The following chiropractic appliances are covered when prescribed by a participating chiropractor and approved by ASH Plans:

- Back support (thoracic)
- Cervical collar
- Cervical pillow
- Elbow support
- Heel lifts
- Home traction units (cervical, lumbar)

- Hot or cold packs
- Lumbar cushion
- Lumbar support and braces
- Orthotics
- Rib belts and supports
- Ankle and knee braces
- Wrist supports and braces

Management Programs

The following information does not apply to Individual Family Plan (IFP) members.

American Specialty Health Plans, Inc. (ASH Plans) provides the following management programs for plans with supplemental chiropractic coverage:

- Provider management - manages the quality, competence and availability of network providers
- Utilization management - eliminates overuse and ensures the quality of chiropractic care
- Quality assurance management - identifies, evaluates and resolves problems that relate to access, continuity, quality of care, use, and cost of services
- Data management - provides comprehensive methods of collecting, evaluating and reporting data
- Administrative management - provides administrative services to all ASH Plans programs

Clinical Trials

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information for clinical trials services.

Select any subject below:

- Coverage Explanation

Coverage Explanation

Provider Type: Physicians |Hospitals | Participating Physician Groups (PPG) | Ancillary

Health plans or delegated participating physician groups (PPGs) must cover all medically necessary routine patient care costs related to a clinical trial for a member who has been accepted for participation in a nationally recognized phase I, II, III, or IV clinical trial. The member must also be diagnosed with cancer or other life-threatening disease or condition, or their physician otherwise recommended participation in the clinical trial.

The Health Net prior authorization letter for an approved clinical trial identifies items and services that are considered part of the clinical trial to the extent they are known at the time of initial review. These items and services are covered by the study entity. For HMO plans, the initial and any follow-up authorizations also specify which foreseeable items are routine services and costs that the member must obtain in-network, unless the member's PPG authorizes the services to be rendered out-of-network.

Services rendered as part of an approved clinical trial may be provided by Health Net-participating providers or non-participating providers when the protocol for the trial is not available through a participating provider. The provider's recommendation for participation must be based on a determination that participation in the clinical trial has a "meaningful potential to benefit the member." Members participating in approved clinical trials must continue to obtain primary and specialty health care services from or through their primary care physicians (PCPs). Authorization requirements that would apply to services if they were not performed in relation to a clinical trial continue to apply to routine services provided in relation to a clinical trial. PPGs and PCPs should authorize the services of, and refer members to, in-network providers whenever it is medically appropriate. Copayments and deductibles for routine services provided in relation to a clinical trial are the same as for services that are not provided in a clinical trial.

Members are eligible for participation in clinical trials if they meet the trial protocol. These trials are for treatment with a medication that is exempt from federal regulation in relation to a new medication application, or is approved or funded by one of the following:

- Agency for Healthcare Research and Quality (AHRQ).
- Centers for Disease Control and Prevention (CDC).
- Centers for Medicare & Medicaid Services (CMS).
- National Institutes of Health (NIH).
- Food and Drug Administration (FDA) as an investigational new medication application.
- A cooperative group or center for any of the entities described in clauses (i) to (iv) above, inclusive, the United States Department of Defense (DOD), the Department of Veterans Affairs (VA) or the Department of Energy..
- Qualified non-governmental research entity identified in the guidelines issued by NIH and meets criteria established by the NIH for grant eligibility.

Providers must provide the treatment or conduct the study within their scope of practice, experience and training. They must also agree to accept reimbursement as payment in full from Health Net at Health Net-established rates that is not more than the level of reimbursement for other similar services provided by participating providers.

Refer to definition of clinical trials for more information.

Exclusions

Coverage for approved clinical trials does not include health care services that would not normally be covered and are provided only as a result of a member's participation in the clinical trial. Coverage for clinical trials does not include:

- Medications or devices not approved by the Food and Drug Administration (FDA)
- Travel, housing, companion expenses, and other non-clinical expenses
- Items or services used solely for data collection and analysis. Health Net does not cover imaging or lab tests beyond those reasonably necessary for routine care
- Health care services customarily provided free of charge by the research sponsors of the clinical trial

- Any medication, item, device, or service that is specifically excluded from coverage under the medical plan
- Any investigation medication or device provided in a phase I clinical trial
- Any costs for managing the research of the clinical trial
- Treatment or services outside California are not covered if the clinical trial is offered in California
- Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis

Health plans are not required to provide benefits for routine patient care services provided outside of the plan's provider network unless out-of-network benefits are otherwise provided by the plan.

When a referral to a non-participating provider is necessary because a clinical trial is not available through a participating provider, Health Net or the PPG may condition the referral to the nonparticipating provider on its acceptance of a negotiated rate that Health Net or the PPG would otherwise pay to a participating provider for the same services, less any applicable copayments and deductibles or for the clinical trial to work with the PPG to have the routine services done within the network.

Qualified Individual

A Health Net member in a group or individual health plan who meets the following criteria is considered a qualified individual for a clinical trial:

- Diagnosis of cancer or other life-threatening disease or condition, or otherwise eligible to participate in an approved clinical trial according to the trial protocol
- Member or member's provider supplies medical and scientific documentation establishing that the member's participation in such a trial would be appropriate based upon them meeting the guidelines and eligibility criteria

Routine Patient Care Cost

By state and federal law, payment for routine patient care costs associated with participation in the approved clinical trial must be provided under the member's medical plan. This means that if the medical plan covers a medication, item, device, or service for care not related to participation in the approved clinical trial, then the charges for the same care related to participation in the approved clinical trial must be covered. Some examples of routine patient care costs that might be covered include:

- Physician consultations
- Medications
- Radiological or diagnostic testing services
- Inpatient care
- Services required for the provision of the medication, device or medical treatment being tested in the clinical trial
- Clinically appropriate monitoring of the effects of the medication, device or treatment being tested
- Any reasonable and necessary care for the prevention of complications

Utilization Management Process

PPGs or directly contracting physicians should use the following process when requesting that Health Net provide prior authorization for a Health Net member to participate in an approved clinical trial:

- Request a copy of the clinical protocol summary sheet and other pertinent documents
- Identify the sponsor of the clinical trial
- Confirm that the medications or service being evaluated meet the criteria established in the legislation
- Require documentation by the treating physician that the trial may have therapeutic benefit for the member
- Obtain a copy of the member's informed consent
- Submit the completed prior authorization request to Health Net as an urgent review request

All prior authorization requests for clinical trials are considered urgent prior authorization requests, unless otherwise noted.

When Health Net receives a direct communication from a provider requesting authorization to allow a member to participate in an approved clinical trial, Health Net alerts the PPG of such request in order to better ensure that the member is appropriately case managed.

Cosmetic and Reconstructive Surgery

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information on cosmetic and reconstructive surgery.

Select any subject below:

Overview

Provider Type: Physicians | Participating Physician Groups (PPG)

Reconstructive surgery is covered by Health Net. Reconstructive surgery is defined as surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, to do either of the following:

- Improve function
- Create a normal appearance to the extent possible

In the case of transgender members, gender dysphoria is treated as a “developmental abnormality” for purposes of the reconstructive statute and “normal” appearance is to be determined by referencing the gender with which the member identifies.

Cosmetic surgery is defined as surgery that is performed to alter or reshape normal structures of the body to improve appearance. Health Net does not cover cosmetic surgery. For Medicare Advantage (MA) members, Medicare generally does not cover cosmetic surgery unless it is needed due to accidental injury or to improve the function of a malformed part of the body. Medicare covers breast reconstruction if the member has had a mastectomy due to breast cancer.

Prior authorization for reconstructive surgery procedures, services and evaluations may be required. Providers should refer to the applicable prior authorization requirements under the Prior Authorization section for more information. Upon review, requests may be denied in any of the following situations:

- Denial of the proposed surgery if there is another more appropriate surgical procedure that is approved for the member
- Denial of the proposed surgery or surgeries if the procedure or procedures, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery, offer only minimal improvement in the member's appearance
    - The determination of whether a surgery will produce only minimal improvement should be based upon the standard of care, as practiced by physicians specializing in reconstructive surgery or other licensed physicians competent to evaluate the specific clinical issues involved in the care rendered
- Denial of payment for procedures performed without prior authorization
- For services provided by the Medi-Cal program (Chapter 7 (commencing with Section 14000), Part 3 of Division 9 of the Welfare and Institutions Code), denial of the proposed surgery if the procedure offers only a minimal improvement in the appearance of the member, as may be defined in any regulations that may be promulgated by the California Department of Health Care Services (DHCS)

Participating physician groups (PPGs) or attending physicians can refer to the Reconstructive Surgery Decision Tree (PDF) for guidance in making decisions about reconstructive surgery cases.

Breast Cancer Reconstructive Surgery

Provider Type: Physicians | Participating Physician Groups (PPG)

Mastectomy is defined as the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician and surgeon. Partial removal of a breast includes, but is not limited to, lumpectomy, which includes surgical removal of the tumor with clear margins. Complications from a mastectomy are covered, including lymphedema. Lymphedema sleeves and gloves are covered as prosthetic devices.

Treatment for breast cancer includes coverage of prosthetic devices or reconstructive surgery to restore and achieve symmetry for the member incident to a mastectomy.

In addition to coverage of prosthetic devices and reconstructive surgery for the diseased breast on which the mastectomy was performed, prosthetic devices and reconstructive surgery for the healthy breast are also covered when necessary to achieve normal symmetrical appearance.

A subsequent request for additional surgery to change the previously achieved symmetry is considered cosmetic unless the subsequent surgery is medically necessary or is being performed again to achieve

symmetry after subsequent surgery has been performed on the diseased breast. Such cosmetic surgery is not a covered benefit.

Cleft Palate Diagnoses

Provider Type: Physicians | Hospitals| Participating Physician Groups (PPG)

Treatment for cleft lip/palate as covered under California Children's Services (CCS). Cleft palate may also include, cleft lip or other craniofacial anomalies associated with cleft palate. Health Net covers medically necessary services that are an integral part of cleft palate reconstruction and are not approved by CCS. To the extent that Medi-Cal members who require medically necessary dental or orthodontic services are determined eligible for the California Children's Services (CCS) program, these services are provided by CCS.

Cleft palate reconstruction services require prior authorization.

Dental Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information on dental screening and services.

Select any subject below:

- Overview
- General Anesthesia Coverage and Exclusions

Overview

Provider Type: Physicians | Participating Physician Groups (PPG)

Some Medicare Advantage members have basic and/or restorative dental coverage. For a comprehensive list of covered dental services for these members, refer to the member's Evidence of Coverage (EOC) or Schedule of Benefits.

Dental services are generally not covered, with the exception of dental services covered for pediatric members under age 19 (until at least the end of the month in which the enrollee turns 19 years of age) enrolled in a Health Net plan that includes dental coverage required by the Affordable Care Act (ACA). Pediatric dental services are administered by Dental Benefit Partners (DBP).

When a member is hospitalized for non-covered dental treatment only, neither the professional services of the dentist nor the inpatient hospital services are covered. However, if a member is hospitalized for a non-covered dental procedure and hospitalization is required to ensure proper medical management, control or treatment of a non-dental impairment, the inpatient hospital services are covered. An example is a member with a history of repeated heart attacks who is hospitalized in order to undergo extensive dental treatment.

General anesthesia and associated facility services are covered when the clinical status or underlying medical condition of the member requires that an ordinarily non-covered dental service normally treated in the dentist's office without general anesthesia must instead be treated in a hospital or outpatient surgical center.

For questions pertaining Medicare coverage and dental services, contact the Health Net Medicare Member Services Department.

Coverage Explanation

If a member is hospitalized for a non-covered dental procedure and hospitalization is required to ensure proper medical management, control or treatment of a non-dental impairment, inpatient hospital services are covered. An example is a member with a history of repeated heart attacks who is hospitalized in order to undergo extensive dental treatment.

Immediate emergency treatment to the natural teeth as a result of an accidental injury is covered (damage to the teeth while chewing is not considered an accidental injury). Coverage of follow-up care to the natural teeth is limited to emergency treatment required following the injury. Crowns, inlays and onlays, teeth replacements, dental implants, and endodontic services are not covered.

The services listed below for disorders of the temporomandibular joint (TMJ) are covered:

- Surgical procedures to correct abnormally positioned or improperly developed bones of the upper or lower jaw if the services are medically necessary due to recent injury, the existence of cysts, tumors or neoplasms, or a currently evidenced objective functional disorder
- Surgical procedures and oral splint or oral appliance to correct disorder to the TMJ, if medically necessary

Unless specified in the member's Evidence of Coverage (EOC) or Schedule of Benefits, as described below, the following appliances are not covered for the treatment of TMJ:

- Crowns
- Inlays
- Onlays
- Dental implants
- Bridgework (to treat dental conditions related to TMJ disorders)
- Braces and any other orthodontic services

Members Ages 19 and Under Enrolled in a Health Net Plan that Includes Dental Coverage

For members under age 19 enrolled in a Health Net plan that includes dental coverage, an annual dental check-up is included under the member's coverage, as required by the Affordable Care Act (ACA). Pediatric dental services are administered by Dental Benefit Partners (DBP).

For a comprehensive list of covered appliances and dental services for these members, refer to the member's EOC or Schedule of Benefits.

General Anesthesia Coverage and Exclusions

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

General Anesthesia Coverage

Health Net does not cover any charges for the dental procedure itself, including the professional fee of the dentist or any other provider.

However, general anesthesia and associated facility charges for non-covered dental care rendered in a hospital or surgery setting are covered if under one or more of the following circumstances:

- Members are under age seven
- Members are developmentally disabled, regardless of age
- Members' health is compromised and for whom general anesthesia is medically necessary, regardless of age

Health Net provides coverage if the services are rendered in a Health Net participating facility. Prior authorization is required. Refer to the Prior Authorization section for more information regarding prior authorization procedures.

General Anesthesia Exclusions

Health Net does not cover any charges for the dental procedure itself, including the professional fee of the dentist or any other provider for administration of anesthesia.

Dialysis

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information on dialysis.

Select any subject below:

- Overview

Overview

Provider Type: Physicians | Participating Physician Groups (PPG) | Ancillary

Dialysis services are covered on all plans. Refer to the specific plan chart in the Schedule of Benefits.

Out-of-Area Dialysis

If an end-stage renal disease (ESRD) member receiving dialysis informs their participating physician group (PPG) or physician of an intention to travel within the United States, making it impossible for the member to use the customary in-area services or facilities, the PPG or Health Net will:

- Authorize dialysis services by other providers
- Arrange for the services to be performed by providers in the member's temporary location
- Inform the member it may be necessary to change the type of setting in which dialysis is performed, because local circumstances may not allow the same type of setting to be used
- Authorize the services for the length of the planned trip
- Inform the member in writing about the details of what has been authorized and state, if travel plans change and additional time is needed, the member must inform the PPG or Health Net. If the member extends the duration of the trip and informs the PPG or Health Net, a one-time modification of the authorization is made to cover the additional time period

Costs are borne in the same manner as if the member received the services within their service area. Non-emergency dialysis received out of the United States is not a covered service.

Refer to the plan charts in the Schedule of Benefits for specific plan information.

Out-of-Country Dialysis

Non-emergency dialysis received out of the United States is not a covered service, which includes all outpatient dialysis received by members presently diagnosed with ESRD and already receiving dialysis services.

Durable Medical Equipment

Provider Type: Physicians | Participating Physician Groups (PPG) (does not apply to HSP) | Hospitals | Ancillary

This section contains general member benefit information on durable medical equipment.

Select any subject below:

Coverage

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

Medically necessary durable medical equipment (DME) is covered under all health plans. Refer to the Schedule of Benefits and the member's Certificate of Insurance or Evidence of Coverage (EOC) as applicable to determine exclusions and limitations, as applicable. Apria Healthcare is the preferred provider for DME for PPO and EPO plans.

DME benefits include but are not limited to:

- Wheelchairs
- Walkers
- Crutches
- Canes
- Braces - Orthopedic appliance or apparatus used to support, align, prevent, or correct deformities, or to improve the function of moveable parts of the body. Coverage includes leg, arm, back, and neck braces, and trusses. Back braces include special corsets and sacroiliac, sacrolumbar and dorsolumbar corsets and belts
- Intermittent positive-pressure breathing machines
- Oxygen
- Blood glucose monitoring devices, if authorized. Blood glucose test strips and lancets are covered under the pharmacy benefit. Insulin-dependent and non-insulin-dependent diabetics may receive these supplies:
    - Members are offered blood glucose monitoring devices and supplies as listed in the Health Net Recommended Drug List (RDL). New members may change their current blood glucose monitoring device for one of the preferred brands at no charge

  Members who do not have diabetic supply coverage through their pharmacy benefit, have a benefit for diabetic supplies under their DME coverage. They should obtain test strips and supplies from a contracted DME vendor. For more information regarding a member's benefits, refer to the introduction pages in the Schedule of Benefits. Refer to the Schedule of Benefits to determine coverage.

- Insulin pumps are covered through DME when specific medical criteria are met. For more information, refer to Health Net's medical policy on insulin pumps, available on the Health Net provider website
- Infant apnea monitor - This item is covered for use in the hospital or at home
- Phototherapy (bilirubin lights)
- Medically necessary lactation DME (electric breast pump) - Health Net's preferred breast pump provider is Pumping Essentials

Prescriptions for lactation-related DME must be written by a licensed physician, physician's assistant, nurse practitioner, certified nurse midwife, or certified lactation consultant with a license to practice medicine or nursing. Health Net requires a prescription from the member's physician for a breast pump from Pumping Essentials; however, no prior authorization is needed.

Lactation-related DME, including electric pumps (if the member prefers, battery operated pumps can be substituted) and pump kits (one per member), do not require prior authorization from the PPG for the first two months of use. Longer use requires documentation of continued clinical need and current successful use.

Custom footwear and custom shoe inserts are not a standard covered benefit, and are only covered on specific plans. However, custom footwear and custom shoe inserts are covered for members with diabetes, to prevent or treat diabetes-related complications. For members with diabetes the extra foot orthotic benefit coverage includes one pair of extra depth or custom molded shoes (including non-customized removable inserts provided with the shoes) and three pairs of inserts each calendar year.

Exclusions and Limitations

Provider Type: Physicians | Ancillary | Participating Physician Groups (PPG)

Durable medical equipment (DME) is a covered benefit on all health plans. Refer to the Schedule of Benefits and coverage documents to determine exclusions and limitations, as applicable. Additional non-covered items are:

- Disposable supplies for home use
- Exercise or hygienic equipment, including shower chairs and bath tub lifts
- Corrective appliances (except casts, splints, and surgical dressings)
- Support appliances and such supplies as stockings, arch supports, foot orthotics (except when it is a foot orthotic that has been incorporated into a cast, brace or strapping of the foot or sleeves and gloves for lymphedema), and corrective shoes and devices unless member has a rider for custom footwear or is a diabetic
- Comfort items for example, diapers, incontinent pads, pillows, beds
- Contact or corrective lenses (except an implanted lens that replaces the organic eye lens) and eyeglasses (unless specifically provided elsewhere in the subscriber's Evidence of Coverage (EOC)
- Jacuzzi or whirlpool
- Fully electric beds
- More than one device for the same part of the body or more than one piece of equipment that serves the same function
- Running or sport devices, and other devices considered lightweight, when not medically necessary
- Consultations of an environmental engineer, air conditioners, humidifiers not used as part of DME equipment, dehumidifiers, purifiers, pillows, Jacuzzis, saunas, exercise equipment and bicycles, and elevators
- Replacement of lost devices

Orthotics

Provider Type: Physicians (does not apply to CMC) | Ancillary| Participating Physician Groups (PPG) (does not apply to HSP)

Orthotics are rigid or semi-rigid device affixed to the body externally and required to support or correct a defect of form or function of a permanently inoperative or malfunctioning body part or to restrict motion in a diseased or injured part of the body. Orthotic items are covered through the durable medical equipment (DME) option.

Orthotic items that can be purchased over the counter are not covered. Foot orthotics, except when incorporated into a cast, brace, or strapping of the foot, are not covered, unless an employer has specifically purchased this coverage.

Service Providers

Provider Type: Physicians | Ancillary | Participating Physician Groups (PPG)

Durable medical equipment (DME) is paid for in accordance with the Provider Participation Agreement (PPA). Fee-for-service (FFS) providers may be directed to any participating Health Net DME provider, including Apria Healthcare, Inc. Custom rehabilitation equipment services are obtained through the following organizations:

- Custom Rehab Network
- National Seating & Mobility
- Hoveround, Inc.
- Numotion.

For insulin pumps and supplies, contact Advanced Diabetes Supply, MiniMed, Inc.,CCS Medical, or Tandem Diabetes.

Orthotics and prosthetics can be obtained from any Health Net participating provider, such as Linkia, LLC. Refer to the PPA to determine financial responsibility.

For delegated providers, please contact the PPGs for more information.

Essential Health Benefits

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

Health Net provides coverage consistent with the Essential Health Benefits (EHBs) coverage requirement in accordance with the Affordable Care Act (ACA). EHBs include items and services that fall into at least the following categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription medications
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services, and chronic disease management
- Pediatric services, including dental and vision care

Actual EHB services vary by state, as each state may define EHB in accordance with its state benchmark plan. Plans subject to the EHB requirement must provide benefits that are equal to or greater than the state benchmark plan's benefits. Annual dollar limits on EHB are prohibited. Additional information regarding state benchmark plans is available on the Center for Consumer Information and Insurance Oversight (CCIIO) website at www.cms.gov/cciio/index.html.

Family Planning

Provider Type: Physicians | Participating Physician Groups (PPG)Participating Physician Groups (PPG) (does not apply to HSP) | Hospitals | Ancillary

This section contains general member benefit information on family planning services.

Select any subject below:

- Overview
- Infertility Treatment

Overview

Provider Type: Physicians | Ancillary | Participating Physician Groups (PPG) (does not apply to HSP)

Family planning services are covered by all Health Net plans, subject to scheduled member cost-share amounts including deductibles, copayments and coinsurance. The following are generally covered:

- Counseling by a physician to determine the number and spacing of the member's children through effective methods of birth control.
- Fitting, insertion and removal of implantable birth control devices, cervical caps, diaphragms, and intrauterine devices (IUDs).
- Sterilization for males and females and termination of pregnancy (abortions) are also covered. Refer to the Schedule of Benefits and the member's Evidence of Coverage (EOC) for coverage information and applicable copayments.

Contraceptive Devices

Health plans are required to cover up to a 12-month supply of U.S. Food and Drug Administration (FDA)-approved, self-administered hormonal contraceptives, such as the ring, the patch and oral contraceptives, when dispensed at one time. This is pursuant to a valid prescription that specifies an initial quantity followed by periodic refills and when the annual supply is requested by the enrollee.

Contraceptive coverage under the member's medical plan includes injectable contraceptives, Depo Provera® and Depo-SubQ Provera 104®. Depo Provera and Depo-SubQ Provera 104 is covered as all other injectables. Refer to the Schedule of Benefits and the member's EOC for coverage information and applicable copayments.

Contraceptive coverage through the member's prescription medication coverage includes oral contraceptives, diaphragms, cervical caps, contraceptive patches, the contraceptive ring, and women's over-the-counter contraceptive products. Not all members have prescription medication coverage. Typically, coverage is still required, even if a member does not have prescription medication coverage. The fitting and insertion of contraceptive devices are covered under the medical plan.

If the member's physician determines that none of the contraceptive methods specified in the member's EOC are medically appropriate for the member based on the member's medical or personal history, another prescription contraceptive method approved by the Food and Drug Administration (FDA) and prescribed by the member's physician is covered. Devices or medications covered under the prescription medication benefit are only covered for members who have a prescription medication benefit.

The Schedule of Benefits plan chart or the prescription medication benefit coverage listed in the member's EOC indicates which contraceptive devices are covered and the applicable member cost-share amount. If a member cost-share is required, it is applied toward the member's out-of-pocket maximum (OOPM).

Intrauterine Devices

Types of IUDs include ParaGard® Copper T 380A and Mirena®. The fitting, insertion and removal of an IUD are covered.

Exclusions and Limitations

The following are exclusions and limitations on family planning coverage:

- Artificial conception (impregnation or fertilization) involving the harvesting or manipulation (physical, chemical or by any other means) of the human ovum, such as ovum transfer or in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT) are not covered.
- A search for a sperm or ovum donor is not covered.
- Collection of sperm and ova is not covered.
- Purchase and storage of sperm or ova are usually not covered. Refer to Health Net's Medical Policies > Assisted Reproductive Technology.
- Reversal of sterilization is not covered under most plans.

Refer to the Schedule of Benefits or member's EOC for exceptions.

Infertility Treatment

Provider Type: Physicians | Ancillary | Participating Physician Groups (PPG)

Some plans cover specific infertility services as referenced in the member's Evidence of Coverage (EOC) or Certificate of Insurance (COI). Before beginning infertility treatment, the member's treating practitioner must establish a treatment plan. Refer to the Schedule of Benefits for specific information concerning plans that cover gamete intrafallopian transfer (GIFT). If these benefits have not been purchased, Health Net must notify the member in writing of coverage limitations.

If a member has not conceived in a particular treatment plan, the member's treating practitioner should re-evaluate the plan and change the therapy. If the member is still unsuccessful, advanced treatment under the guidance of a reproduction endocrinologist or fertility specialist should be considered. The treatments below are covered when the following specified conditions are met:

- Artificial insemination (AI), intrauterine insemination (IUI), GIFT and sperm washing - Covered when used in treatment of infertility (ovulation sticks are not covered)
- IVF/ZIFT - Only certain plans cover IVF or ZIFT. Refer to the Schedule of Benefits for specific plan information

Refer to the Schedule of Benefits (SOB) for availability of infertility treatment; this is also referenced within the member's Evidence of Coverage. The treatment used for each infertile member may be different and should be individualized based on medical indications. Most Health Net plans subject infertility services to a 50 percent copayment. The copayment amount is based on the percent copayment multiplied by the average wholesale price or the actual cost of the injected substance, whichever is less.

The required copayments for infertility procedures may or may not apply to the out-of-pocket maximum (OOPM). Refer to the Introduction pages of the Schedule of Benefits for a list of exception groups.

GIFT is covered when:

- Plan covers standard infertility treatments/benefits
- GIFT procedure is medically indicated
- GIFT is performed by a reproductive endocrinologist or fertility specialist

Infertility Treatment (Ancillary and PPGs only)

Diagnosis of infertility may be appropriate for members who have not yet gone through menopause and have any of the following:

- The member has had coitus relations on a recurring basis for one year or more without use of contraception or other birth control methods which has not resulted in a pregnancy, or when a pregnancy did occur, a live birth was not achieved.
- The member does not have coitus with a male partner.
- A licensed physician's determination of infertility, based on the member's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors.

Infertility services is an optional benefit in employer group plans. When Health Net plans cover infertility treatment, coverage includes procedures consistent with established medical practices in the treatment of infertility by licensed physicians and surgeons including but not limited to diagnosis, diagnostic tests, medication, surgery, artificial insemination (AI), intrauterine insemination (IUI) and gamete intrafallopian transfer (GIFT). Some custom employer group plans include coverage of advanced reproductive technologies (ART), in vitro fertilization (IVF) and zygote intrafallopian transfer (ZIFT). Refer to the Schedule of Benefits and Evidence of Coverage (EOC) or Certificate of Insurance (COI) for coverage information and applicable copayments. Before beginning infertility treatment, the member's treating provider must establish a treatment plan.

If a member has not conceived in a particular treatment plan, the member's treating provider should re-evaluate the plan and change the therapy. If the member is still unsuccessful, advanced treatment under the guidance of a reproductive endocrinologist or fertility specialist should be considered. The number of cycles, or a dollar amount limit of a particular treatment plan and assistive reproductive technologies, may be limited under the member's plan. Consult the member's evidence of coverage. The standard and advanced treatments below are covered when the specified conditions are met.

Standard Infertility Treatments

Intrauterine insemination may be performed using either the partner's sperm or donor sperm.

Donation, storage and banking of member or donor sperm are not covered.

GIFT is covered when:

- Plan covers standard infertility treatments/benefits
- GIFT procedure is medically indicated
- GIFT is performed by a reproductive endocrinologist or fertility specialist licensed in the field

The required copayment for infertility procedures may or may not apply to the out-of-pocket maximum (OOPM), Refer to the introduction of the Schedule of Benefits for a list of exception groups.

Advanced Infertility Treatments

Assisted reproductive technologies (ART), IVF and ZIFT are advanced infertility treatment procedures.

For plans that cover ART, but limit the services to dollar limits, or a specified number of cycles per lifetime, ART is defined as:

- All office visits, procedures, blood work, and ultrasounds performed in preparation for oocyte retrieval
- Retrieval of the oocyte itself
- Culture and fertilization of the oocyte
- Embryo transfer

A cycle is counted toward the lifetime maximum once the member has had her oocytes retrieved, whether or not there is fertilization of the oocyte.

Before a member is eligible for ART coverage, alternate treatments must be attempted without success. The treatment used for each infertile member may be different and should be individualized based on medical indications. Most Health Net plans subject infertility services to a 50 percent copayment. The copayment amount is based on the percent copayment multiplied by the average wholesale price or the actual cost of the injected substance, whichever is less.

The required copayments for infertility procedures may or may not apply to the out-of-pocket maximum (OOPM). Refer to the Introduction of the Schedule of Benefits for a list of exception groups.

Exclusions and Limitations

General infertility services that are not covered include:

- Ovulation kits
- Partner's diagnosis and treatment if the partner is not covered by Health Net
- Benefits for reversal of voluntary sterilization unless otherwise stated by the member's EOC or COI
- Infertility treatment needed as a result of prior voluntary sterilization
- Donation, storage and banking of member or donor sperm or ova for future use
- Unless otherwise stated in the EOC or COI, the testing, storage and transport fees or any other charges incurred
- Sperm washing when used in preparation for a non-covered procedure
- Surrogacy or gestational carriers unless the surrogate is a Health Net member who has been diagnosed with infertility. When compensation is obtained for the surrogacy, Health Net or the participating provider may have a lien on such compensation to recover its medical expense
- Gender selection
- Donor eggs for women with genetic oocyte defects
- Donor sperm for men with genetic sperm defects
- Genetic engineering
- Co-culture of embryos

General Benefit Exclusions and Limitations

Provider Type: Physicians | Participating Physician Groups (PPG) (does not apply to HSP) | Hospitals | Ancillary

Limitations to Health Net's coverage are described below. In addition, services or supplies that are excluded from coverage in the Evidence of Coverage (EOC), exceed limitations, are follow-up care to EOC exclusions, or which are related in any way to EOC exclusions or limitations, are not covered.

- Blood - Services and supplies for the collection, preservation and storage of umbilical cord blood, cord blood stem cells and adult stem cells are not covered
- Conception by medical procedure - The collection, storage or purchase of sperm or ova is not covered
- Cosmetic services and supplies - Services and supplies performed solely to alter or reshape normal structures of the body in order to improve appearance are not covered. These include:
    - Hair transplant, hair analysis, hairpieces, wigs, and cranial or hair prostheses
    - Chemical face peels and abrasive procedures of the skin
    - Liposuction of any body part
    - Epilation
- In contrast to the exclusion for cosmetic surgery, reconstructive surgery is covered when surgery is performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:
- To improve function

- To create a normal appearance, to the extent possible
- Coverage for reconstructive surgery also includes:
  - Breast surgery and all stages of reconstruction for the breast on which a medically necessary mastectomy was performed and to produce a symmetrical appearance, surgery and reconstruction of the unaffected breast
  - Medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate, including cleft lip or other craniofacial anomalies associated with cleft palate
- Custodial or domiciliary care - Services and supplies that are provided primarily to assist with the activities of daily living are not covered, regardless of the type of facility. Hospice care for a terminally ill member or for a condition that requires continuous skilled nursing services is not considered custodial or domiciliary
- Dental services - Care or treatment of teeth and gingival tissues, extraction of teeth; treatment of dental abscess or granuloma, other than tumors, dental examinations, spot grinding, crowns, bridge work, onlays, inlays, dental implants, braces, and any orthodontic appliances are not covered unless specifically provided in the member's EOC
- Disorders of the jaw - Treatment and services for temporomandibular joint (TMJ) disorder are covered when determined to be medically necessary, except:
  - Crowns
  - Inlays
  - Onlays
  - Dental implants
  - Bridgework (to treat dental conditions related to TMJ disorder)
  - Braces and active splints for orthodontic purposes (movement of teeth)
- Disposable supplies - Disposable supplies for home use are not covered (for example, plastic gloves, diapers, incontinence pads, and wipes). Coverage for outpatient prescription medications includes coverage for disposable devices that are medically necessary for the administration of a covered outpatient prescription medication, such as spacers and inhalers for the administration of aerosol outpatient prescription medications, and syringes for self-injectable outpatient prescription medications that are not dispensed in pre-filled syringes
- Experimental or investigative services and supplies - All services and supplies not generally recognized under standards of care in the medical community are not covered, except for routine patient care costs associated with participation in clinical trials for a Health Net member with a diagnosis of cancer and has the recommendation of their treating physician. The exclusion from coverage does not include treatment of medical complications relating to, or arising out of, such services and supplies. Health Net decides whether a service or supply is experimental or investigational
- Eyeglasses and contact lenses - Contact lenses (except an implanted lens that replaces the organic eye lens) and eyeglasses are not covered, unless specifically provided in the member's EOC
- Genetic testing and diagnostic procedures - Covered when determined by Health Net to be medically necessary. The prescribing physician must request prior authorization for coverage. Genetic testing is not covered for non-medical reasons or when a member has no medical indication or family history of a genetic abnormality. Every health care service plan contract that covers hospital, medical or surgical expenses through an employer group, and which offers maternity coverage in such groups, also offers coverage for prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy
- Hearing aids - Any device inserted in or affixed to the outer ear to improve hearing is not covered, unless specifically provided in the member's EOC

- Ineligible status - Services or supplies provided before the effective date of coverage or after the date coverage has ended are not covered, except as specified in the extension of benefits portion of the member's EOC
- No-charge items - Services or supplies the member is not required to pay for or for which no charge is made are not covered
- Non-covered items - Durable medical equipment (DME) is a covered benefit on all health plans. Refer to the Schedule of Benefits to determine exclusions, limitations and applicable copayments. Non-covered items are:
- Exercise or hygienic equipment, including shower chairs and benches, bath tub lifts, exercise bicycles, treadmills, free weights
- Supplies to achieve cleanliness even when related to other medical services
- Surgical dressings, except primary dressings that are applied directly to lesions either of the skin or surgical incision, which are covered as a standard medical benefit. Over-the-counter dressings and supplies are not covered
- Jacuzzis and whirlpools
- Stockings, such as elastic stockings, job stocking and support hose, garter belts and similar devices, as not within the definition of brace
- Orthotics that are not custom-made to fit the member's body. Orthotics are orthopedic appliances or apparatus used to support, align, prevent, or correct deformities or to improve the function of moveable parts of the body. Coverage includes leg, arm, back, and neck braces and trusses. Back braces include special corsets and sacroiliac, sacrolumbar and dorsolumbar corsets and belts
- Corrective footwear (specialized shoes, arch supports and inserts) except for the treatment of diabetes-related medical conditions or as specifically provided in the member's EOC
- Non-eligible institutions - Services or supplies provided by any institution other than a licensed and approved hospital or Medicare-approved skilled nursing facility (SNF) or other properly licensed facility specified as covered in the member's EOC are not covered. Any institution that is primarily a place for the aged, a nursing home or any similar institution, regardless of how designated, is not an eligible institution
- Non-prescription (over-the-counter) medications, equipment and supplies - Any medication, equipment and supplies that can be purchased without a prescription order is not covered, even if a physician writes a prescription for it (except insulin and diabetic supplies or as specifically provided in the EOC)
- Personal or comfort items - Personal or comfort items such as a telephone or television in the room at a hospital or SNF are not covered
- Private-duty nursing - Private-duty nurses are not covered for a registered bed patient in a hospital or long-term care facility
- Private rooms - Private rooms in a hospital or SNF are not covered unless it is deemed to be medically necessary
- Refractive eye surgery - Any eye surgery for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), far-sightedness (hyperopia) and astigmatism, is not covered
- Reversal of surgical sterilization - Reversal of a prior voluntary surgical sterilization procedure is not covered
- Routine physical examinations - Routine physical examinations are not covered for insurance, licensing, employment, school, camp, or other non-preventive purposes, unless specifically provided otherwise in the EOC. On plans that cover routine physical examinations, the exam itself and any related X-ray and laboratory procedures are covered; however, completion of any related forms are not covered. Refer to the specific plan in the Schedule of Benefits
- Services for obtaining or maintaining insurance are not covered
- Sterilization is not covered for males and females. Refer to the specific plan in the Schedule of Benefits or EOC for exceptions

- Substance abuse - Treatment of chronic alcoholism, drug addiction and other substance abuse problems, except for acute detoxification and the acute medical treatment of these problems. Other services not covered include: non-medical ancillary services; prolonged rehabilitation services, including inpatient, residential and outpatient substance abuse program; psychological counseling and aversion therapy. The terms and conditions applied to these benefits must be the same as those applied to other medical benefits under the plan contract due to federal mental health parity laws. Refer to the specific plan in the Schedule of Benefits for exceptions
- Unauthorized services and supplies - Any services or supplies not authorized according to procedures Health Net and the participating physician group (PPG) have established are not covered
- Unlisted services - Services or supplies that are not specified as covered services or supplies are not covered, unless coverage is required by law

General Benefit Exclusions and Limitations (Physicians Only)

Limitations to Health Net's coverage are described below. In addition, services or supplies that are excluded from coverage in the Evidence of Coverage (EOC), exceed limitations, are follow-up care to EOC exclusions, or which are related in any way to EOC exclusions or limitations, are not covered.

- Blood - Services and supplies for the collection, preservation and storage of umbilical cord blood, cord blood stem cells and adult stem cells are not covered
- Conception by medical procedure - The collection, storage or purchase of sperm or ova is not covered
- Cosmetic services and supplies - Services and supplies performed solely to alter or reshape normal structures of the body in order to improve appearance are not covered. These include:
    - Hair transplant, hair analysis, hairpieces, wigs, and cranial or hair prostheses
    - Chemical face peels and abrasive procedures of the skin
    - Liposuction of any body part
    - Epilation
- In contrast to the exclusion for cosmetic surgery, reconstructive surgery is performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:
    - To improve function
    - To create a normal appearance, to the extent possible
    - Coverage for reconstructive surgery also includes:
        - Breast surgery and all stages of reconstruction for the breast on which a medically necessary mastectomy was performed and to produce a symmetrical appearance, surgery and reconstruction of the unaffected breast
        - Medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate, including cleft lip or other craniofacial anomalies associated with cleft palate
    - Custodial or domiciliary care - Services and supplies that are provided primarily to assist with the activities of daily living are not covered, regardless of the type of facility. Care provided by a hospice for a terminally ill member or for a condition that requires continuous skilled nursing services is not considered custodial or domiciliary
- Dental services - Care or treatment of teeth and gingival tissues, extraction of teeth; treatment of dental abscess or granuloma, other than tumors, dental examinations, spot grinding, crowns, bridge

work, onlays, inlays, dental implants, braces, and any orthodontic appliances are not covered unless specifically provided in the member's EOC
- Disorders of the jaw -Treatment and services for temporomandibular joint (TMJ) disorder are covered when determined to be medically necessary, except:
    - Crowns
    - Inlays
    - Onlays
    - Dental implants
    - Bridgework (to treat dental conditions related to TMJ disorder)
    - Braces and active splints for orthodontic purposes (movement of teeth)
- Disposable supplies - Disposable supplies for home use are not covered (for example, plastic gloves, diapers, incontinence pads, and wipes). Coverage for outpatient prescription medications includes coverage for disposable devices that are medically necessary for the administration of a covered outpatient prescription medication, such as spacers and inhalers for the administration of aerosol outpatient prescription medications, and syringes for self-injectable outpatient prescription medications that are not dispensed in pre-filled syringes
- Experimental or investigative services and supplies - All services and supplies not generally recognized under standards of care in the medical community are not covered, except for routine patient care costs associated with participation in clinical trials for a Health Net member with a diagnosis of cancer who has the recommendation of their treating physician. The exclusion from coverage does not include treatment of medical complications relating to, or arising out of, such services and supplies. Health Net decides whether a service or supply is experimental or investigational
- Eyeglasses and contact lenses - Contact lenses (except an implanted lens that replaces the organic eye lens) and eyeglasses are not covered, unless specifically provided in the member's EOC
- Genetic testing and diagnostic procedures - Covered when determined by Health Net to be medically necessary. The prescribing physician must request prior authorization for coverage. Genetic testing is not covered for non-medical reasons or when a member has no medical indication or family history of a genetic abnormality. Every health care service plan contract that covers hospital, medical or surgical expenses through an employer group, and which offers maternity coverage to such groups, also offers coverage for prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy
- Hearing aids - Any device inserted in or affixed to the outer ear to improve hearing is not covered, unless specifically provided in the member's EOC
- Ineligible status - Services or supplies provided before the effective date of coverage or after the date coverage has ended are not covered, except as specified in the extension of benefits portion of the member's EOC
- No-charge items - Services or supplies the member is not required to pay for or for which no charge is made are not covered
- Non-covered items - Durable medical equipment (DME) is a covered benefit on all health plans. Refer to the Schedule of Benefits to determine exclusions, limitations and applicable copayments. Non-covered items are:
    - Exercise or hygienic equipment, including shower chairs and benches, bath tub lifts, exercise bicycles, treadmills, and free weights
    - Supplies to achieve cleanliness even when related to other medical services
    - Surgical dressings, except primary dressings that are applied directly to lesions either of the skin or surgical incision, which are covered as a standard medical benefit. Over-the-counter dressings and supplies are not covered
    - Jacuzzis and whirlpools

    - Stockings, such as elastic stockings, job stocking and support hose, garter belts and similar devices, as not within the definition of brace
    - Orthotics that are not custom-made to fit the member's body. Orthotics are orthopedic appliance or apparatus used to support, align, prevent, or correct deformities or to improve the function of moveable parts of the body. Coverage includes leg, arm, back, and neck braces and trusses. Back braces include special corsets and sacroiliac, sacrolumbar and dorsolumbar corsets and belt
    - Corrective footwear (specialized shoes, arch supports and inserts) except for the treatment of diabetes-related medical conditions, or as specifically provided in the member's EOC
- Non-eligible institutions - Services or supplies provided by any institution other than a licensed and approved hospital or Medicare-approved skilled nursing facility (SNF) or other properly licensed facility specified as covered in the member's EOC are not covered. Any institution that is primarily a place for the aged, a nursing home, or any similar institution, regardless of how designated, is not an eligible institution
- Non-prescription (over-the-counter) medications, equipment and supplies - Any medications, equipment and supplies that can be purchased without a prescription order is not covered, even if a physician writes a prescription for it (except insulin and diabetic supplies or as specifically provided in the EOC)
- Personal or comfort items - Personal or comfort items, such as a telephone or television in the room at a hospital or SNF, are not covered
- Private-duty nursing - Private-duty nurses are not covered for a registered bed patient in a hospital or long-term care facility
- Private rooms - Private rooms in a hospital or SNF are not covered unless it is deemed to be medically necessary
- Refractive eye surgery - Any eye surgery for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), far-sightedness (hyperopia) and astigmatism is not covered
- Reversal of surgical sterilization - Reversal of a prior voluntary surgical sterilization procedure is not covered
- Routine physical examinations - Routine physical examinations are not covered for insurance, licensing, employment, school, camp, or other non-preventive purposes, unless specifically provided otherwise in the EOC. On plans that cover routine physical examinations, the exam itself and any related X-ray and laboratory procedures are covered; however, completion of any related forms are not covered. Refer to the specific plan in the Schedule of Benefits
- Services for obtaining or maintaining insurance are not covered
- Sterilization is not covered for males and females. Refer to the specific plan in the Schedule of Benefits or EOC for exceptions
- Substance abuse - Treatment of chronic alcoholism, drug addiction and other substance abuse problems are not covered, except for acute detoxification and the acute medical treatment of these problems. Other services not covered include: non-medical ancillary services; prolonged rehabilitation services, including inpatient, residential and outpatient substance abuse program; psychological counseling and aversion therapy. The terms and conditions applied to these benefits must be the same as those applied to other medical benefits under the plan contract due to federal mental health parity laws. Refer to the specific plan in the Schedule of Benefits for exceptions
- Unauthorized services and supplies - Any services or supplies not authorized according to procedures Health Net has established are not covered
- Unlisted services - Services or supplies that are not specified as covered services or supplies are not covered, unless coverage is required by law

Genetic Testing

Provider Type: Physicians | Participating Physician Groups (PPG) (does not apply to HSP) | Hospitals | Ancillary

In general, Health Net covers genetic testing when medically necessary and all of the following are met:

- The member has personal or family history features suggestive of an inheritable condition
- The test can be adequately interpreted
- The results of the test will aid in diagnosis or directly impact the treatment being delivered to the member or family
- Sensory impairment, especially if accompanied by any of the above indications

Genetic Testing Coverage

Medically necessary genetic testing is covered for the following conditions:

- Tay-Sachs disease (TSD)
- Von Hippel-Lindau disease (or syndrome)
- Huntington's disease (HD)
- Hereditary nonpolyposis colorectal cancer (HNPCC)
- Cystic fibrosis (CF)
- Breast cancer (BRCA)
- Long QT syndrome (LQTS)
- High-risk pregnancies
- Pregnancy abnormalities:
    - Maternal serum alpha-fetoprotein
    - Fetal chromosomal aneuploidy genomic sequence analysis panel, circulating cell-free fetal DNA (cfDNA) in maternal blood, (trisomy 13, 18 and 21), and sex chromosome aneuploidy (X, XXY, XYY, XXX) screening
    - Fetal aneuploidy (trisomy 13, 18 and 21), DNA sequence analysis of selected regions using maternal plasma
    - Ultrasound examination
    - Chorionic villus sampling (CVS)
    - Amniocentesis for women age 35 or older

Prenatal or preconceptional genetic counseling for members or couples is also covered.

Indications for Covering Genetic Testing

Health Net covers medically necessary genetic testing, including, but not limited to, the following:

- Unexplained developmental delay or mental retardation
- Unusual facial appearance or other dimorphic features, especially accompanied by failure to thrive or sub-optimal psychomotor development
- Movement disorder

- Positive newborn screen, for example, phenylketonuria (PKU), congenital hypothyroidism, congenital adrenal hyperplasia (CAH), biotinidase deficiency, maple syrup urine disease, galactosemia, homocystinuria, sickle cell anemia, medium chain acyl-CoA dehydrogenase deficiency (MCAD), or hearing loss
- Common birth defects, such as cleft lip or palate, neural tube defects, clubfoot, congenital heart disease, or congenital kidney defect
- Known or suspected metabolic disorder, including symptoms, such as failure to thrive, organomegaly or loss of previously acquired developmental milestones, as well as occurrences of neonatal death
- Abnormal sexual development, primary amenorrhea, aspermia, infertility, or multiple miscarriages
- Ambiguous genitalia
- Growth retardation or failure to thrive
- Sensory impairment
- Two or more close relatives with the same disease or related diseases, such as cancer, mental illness or neurologic disorders
- Familial cancer (for example, retinoblastoma, Wilms' tumor, renal carcinoma, optic glioma, or acoustic neuroma)Exclusions and Limitations

For additional information on genetic testing policies, including exclusions and limitations of genetic testing, refer to Health Net's medical policies online at the provider portal.

Hearing

Provider Type: Physicians | Participating Physician Groups (PPG) (does not apply to HSP) | Ancillary

Health Net plans cover ear examinations and audiometric screening procedures. If an auditory defect is suspected, an evaluation by a specialist should be arranged. Refer to the member's Schedule of Benefits, Evidence of Coverage (EOC) or Certificate of Insurance (COI) for benefit exclusions, limitations and applicable copayments.

Coverage includes tests for diagnosis and correction of hearing and fittings. A member may receive audiometric examinations and hearing aid evaluation tests. Hearing aids are covered as needed when the member's plan includes a hearing aid benefit, subject to applicable limitations listed in the member's EOC.

Hearing Aid

Hearing aids are not covered for Individual Family Plans (IFP).

The member's plan must include the supplemental hearing aid rider for a hearing aid to be covered. For plans that do cover hearing aids, refer to the member's Schedule of Benefits, EOC or COI for benefit exclusions, limitations and applicable copayments.

When hearing aids are a covered benefit, coverage includes a standard hearing device, analog or digital, inserted into the canal or affixed to the outer ear to restore adequate hearing to the member and as determined to be medically necessary by a Health Net participating provider or audiologist. This includes repair and

maintenance of the devices at no cost to the member. Plans may limit the number of hearing aids or covered charges permitted in a certain time period.

Exclusions and Limitations

Hearing aid tests and a hearing aid are not covered for IFP.

Hearing aid tests and a hearing aid are not covered unless specifically included as covered benefits stated in the member's EOC or COI. Refer to the specific plan chart in the Schedule of Benefits. Replacement batteries are not covered.

If the member has a personal preference for an alternative model of hearing aid carried by the participating hearing aid provider, the member is liable for any difference in cost from the covered standard model and the preferred alternative model. A member who would like to purchase a model with special features is entitled to be informed of the additional cost before purchasing the hearing aid. There are no cash benefits for purchase of a device from a non-participating hearing aid provider.

Home Health Care

Provider Type: Physicians | Participating Physician Groups (PPG) (does not apply to HSP) | Hospitals | Ancillary

Intermittent home health care is defined as those medical services customarily provided to members in their place of residence. Members affiliated with a participating physician group (PPG) must use a Health Net participating home health care agency.

Home Health Care Services

Home health care services in the member's home are provided by a registered nurse (RN); licensed vocational nurse (LVN); tech nurse, pediatric RN; licensed physical, occupational or speech therapist; MSW; or home health aid. These services may include, but are not limited to, skilled nursing services, medical social services, rehabilitation therapy (including physical, speech and occupational), and cardiac rehabilitation therapy. These services are subject to the conditions and limitations in the member's Evidence of Coverage (EOC) or Cal MediConnect Member Handbook.

The following are additional components of home health care:

- Home health aid services - Coverage for medically necessary home health care provided by a home health aid is authorized only in conjunction with skilled nursing services provided by a certified licensed RN, LVN, tech nurse, pediatric RN, physical or speech therapist, or MSW. The home health aid provides personal care to the member. Custodial care is not covered.
- Medical supplies - Routine supplies, because of their specific therapeutic or diagnostic characteristics, are essential in enabling home health care staff to provide effective care. Home health care covers the medical supplies and services needed to provide the skilled care.

Home health care services are in place of continued hospitalization, confinement in a skilled nursing facility, or outpatient services provided outside of the member's home.

Home health care services that can be safely and effectively performed or self-administered by the average, unlicensed, non-medical person without direct supervision of a licensed nurse are not skilled nursing services, even though a licensed nurse may provide the service.

Service Providers

Once authorized by Health Net or the delegated participating physician group (PPG), primary care physicians (PCPs) may refer members for home health services through Health Net's directly-contracting home health providers.

Medicare Advantage (MA) Violet PPO plan members may use an in-network or out-of-network provider depending upon the desired level of coverage.

Providers must reference the Division of Financial Responsibility (DOFR) for the agreement governing the relationship to ensure services are directed to the appropriate providers.

Homebound Determination

A member is considered homebound if the following criteria are met:

- The member must either, because of illness or injury, need the aid of supportive devices, such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence; or have a condition that makes leaving their home medically contraindicated.

If the member meets any of the above criteria, then they must also meet both requirements as follows:

- Inability to leave home, and leaving home requires a considerable and taxing effort.

If the member does leave home, they are considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive health care treatment. Absences attributable to the need to receive health care treatment include, but are not limited to:

- attendance at adult day centers to receive medical care.
- ongoing outpatient kidney dialysis.
- outpatient chemotherapy or radiation therapy.

The physician requesting the home health services determines the homebound criteria. Obstetric (OB) criteria do not qualify as homebound. Women and newborns in the immediate postpartum phase may require skilled observation and evaluation. The following selection criteria apply:

- Members who have had a caesarean section and were discharged from the hospital within 96 hours after delivery are eligible for one home health care visit at the attending physician's request. Authorization is not required. Requests for visits to members discharged after 96 hours are evaluated on a case-by-case basis.
- Members who delivered vaginally and were discharged from the hospital within 48 hours after delivery are eligible for one home health visit at the attending physician's request. Authorization is

not required. Requests for visits for members discharged after 48 hours are evaluated on a case-by-case basis for medical necessity.

Additionally, to receive home health care services, skilled nursing care must be appropriate for the medical treatment of a condition, illness, disease, or injury, or home health care services are part-time and intermittent in nature; for example, a visit lasts up to four hours in duration every 24 hours.

Occasional absences from the home to attend, for example, a family reunion, funeral, graduation, or other infrequent or unique event do not necessitate a determination that the member is not homebound if:

- absences are infrequent.
- absences are of relatively short duration.
- absences do not indicate that the member has the capacity to obtain the health care provided outside rather than in the home.

Exclusions and Limitations

The following are not covered:

- food, housing, homemaker services, and home-delivered meals.
- supportive environmental equipment, such as handrails, ramps, and similar appliances and devices (not an exclusion for Cal MediConnect members).
- services not deemed to be medically necessary by the PPG, PCP or Health Net.
- exercise equipment, gravitonic devices, treadmills, room air purifiers, air conditioners, and similar devices.
- any other equipment that is not considered by the Centers for Medicare & Medicaid Services (CMS) to be durable medical equipment (DME).

Authorization Guidelines

The participating provider prescribes treatment and the home health agency then proposes, develops and submits a treatment plan, signed by the physician, to the participating physician group (PPG) (for members affiliated with a PPG) or Health Net (for members not affiliated with a PPG) for review and approval. For members affiliated with a PPG, the PPG is required to complete the Authorization for Treatment form for the member. The treatment plan summarizes the services provided, the member's progress, the member's response to treatment, and recommendations for continued service. The participating provider reviews the treatment plan at least every 60 days and signs it to verify that the services provided are medically necessary.

When determining the appropriateness of home health services the following factors are considered:

- mental status of member
- types of services and equipment required (including frequency, duration, dressings, injections, and treatments)
- frequency of visits
- prognosis
- rehabilitation potential
- activities performed
- nutritional requirements
- medications and treatments (including amount, frequency and duration)

- homebound status
- any safety measures to protect against injury
- instructions for timely discharge or referral
- any other relevant items

Providers should initiate arrangements for home health services upon finalizing a hospitalized member's discharge plan.

Providers must use the Urgent Request for Continuing Home Health Services (PDF) form for HMO/POS, PPO, EPO, and Medicare Advantage members continuing home health services. Completed forms must be faxed to the Health Net Prior Authorization Department.

Physician Certification

Medicare Part A, Part B and Part C (Medicare Managed Care) and Medi-Cal requires physician certification for home health services. A physician must certify that the medical and other covered health services provided by the home health agency were medically required. If the member's underlying condition or complication requires a registered nurse to ensure that essential non-skilled care is achieving its purpose and necessitates a registered nurse be involved in the development, management and evaluation of a patient's care plan, the physician must include a brief narrative describing the clinical justification of this need. This certification needs to be made only once where the member may require over a period of time the furnishing of the same item or service related to one diagnosis.

Physician Recertification

Additionally, at the end of a 60-day period, a decision must be made whether or not to recertify the member for a subsequent 60-day period. An eligible member who qualifies for a subsequent 60-day episode of care would start the subsequent 60-day period on day 61. The plan of care must be reviewed and signed by the physician every 60 days unless the member transfers to another home health agency or is discharged and returns to the same home health agency during the 60-day period.

Ongoing Care

Participating providers initiate home health care services as follows:

- The participating provider or designee contacts the home health or home medical equipment/ respiratory provider with orders for continuation of therapy and additional needs.
- The ancillary provider's staff communicates with the ordering physician about changes in the member's condition and questions regarding care or the need for extension or termination of services.
- The ancillary provider's staff cannot deny a service as being not covered without consulting the participating physician group's (PPG's) Utilization Management (UM) Department or a Health Net regional medical director. The participating provider communicates all denials to the ordering physician and the PPG's UM Department or a Health Net regional medical director. The PPG's UM Department or Health Net issues any denial letter to the member.
- The participating provider contacts the ordering physician to discuss ongoing care before authorized services come to an end.

For more information, select any subject below:

- Skilled Nursing Services

Skilled Nursing Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The following are skilled services other than skilled nursing services:

- Physical, speech and occupational therapy must relate directly and specifically to a written treatment plan established by a participating provider or Health Net, usually after the participating provider has consulted with a qualified therapist. The therapy must be medically necessary for treatment of the member's illness or injury.
- Medical social services are covered if they are prescribed by a participating provider or Health Net, are included in the member's treatment plan, and are medically necessary. An indication that there exist social problems, which prevent effective treatment is required. Only a licensed medical social worker may perform medical social services.

Skilled Nursing Observation and Evaluation

If all other eligibility and coverage requirements under the home health benefit are met, skilled nursing services are covered when an individualized assessment of the member's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a registered nurse or licensed vocational practical skilled care nurse are necessary. Skilled nursing services are covered when necessary to maintain the member's current condition or prevent or slow further deterioration as long as the member requires skilled care for the services to be safely and effectively provided. When services can safely and effectively be performed by the patient or unskilled caregivers, such services are not covered under the home health benefit.

The skilled nursing service must be reasonable and necessary to the diagnosis and treatment of the member's illness or injury within the context of the member's unique medical condition. A physician determines whether the services are reasonable and necessary.

Observation and assessment of the member's condition by a nurse are reasonable and necessary skilled services when the likelihood of change in the member's condition requires skilled nursing staff to identify and evaluate the member's need for possible modification of treatment or initiation of additional medical procedures until the member's clinical condition and treatment regimen has stabilized. Where a member was admitted to home health care for skilled observation because there was a reasonable potential of a complication or further acute episode, but did not develop a further acute episode or complication, the skilled observation services are still covered for three weeks or as long as there remains a reasonable potential for such a complication or further acute episode.

Information from the member's home health record must document that there is a reasonable potential for a future complication or acute episode and, therefore, may justify the need for continued skilled observation and assessment beyond the three-week period. Signs and symptoms, such as abnormal or fluctuating vital signs, weight changes, edema, symptoms of medication toxicity, abnormal/fluctuating lab values, and respiratory

changes on auscultation, may justify skilled observation and assessment. When these signs and symptoms demonstrate reasonable potential that skilled observation and assessment by a licensed nurse will result in changes to the member's treatment, then services are covered. However, observation and assessment by a nurse is not reasonable and necessary for the treatment of the member's illness or injury where fluctuating signs and symptoms have been part of a longstanding pattern of the member's condition, which has not previously required changes to the prescribed treatment.

Hospice Care

Provider Type: Physicians | Participating Physician Groups (PPG) (does not apply to HSP) | Hospitals | Ancillary

This section contains general member benefit information and the referral process for hospice care services.

Select any subject below:

- Hospice Services
- Claims Submission
- Election Statement
- Hospice Agency
- Interdisciplinary Team
- Prior to Election of Hospice Services

Hospice Services

Provider Type: Physicians | Participating Physician Groups (PPG) (does not apply to HSP) | Hospitals | Ancillary

Hospice is a specialized health care program for terminally ill members who chose supportive and palliative care rather than curative measures and aggressive treatments for their terminal illness. It focuses on symptom control, pain management and psychosocial support for members with a life expectancy of one year or less to live. Hospices do not speed up or slow down the dying process. Rather, hospice programs provide state-of-the-art palliative care and supportive services to members at the end of their lives, as well as to their family and significant others, in both the home and facility-based settings. It consists of a physician-directed, nurse-coordinated interdisciplinary team consisting of social workers, counselors, clergy, physical and occupational therapists, and specially trained volunteers.

For additional information refer to Criteria for Hospice Appropriateness (PDF) or Definition of Hospice Services.

Description

A hospice care program consists of, but is not limited to, the following:

- Professional services of a registered nurse, licensed practical nurse or licensed vocational nurse
- Physical therapy, occupational therapy and speech therapy
- Medical and surgical supplies and durable medical equipment (DME)
- Prescribed medications
- In-home laboratory services
- Medical social service consultations
- Inpatient hospice room, board and general nursing service
- Inpatient respite care, which is short-term care provided to the member only when necessary to relieve the family or other persons caring for the member
- Family counseling related to the member's terminal condition
- Dietitian services
- Pastoral services
- Bereavement services
- Educational services

Hospice Consideration Request

To further assist providers in proper utilization of hospice care, Health Net has developed a Hospice Consideration Request letter (PDF). The letters (generic) may be used when notifying a primary care physician (PCP) or attending physician of the member's need for hospice care.

Certification of Terminal Illness

Health Net follows the California regulations on certification that states a member whose prognosis indicates a life expectancy of one year or less is considered to be terminally ill. A participating physician can contact Health Net for authorization for each certification period while the member is receiving hospice care. Each certification period needs to be authorized and consists of two 90-day periods and an unlimited number of 60-day periods.

Hospice Referrals

Participating providers make arrangements for medically necessary hospice care. An Authorization for Treatment of Health Net Member form must be completed. For cases that involve a hospitalized member, the request should be made as soon as discharge planning is finished.

Medications, Medical Equipment, and Supplies

Medications, medical equipment and supplies may include durable medical equipment (DME), as well as other self-help items related to palliation and management of the member's terminal illness and related conditions.

Respiratory medications are covered through the Health Net prescription drug program.

The hospice agency provides standard DME items for use in the member's home while under hospice care. Medical supplies are covered if they are part of the written plan of care. Necessary DME that falls outside the hospice member's written plan of care may be obtained through the member's DME benefit.

Short-Term Inpatient Care

Short-term inpatient care provides continuity of care and appropriate services for members who cannot be managed at home because of acute complications or the temporary absence of a capable caregiver.

Short-term inpatient care is considered acute care hospitalization.

Skilled Nursing Services

Skilled nursing services are provided by, or under the supervision of a registered nurse (RN). The services are covered under the plan of care that pertains to the palliative, supportive services required by the member. Skilled nursing services include:

- Member assessment
- Evaluation and case management of the medical nursing needs
- Performance of prescribed medical treatment for pain and symptom control
- Emotional support of both the member and the family, including the significant other
- Instruction of caregivers who provide personal care to the member
- Services available on a 24-hour, on-call basis during period of crisis

Counseling Services

Counseling and spiritual services are provided to the member and the member's family, including the significant other. Counseling is provided to minimize the stress and problems that arise from social, economic, psychological, or spiritual needs and to help the member and those providing care to adjust to the member's approaching death.

Dietary counseling by a qualified participating provider must also be provided when needed.

Bereavement Counseling

Bereavement services are available to surviving family members, including significant others, for a period of at least one year after the death of a member. Services include an assessment of the bereaved family's needs and the development of a care plan that meets these needs, both prior to and following the death of a member.

Period of Crisis

A period of crisis is time during which the member requires continuous primary nursing care to achieve palliation or to manage acute medical symptoms. Nursing care may be covered for up to 24 hours a day during periods of crisis if necessary to allow the member to remain at home. Care during such a period must be predominantly nursing care.

Respite Care

Respite care is short-term inpatient care provided to a member only when necessary to relieve caregivers at home. Respite care may be provided only occasionally and reimbursement may not be for more than five consecutive days at a time per certification period.

Volunteer Services

Volunteer services are those services provided by a trained hospice volunteer under the direction of a hospice staff member. The services are to provide support and companionship to the member and the member's family, including the significant other, during the member's remaining days and to the surviving family after the member's death.

Claims Submission

Provider Type: Physicians | Participating Physician Groups (PPG) | Ancillary

All hospice claims submitted to Health Net for payment must be identified as hospice claims, as some services provided through hospice (for example, durable medical equipment (DME) and medications) may only be eligible though hospice coverage and not through other coverage under the member's plan.

The participating physician group (PPG) must inform both the hospice agency and the member that, regardless of the forms signed upon admission to a hospice program, the member is still required to have all non-hospice care directed, authorized and arranged for by a Health Net participating provider.

To avoid rejections and delays in payment, all hospice providers are required to submit their claims with the member's signed election statement, the provider's certification of terminal illness, and the medical prognosis to the Health Net Claims Department.

Hospice Agency

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

A hospice agency is an entity that provides hospice services to a terminally ill person and holds a current license as a hospice pursuant to Health and Safety Code section 1747, or a home health agency with federal Medicare certification pursuant to Health and Safety Code sections 1726 and 1747.1.

Election Statement

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Each hospice agency designs its own election statement, which should include the following elements:

- Identification of the particular hospice agency to provide the care
- A statement describing the hospice program
- Member's acknowledgment of full understanding
- Effective date
- Signature of member or guardian
- A statement explaining the member may revoke hospice services at any time
- Requirements for hospice care

The member is required to elect hospice care and the attending physician is required to establish a plan of care before services are provided.

According to AB 1299 (ch. 825, 2004), certain preliminary and palliative services prior to the election of hospice services can be provided. Refer to the Prior to Election of Hospice Services discussion found under the Hospice topic.

Interdisciplinary Team

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

Interdisciplinary hospice services, including palliative care, may be provided to patients with serious illnesses, as determined by the physician and surgeon in charge of their care, and patients who continue to receive curative treatment from other licensed health care professionals.

The interdisciplinary team is the hospice care team, which is a physician-directed, nurse-coordinated interdisciplinary team comprised of social workers, counselors, clergy, physical and occupational therapists, and specially trained volunteers.

Prior to Election of Hospice Services

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

AB 1299 (ch. 825, 2004) permits California-licensed hospice providers to provide certain preliminary and palliative services prior to the election of hospice services and requires the member to remain eligible for coverage of curative treatment.

Preliminary services are provided as determined by the member's primary care physician (PCP) or attending physician or at the member or member's family request and include preliminary:

- Palliative care consultations
- Counseling and care planning
- Grief and bereavement services

Palliative services include medical treatment, interdisciplinary care or consultation provided to the member or member's family that primarily attempt to prevent or relieve suffering and enhance the quality of life, rather than curing the disease.

Health Net members who have not yet elected hospice benefits are covered one time only for hospice consultation services.

Hospital and Skilled Nursing

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information on hospitals and skilled nursing facilities.

Select any subject below:

- Claims Submissions
- Inpatient Services and Skilled Nursing Facility Admissions
- Transfer and Discarge Refusals by Hospitalized Member
- When Coverage Becomes Effective while Member is Hospitalized

Claims Submissions

Provider Type: Participating Physician Groups (PPG) (does not apply to HSP) | Ancillary | Hospitals

Submit claims to the Health Net Claims Department (commercial) (Medicare Advantage) with a complete itemized billing, including evidence of authorization. The Health Net Electronic Data Interchange Claims Department may be contacted for electronic submission of claims. Health Net requires notification within 24 hours or by the next business day after a member is admitted.

Some providers elect to mail claims directly to Health Net, which requires the submission of an attached itemized billing with the claim. Claims that have not been authorized require medical review, and Health Net mails a letter to the provider and the member explaining the procedure.

Inpatient Services and Skilled Nursing Facility Admissions

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

Inpatient Services

Inpatient services are covered on all Health Net plans. Services are covered with unlimited days per admission, subject to benefit calendar year maximums if applicable. Specifics regarding inpatient services are as follows:

- Inpatient services in a hospital, when medically necessary, are covered, subject to the scheduled copayments or coinsurance.
- Elective hospitalization of Health Net members is authorized by the participating physician group (PPG) if the member is affiliated with a capitated PPG that has responsibility for prudent hospital use. Services can be in an acute, general or specialized care hospital.
- Participating providers must contact Health Net or a Payor and the appropriate primary care physician (PCP) or PPG within 24 hours or by the next business day after a member is admitted into a hospital. Services may be in an acute, general or specialized care hospital. Inpatient days subsequent to this admission notification period are subject to authorization rules; failure to notify as set forth herein may result in denial of payment.
- Care in a semi-private room of two or more beds is covered. Special treatment units licensed by the state, such as intensive or coronary care units are also covered, subject to scheduled copayments.
- Benefits for hospital care are limited to the hospital's most common charge for a semi-private (two-bed) room. If the member elects to have a private room, the member is responsible for any amount over the semi-private room rate, plus the plan copayment. If the PPG has authorized a private room as medically necessary, the member has no financial responsibility beyond the required copayment.
- All medically necessary inpatient services and supplies not specifically excluded for the condition necessitating confinement are covered, subject to the scheduled copayment.

Refer to the member's Evidence of Coverage (EOC), Certificate of Insurance (COI) or Schedule of Benefits for coverage information.

Services in a Skilled Nursing Facility, Acute, Long-Term, or Psychiatric Hospital

All admissions and services rendered in a skilled nursing facility (SNF), acute rehabilitation, long-term care, or psychiatric unit or hospital, even if located in the acute hospital's structure, are considered separate admissions. These services are distinct form the acute hospital services and are paid independent of the acute hospital admission once the member is discharged from the hospital and admitted to the designated unit.

Notification of SNF Admission and Discharge

To improve continuity and coordination of care for its members, Health Net requests that SNFs notify the member's PCP within 24 hours of admission to or discharge from a SNF.

When Health Net is the secondary payor and the member is admitted into a SNF or a long-term acute care (LTAC) facility, the facility needs to notify the plan upon admission or within 24 hours of exhaustion of the primary insurance. Health Net has a tracking system for members who are in facilities under a primary insurance, and notification is necessary to ensure that Medical Management has the ability to administer services for the member when Health Net becomes the primary payor.

To facilitate this process, Health Net has developed sample forms SNFs can use when notifying the member's PCP of an admission. If a SNF chooses to use its own notification forms, the following information must be included when notifying the member's PCP:

- Member name
- Identification (ID) number
- Date of birth (DOB)
- Admission date
- Admitting diagnosis
- Attending/admitting physician name
- Attending/admitting physician telephone and fax number
- Facility name
- Facility telephone and fax number
- Level of care

When notifying the member's PCP of a discharge from a SNF, the following information must be provided:

- Member name
- ID number
- DOB
- Admission and discharge dates
- Attending physician name
- Attending physician telephone and fax number
- Diagnosis
- Follow-up appointment date, if known
- Discharge destination
- Responsible party at discharge
- Level of assistance
- Discharge planning needs including equipment, service or other special training needs
- Medications, including dosage and frequency at discharge
- Facility name, telephone number and fax number
- Level of care

For additional information regarding SNF notification, refer to the Hospital Notification Unit (HMO or EPO and PPO) documents under the Utilization Management topic.

Transfer and Discharge Refusals by Hospitalized Member

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

Participating Facility

Health Net recommends the following procedure to protect the participating physician group (PPG) and Health Net from liability in cases where a member or the admitting physician at a nonparticipating facility within a 30-mile radius of the member's home refuses to allow a transfer or discharge. This procedure is applicable to either transfer refusal or discharge refusal:

1. The PPG physician must contact the attending physician. As soon as the PPG is aware of the hospitalization, the PPG physician must advise the attending physician that transfer of the member to a participating facility must occur as soon as the condition is stable.
2. If the attending physician refuses to transfer, the PPG physician must monitor the member's condition through the attending physician to determine when the member can be transferred to a participating facility.
3. The physician, in conjunction with the PPG case manager, must collaborate with the attending physician to determine a facility appropriate for transfer. If indicated, an appropriate specialist must be identified to contact the attending physician at the current hospital to discuss the case and the member's stability for transfer.
4. At times, Health Net may request that the member be transferred to an in-network facility. If the accepting physician (or specialist) and attending physician agree that the member is stable for transfer and a bed is available at the accepting facility, but the attending physician refuses to transfer, the PPG (or Health Net) must issue a facility non-payment letter advising the facility of non-payment, effective the date agreed upon by both physicians that the member was stable for transfer. Health Net and PPGs ensure that a participating physician is available 24 hours a day to authorize medically necessary post-stabilization care and coordinate the transfer of stabilized members in an emergency department, if necessary.

- Health Net does not cover continued hospitalization if the accepting physician (or matching specialist) and attending physician agree that member is stable for transfer and a bed is available at the accepting facility, but the member refuses to transfer. The PPG must issue a member denial letter for refusal to transfer (PDF). Member denial is effective 24 hours after the date the member receives the letter.

Transfer of Hospitalized Member to Participating Facility

A Health Net member may be hospitalized at an out-of-network facility for emergency care. A member affiliated with a capitated participating physician group (PPG) should be transferred to a PPG-participating facility as soon as the member's medical condition allows. For PPG responsibilities regarding non-participating hospitals refer to Shared Risk UM Responsibilities.

There are situations when a Health Net member is hospitalized in a non-participating facility within the PPG's service area. The member should be transferred to a facility inside the service area that contracts with the PPG as soon as the member's medical condition allows.

Overview

Provider Type: Participating Physician Groups (PPG) | Hospitals

Participating physician groups (PPGs) with delegated utilization management (UM) status are required to consistently meet Health Net's UM standards related to inpatient care, outpatient care, discharge planning, case management, retrospective review, and timeliness of authorizations and denials. Health Net's UM standards are updated as necessary to comply with standards established by federal and state regulatory

agencies and accreditation entities, such as the National Committee for Quality Assurance (NCQA). Delegation of UM activities allow for autonomy based on PPG capabilities and creates accountability to Health Net. Health Net audits PPGs for accountability and reporting of PPG activities.

Health Net conducts annual audits and ongoing oversight and monitoring of delegated activities.

Multidisciplinary medical management staff may perform additional ongoing operational assessments. Based on the PPGs performance and abilities, Health Net may modify delegation status.

The regional medical director (RMD), regional network director (RND) and/or Delegation Oversight staff contacts the PPG prior to a change in delegation status. The PPG may also request an additional assessment or change in delegation status from the RMD or RND.

Program Description

PPGs with delegated responsibilities for UM are required to have a written UM program that documents all facets of the delegated authority. All decisions regarding approval or denial of health care services under delegation are made in accordance with the PPG UM program, which includes a UM committee review process.

PPGs with delegated functions are required to use standardized, nationally recognized UM criteria, such as InterQual® Guidelines, to ensure consistent decision-making at all levels of review. The UM program must specify the medical criteria and process used to determine medical necessity. The PPG must consider age, comorbidities, complications, treatment progress, psychosocial situation, and home environment (when applicable) when applying medical criteria. The PPG must also consider characteristics of the local delivery system available to a particular member, such as skilled nursing facilities (SNFs) and access to local hospitals and home health care.

The PPG UM program is evaluated annually by the UM Compliance Auditor for compliance with Health Net standards and is required to be approved by the governing board of the PPG annually, with written documentation of review and approval. Health Net's UM standards are updated as necessary to comply with standards established by federal and state regulatory agencies and accreditation entities, such as the NCQA when applicable.

A PPG's UM program should provide evidence that internal procedures for UM are operationally sound, and include documentation that:

- A specific person or position is designated to ensure that necessary authorization procedures are performed.
- Authorizations for elective and urgent health care services are within established time standards.
- Utilization deliberations and decisions are available and accomplished daily. A summary report of utilization activities is reviewed by the PPG UM committee.
- Documentation of the UM process includes the decision, member notification, and provider notification. In the case of a denial, the specific reason for the denial, including the specific utilization review criteria or benefit provision used in the determination, an alternative treatment plan and the appeal process must be included.
- Timely, documented member notification of approval or denial is on record.
- Weekly logs of hospital admissions and denials must be submitted to the Health Net Notification Unit.
- UM system controls are in place and meet NCQA guidelines.

Additional guidelines for elements that should be addressed in the PPG UM program description are incorporated in the Delegation Oversight Interactive Tool (DOIT) for evaluating structural and process elements. The responsibilities of Health Net and delegated providers are outlined in the UM-Delegation Agreement.

Policy Development

The utilization management (UM) criteria or guidelines used to determine whether to authorize, modify, or deny health care services must be evaluated at least annually and updated, as necessary. For Medi-Cal and Commercial lines of business, written policies and procedures must include disclosures pertaining to the use and oversight of the AI, algorithm or other software tool used in the UM determination process.

UM Committee

Each PPG is required to have a UM committee that meets not less than quarterly, and more frequently if necessary. UM committees that are responsible for authorization decisions are required to meet more frequently. The UM committee's purpose and responsibilities must be written and on file. The committee minutes must be on file and available for review by Health Net on request.

Delegated Prospective Review of Emergency Services

If an injury or illness requires emergency services, members are instructed to call 911 or go to the nearest hospital or urgent care center. When emergency services are received, members must contact their primary care physician (PCP) or participating physician group (PPG) as soon as possible to notify them of the emergency services received.

Emergency services are a covered benefit if a prudent layperson, acting reasonably, believes that the condition requires emergency medical treatment or if an authorized representative, acting for the organization, has authorized the emergency services or directed the member to the emergency room. A physician reviews emergency claims for medical necessity, and considers presenting symptoms, as well as the discharge diagnosis, for the emergency services.

A prudent layperson is a person who is without medical training and who draws on their practical experience when making a decision regarding whether emergency medical treatment is needed. A prudent layperson is considered to have acted "reasonably" if other similarly situated laypersons would have believed, on the basis of observation of the medical symptoms at hand, that emergency medical treatment was necessary.

PPGs are required to notify the Hospital Notification Unit if an inpatient admission is required at a participating hospital. The plan requires notification from the PPG within 24 hours of admission if it occurs on a weekday, or the next business day if the admission occurs on a weekend or holiday. This applies to all shared-risk and fee-for-service (FFS) PPGs, inpatient facilities and PPGs regardless of risk arrangement.

Encounter Data

Health Net requires submission of encounter data for the purpose of conducting a retrospective review. Encounter data is collected across the provider network for both outpatient and inpatient services. Participating physician group (PPG)-specific data is analyzed and compared to plan-wide data in order to identify more effective methods for management of health care resources.

Aggregate data analysis allows the PPG to assess overall trends of utilization. Reports of all services approved following the PPG utilization management (UM) program are submitted to Health Net through encounter data. The encounter data system assists in tracking and trending utilization patterns across Health Net's provider network. A successful encounter-reporting schedule is important to assure that service data is submitted to Health Net in an accurate and timely manner. Contact the Encounter Department for assistance. Failure of the PPG to submit timely and accurate data, as well as failure to meet these standards, results in development of a corrective action plan (CAP).

Shared Risk UM Responsibilities

Shared risk is assigned to participating physician groups (PPGs) that have demonstrated the capacity to manage selected operational functions. These groups have agreed to a shared-risk agreement for institutional services. The plan performs selected oversight of the PPG management of delegated services and shared management responsibility. Refer to the discussions in the Provider Evaluation for Delegation section for more information about the standardized program reviews, including the use of the Delegation Oversight Interactive Tool (DOIT).

PPG Responsibilities

In a shared-risk relationship, PPGs are responsible for the following:

- Conducting prospective, concurrent and retrospective reviews with advice from and guidance by medical management when requested or needed.
- Cooperating with medical management on all out-of-area admissions, including but not limited to, repatriation.
- Reporting inpatient admissions within 24 hours or on the next business day.
- Conducting concurrent reviews and providing findings and recommendations on level of care and lengths of stay for each inpatient admission within 24 hours or on the next business day.
- Assisting in identification of coordination of benefits (COB) and third-party payer information.
- Having a written utilization management (UM) program description and plan approved by the plan. The program and plan are evaluated annually for effect on members and providers and are reviewed and approved by the governing body of the PPG, with signature and minutes documenting the approval.
- Establishing a UM committee comprised of board-certified providers, who make decisions regarding the approval or denial of health care services to members.
- Using standardized nationally recognized UM criteria to ensure consistent medical necessity determination at all levels of review and interrater reliability (IRR) for all individuals involved in the UM process.
- Having written specific procedures for prospective, concurrent and retrospective reviews and case management that are supervised by qualified medical professionals and physician consultants from the applicable specialties of medicine and surgery. Physicians used to assist in medical necessity determinations are certified by one of the American boards of medical specialties.
- Having UM program policies and procedures, which specifically outline member and provider notification of medically necessary determinations, including approvals and denials. The PPG clearly documents and communicates the reasons for each denial, including the specific utilization

review criteria or benefits provision used in the determination. The denial process is clearly outlined and includes an appeal process. For Medi-Cal and Commercial lines of business, written policies and procedures must include disclosures pertaining to the use and oversight of the AI, algorithm or other software tool used in the UM determination process.
- Having a denial policy and procedure and member letters that include required regulatory statements indicating how the member can appeal directly to the plan.
- Having a denial process that includes specific regulatory language indicating that participating providers (for example, physicians, inpatient facilities and ancillary providers) may appeal directly to the plan.
- Conducting daily inpatient reviews to provide review information to a designated utilization and/or care management nurse upon request. Review information can be submitted by telephone or fax. The plan, to the extent necessary and at its own discretion, may assist the PPG in performing concurrent reviews, coordinating the discharge plan, determining medical necessity and appropriate level of care, and consulting on quality improvement screening when the health plan identifies concerns related to under- or over-utilization.
- Administering member coverage based on member's Evidence of Coverage (EOC).
- Participating with the plan in meetings as scheduled.
- Actively collaborating with Care Management to maximize effectiveness in managing the member's care.
- Providing valid, reliable and timely encounter data as requested and complying with the UM program.
- Conducting reporting and analysis semi-annually for commercial members and quarterly for Medicare Advantage members, which includes:
    - Acute inpatient bed days/1,000, admits/1,000, average length of stay.
    - Skilled nursing facility (SNF) bed days/1,000, admits/1,000, average length of stay.
    - Emergency room visits/1,000.
        - Outpatient surgery cases/1,000
- Preparing action plans for any outlier UM indicators.

Refer to other discussions in the Provider Delegation topic for additional information, including a calendar of required submissions.

PPG Responsibilities Regarding Nonparticipating Hospitals

If a nonparticipating hospital emergency room department or the nonparticipating provider calls the member's PPG or primary care physician (PCP) to request authorization for medically necessary post-stabilization care, the PPG or PCP should immediately notify the Hospital Notification Department. Do not issue an authorization or tracking number or confirmation of eligibility to the nonparticipating hospital. (This does not apply to Medicare Advantage HMO members.)

(Note: A PPG in a dual risk relationship with a hospital is responsible for complete utilization management (UM) for members to which the dual risk relationship applies. Such UM includes confirming eligibility, issuing authorizations or tracking numbers to nonparticipating hospitals, and arranging for member transfers or discharges, as appropriate. A PPG participating in a dual risk relationship should notify the plan of any member admissions to nonparticipating hospitals.)

Plan Responsibilities

In a shared-risk relationship, the plan is responsible for the following:

- Assigning a UM nurse to receive concurrent reviews from PPGs (by telephone or onsite) on selected cases, or, as required for the purpose of assisting in arranging for the provision of care at the correct level and in members' discharge planning.
- Assigning a regional medical directors (RMDs) and provider relations & contracting specialist (formally provider network administrator) to act as a liaison with network providers to resolve contractual, operational and service problems.
- Having the Member Services Department function as a liaison between members and the PPG.
- Performing member satisfaction surveys and initiating intervention as needed.
- Assigning a UM Compliance Auditor to conduct pre-contractual evaluations, annual evaluations, and perform oversight and monitoring of the PPG to evaluate the PPG's UM program using the Delegation Oversight Interactive Tool (DOIT), including a review of denial and appeal process, and assisting the PPG in complying with these policies, state and federal regulations and accreditation standards.
- Providing non-participating hospitals in California with one contact telephone number to call to request authorization to provide post-stabilization services to a patient who has received emergency services. After receiving the required information from the PPG, Health Net contacts the nonparticipating hospital with directions for transferring the patient or an authorization for medically necessary post-stabilization care. If the telephone call is not returned within 30 minutes, authorization is deemed to be granted (pursuant to enactment of Assembly Bill 1203 (2008), which amended Health and Safety Code section 1262.8 (b)(3) and section 1371.4. (This does not apply to Medicare Advantage HMO members.).

Integrated organization determination for DSNP members in Exclusively Aligned Enrollment (EAE) counties

Dual Special Needs Plan (DSNP) contractors are required to provide integrated organization determination for the DSNP members in Exclusively Aligned Enrollment (EAE) counties. For DSNP members in EAE counties, the authorization for the services requested need to be reviewed for **both** Medicare and Medi-Cal benefits to determine eligibility for the service requested. PPGs that are delegated to perform the Medicare services shall not deny prior authorization as “not a covered benefit” without checking both Medicare and Medi-Cal covered services (refer to the list of services below).

DSNP prior authorization timelines

PPGs should forward prior authorizations for the services that are not covered under Medicare but that are covered under Medi-Cal to Health Net within the following timelines:

- For standard requests, forward to Health Net within 1 business day upon receipt of the request.
- For expedited requests, forward to Health Net within 24 hours upon receipt of the request.

Fax authorizations to Health Net Medi-Cal Prior Authorization Department fax number

Fax prior authorizations to the Medi-Cal fax number listed under Health Net Prior Authorization Department in the Provider Library’s Contacts section and include:

- The date and time that the service request was initially received.
- The clinical decision that was used to make the initial determination.

Services not covered under Medicare but covered under Medi-Cal

- Asthma remediation
- Community Based Adult Services
- Community Supports
- Community transition services/nursing facility transition services to a home

- Day habilitation programs
- Durable medical equipment (DME) that is covered by Medi-Cal
- Environmental accessibility adaptation (home modification)
- Housing deposit (up to $6,000)
- Housing tenancy and sustaining services
- Housing transition navigation
- Long-term care
- Medically tailored meals
- Nursing facility transition/diversion to assisted living facilities
- Personal care services and homemaker services
- Recuperative care
- Respite services
- Short-term post-hospitalization housing
- Sobering centers

Scenarios where PPGs would be responsible for sending out the Applicable Integrated Plan (AIP) Coverage Decision Letter

Refer to the below table to see the scenarios where PPGs are responsible for sending out the AIP Coverage Decision Letter. This will help PPGs determine when to forward the authorizations to the Plan and when to send the Applicable Integrated Plan Coverage Decision Letter for DSNP members in EAE counties.

Scenario	Delegated PPG	Health Plan
Eligibility denial	Deny and send AIP coverage decision letter.	N/A
Medical necessity denial	Deny and send AIP coverage decision letter.	N/A

Scenarios where PPGs would be responsible for forwarding the request to the Health Plan

Scenario	Delegated PPG	Health Plan
Benefit denial	Forward to Health Plan with the Medicare clinical decision.	Deny and send AIP coverage decision letter.
Out of network	Forward to Health Plan with the Medicare clinical decision.	Deny and send AIP coverage decision letter.

The Applicable Integrated Plan Coverage Decision Letter can be found in the Delegation Oversight Interactive Tool (DOIT)/MetricStream.

Delegation Oversight Interactive Tool

Participating Physician Groups (PPG)

The Delegation Oversight Interactive Tool (DOIT) is the web-based system for interacting with Health Net Delegation Oversight for utilization management annual compliance audit activities including:

- Audit scheduling and confirmation
- Pre-audit document submission
- Audit document submissions and additional requests
- Draft audit issue review
- Audit reports
- Issue management
    - Including delegated claims and credentialing issue management

For any questions about access, users, or use of the Delegation Oversight Interactive Tool, please contact the Delegation Oversight Group.

When Coverage Becomes Effective while Member is Hospitalized

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net and the participating physician group (PPG) are liable whenever a member is hospitalized either inside or outside the Health Net service area when coverage becomes effective. Health Net plans provide coverage for medical services to all members on the effective date of coverage regardless of health status. Health Net requires adherence to the following guidelines for coverage changes during hospitalization:

Health Net or the PPG must be notified that the newly covered member is confined to a hospital

- The member must be willing to receive care from the selected PPG
- If the member can be transferred, financial responsibility for the cost of transportation is based on terms of the contractual arrangement between Health Net and the PPG
- If the member can be transferred but refuses, Health Net and the PPG are not liable for any expenses relating to the hospitalization. If proper documentation has been completed, Health Net and the PPG pay for the care only when it is not medically prudent to move the member or when it is prudent, but the costs of the move would likely exceed the costs of the member remaining in a hospital where the PPG does not have privileges. Refer to the Transfer and Discharge Refusals by Hospitalized Members section for more information
- The physician from the member's new PPG should discuss the member's treatment plan with the attending non-participating physician. The member's new physician is then responsible for assuming care, and the member is obligated to follow that physician's directions

The conditions that may limit Health Net coverage for new members who are confined to a hospital may not apply if a new member declares they have not received a Health Net identification (ID) card or Health Net Evidence of Coverage (EOC) and therefore, was unaware of the proper procedures to follow when obtaining medical care.

Immunizations

Provider Type: Physicians | Participating Physician Groups (PPG) (does not apply to HSP) | Hospitals | Ancillary

This section contains general member benefit information on immunizations, including immunization schedules.

Select any subject below:

- Coverage Explanation

Coverage Explanation

Provider Type: Physicians | Participating Physician Groups (PPG)

Medically necessary immunizations, as determined by Health Net are covered by all Health Net plans and include adult immunizations recommended by the Centers for Disease Control and Prevention (CDC) and childhood immunizations recommended by the American Academy of Pediatrics (AAP). Refer to the CDC website for:

- The adult immunization schedule (PDF).
- The children and adolescents immunization schedule (PDF).
- Some plans may also provide coverage for occupational-related requirements and foreign travel-related immunizations and may be subject to a copayment. Refer to the Schedule of Benefits for coverage and copayment information.

Most immunizations do not require a copayment. Refer to the Schedule of Benefits for exceptions.

For employer group plans travel-related immunizations are covered fully or partially in accordance with the Provider Participation Agreement (PPA) for some Health Net commercial plans. Haemophilus influenza B (HIB) vaccines are also covered fully or partially in accordance with the PPA for some Health Net plans. These immunizations are usually subject to a copayment. Refer to the Schedule of Benefits for copayment information and exceptions.

Vaccines and immunizations may be sub-categorized as adult or pediatric according to the age of the member who receives the immunization.

Injectables

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information and protocols for injectables, including prior authorization requirements.

Select any subject below:

- Copayment Requirements
- Home Infusion
- Human Growth Hormone and Antihemophilic Factor
- Injectable Medication Coverage Policy
- Prior Authorization
- Therapeutic Injections and Other Injectable Substances

Copayment Requirements

Provider Type: Physicians | Participating Physician Groups (PPG)

The following information does not apply to individual family plans (IFP).

For most employer groups, an injectable medication copayment or coinsurance may need to be collected for self-injectable medications. Some employer groups that cover self-injectable medications require a copayment each time the injectable is administered by the participating provider. Some groups require a copayment per course of treatment up to a 30-day supply through a Health Net participating specialty or home infusion pharmacy provider. Refer to the Schedule of Benefits for plans that require copayments.

Home Infusion

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Home infusion services involve the administration of prescribed intravenous substances and solutions administered in the member's home by qualified staff. Members who receive home infusion services do not need to be homebound, but must meet other criteria for home health care, which includes the member's willingness to learn the administration of therapy at home or the presence of another willing and able caregiver to administer the therapy. Injectable medications that require admixing by a home health provider or pharmacy are also included. Infusion medications given in the home setting and approved by Health Net include, but are not limited to:

- Total parenteral nutrition (TPN)
- Intravenous antibiotic and antiviral therapies

- Aerosolized therapy
- Pain management
- Chelation therapy
- Inotropic therapy
- IVIG/IGIV immunoglobins
- Hydration therapy
- Steroid therapy
- Remicade
- Chemotherapy

Home infusion services provided to members affiliated with a shared-risk participating physician group (PPG) must be obtained through Coram Healthcare, Health Net's home infusion provider.

Shared risk members are capitated to Coram and shared risk PPGs should utilize Coram or they will be liable for claims payments.

Refer to the Health Net Injectable Medication HCPCS/DOFR Crosswalk (PDF) table for home health infusion medications.

For Medi-Cal members under age 21, medications used in the treatment of California Children's Services (CCS) eligible conditions are not included in Health Net's coverage responsibilities under its Medi-Cal managed care contract with the Department of Health Care Services (DHCS).

Human Growth Hormone and Antihemophilic Factor

Provider Type: Physicians | Ancillary | Participating Physician Groups (PPG) |

Human growth hormone (HGH) and antihemophilic factors for Food and Drug Administration (FDA)-approved indications are covered. For participating physician groups (PPGs), HGH is defined as a self-injectable medication under most Provider Participation Agreements (PPAs). Refer to the Benefits/Injectable topic for additional information regarding self-injectable medications. Refer to the Medicare Part D Formulary or Cal MediConnect Formulary for HGH and antihemophilic factors.

HGH must be obtained through Pharmacy Services. Antihemophilic factors may be obtained through a Health Net participating specialty pharmacy.

Injectable Medication Coverage Policy

Provider Type: Physicians | Participating Physician Groups (PPG)

Injectable medications, including those for therapeutic purposes, are covered when authorized by the Pharmacy Services or in accordance with the Health Net Provider Participation Agreement (PPA) Division of Financial Responsibility (DOFR).

Prior authorization must be obtained through the Pharmacy Services for self-injectable medications, including antihemophilic factors and human growth hormone (HGH).

Refer to the Benefits/Injectables Prior Authorization topic for additional information. For specific information about specific plan and employer group exceptions, refer to the Schedule of Benefits.

Prior Authorization

Provider Type: Physicians | Participating Physician Groups (PPG)

There are three options for submitting a prior authorization form:

1. Submit the prior authorization electronically through CoverMyMeds which is Health Net's preferred way to receive prior authorization requests.
2. Complete the Prescription Drug Prior Authorization or Step Therapy Exception Request Form (PDF) and submit to Pharmacy Services.
3. Contact Pharmacy Services directly via telephone.

When certain designated injectables are requested by a participating provider or participating physician group (PPG) with a shared-risk arrangement, prior authorization must be obtained through Pharmacy Services. This requirement also applies to PPGs with delegated utilization management. Self-injectable medications require prior authorization whenever Health Net has the risk.

The participating provider or PPG must complete the appropriate California State Prior Authorization Request form detailing the medical necessity and the duration of the requested medication.

For all provider portal needs refer to the Health Net provider secure website.

The completed form must be faxed to Pharmacy Services. The participating provider or PPG may call Pharmacy Services directly for urgent requests.

The approval or request for additional information is faxed back to the original requestor as noted on the Prior Authorization Request form.

Upon approval, Pharmacy Services forwards the approved authorization to one of Health Net's participating specialty pharmacy providers. The specialty provider contacts the Health Net member to arrange for delivery. For additional information regarding injectable medications, refer to the Health Net Injectable Medications HCPCS/DOFR Crosswalk (PDF) table.

Therapeutic Injections and Other Injectable Substances

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

EPO and HMO

Therapeutic injections and other injectable substances are covered, subject to scheduled copayments, when their use is indicated by standard medical practices. These injections are usually administered in the participating provider's office or professional outpatient facility. Refer to the Health Net Injectable Medications HCPCS/DOFR Crosswalk (PDF) table for therapeutic injectables information.

The following contraceptives are covered when determined to be medically necessary for the member and prescribed by a participating provider:

- Depo-Provera® Contraceptive Injections - One injection administered every three months to prevent pregnancy
- Depo-Sub Q Provera® 104 - One injection administered subcutaneously every three months to prevent pregnancy
- Lunelle™ Contraceptive Injections - One injection administered monthly to prevent pregnancy

Except for insulin, injectable medications defined as self-injectables continue to be processed as self-injectable medications when provided in an office setting.

Medi-Cal

Therapeutic and physician-administered injections are usually administered in the participating provider's office or professional outpatient facility. Refer to the Health Net Injectable Medications HCPCS/DOFR Crosswalk (PDF) table for therapeutic injectables information.

These injections may be covered by either Medi-Cal Rx under the pharmacy benefit or by Health Net. If submitted on a medical claim, the above crosswalk applies and financial responsibility for the claim is the plan’s risk. If the claim is submitted by a pharmacy, visit the Medi-Cal Rx website site and view the contract drug list to determine coverage.

The following contraceptives are covered when determined to be medically necessary for the member and prescribed by a participating provider:

- Depo-Provera® Contraceptive Injections - One injection administered every three months to prevent pregnancy
- Depo-Sub Q Provera® 104 - One injection administered subcutaneously every three months to prevent pregnancy
- Lunelle™ Contraceptive Injections - One injection administered monthly to prevent pregnancy

Maternity

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information about maternity care services.

Select any subject below:

Emergency Services

Provider Type: Physicians | Participating Physician Groups (PPG) (does not apply to HSP)

Normal or premature deliveries, including cesarean section, occurring outside the member's service area are considered medical emergencies and are covered regardless of the month of pregnancy. Out-of-area emergency benefits are provided for the delivery. Health Net or the participating physician group (PPG) (as appliable) are required to perform or authorize follow-up care for members affiliated with a capitated PPG.

Start Smart for Your Baby Care

Provider Type: Physicians | Participating Physician Groups (PPG)

Our whole-health approach to pregnancy care combines predictive data modeling, integrated care management and coordination, disease management, and health education to reduce the risk of pregnancy complications, premature delivery, and low birth weight to improve the health of parents and their newborns. Our care management program for pregnant and new parents features personal contact with those who may need the most support to achieve a healthy pregnancy and delivery. In addition to online educational resources, our program’s trimester-based assessment approach ensures continuous care and guidance for existing and developing conditions.

- Trimester-based assessments administered by care managers progressing from pregnancy through postpartum help with early identification of needs related to physical health, behavioral health, and social drivers of health.
- These assessments influence how care managers engage and empower members in accessing medical and behavioral healthcare, wellness programs, medical equipment, community resources

to support social barriers to health, and educational resources to fully equip them to manage their health before and after delivery.
- Member maternal risk stratification is designed to evolve throughout pregnancy and after delivery to account for changes that may require adjustments to the member's care management needs, enabling processes to allocate resources and coordinate care.
- Care managers create care plans to address the unique needs of each participant.
- Support extends past delivery to improve long-term health during the postpartum period and beyond.

To refer a member to Start Smart for Your Baby Care Management, complete the Notification of Pregnancy form.

PROFESSIONAL CARE FOR PREGNANCY

Hospital and professional pregnancy services are covered, including:

- Prenatal, postnatal and newborn care and delivery, including:
  - Professional care for pregnancy provided by a participating provider, including prenatal and postnatal care, delivery and newborn care, subject to the scheduled copayments (Note: Newborn care is not covered under Medicare Advantage plans)
  - Office calls, consultations, laboratory tests, hospital visits, and normal vaginal or cesarean section deliveries.
- In identified cases of high-risk pregnancy, prenatal diagnostic procedures and genetic testing of the fetus are covered.
- Blood specimens. The California Health and Safety Code requires a blood specimen to be obtained on the first prenatal visit or within 10 days of the visit. The blood specimen must be submitted to an approved laboratory for a standard laboratory test for syphilis.
- Maternity care. A female member is entitled to coverage for maternity care and is not required to complete a waiting period. Therefore, a pregnant woman may enroll in Health Net at any time, and the participating physician group (PPG) is obligated to provide covered obstetrical services.
- Minimum maternity inpatient stays required by law: The California Health and Safety Code requires health care plans to provide mothers and newborns with coverage for minimum hospital stays of at least 48 hours following a vaginal delivery, or at least 96 hours following a cesarean section delivery (Note: Newborn care is not covered under Medicare Advantage plans).
  - When a delivery occurs in the hospital, the stay begins at the time of delivery (in the case of multiple births, at the time of the last delivery).
  - When a delivery occurs outside a hospital, the stay begins at the time the mother or newborn is admitted.
  - Coverage for inpatient hospital care may be for less than 48 or 96 hours, respectively, only if both the treating provider and the member agree to an earlier discharge.
- In cases of an early discharge, a member receives a post-discharge follow-up visit at home, in a facility, or in the provider's office within 48 hours of the discharge, as prescribed by the treating provider with no authorization requirement. A licensed health care provider whose scope of practice includes postpartum care and newborn care must provide this covered visit. The treating provider must provide written disclosure of all the above to the member (Note: Newborn care is not covered under Medicare Advantage plans).
- Continuation of obstetrical services for terminated members. If a female member is terminated from a Health Net group agreement, coverage for obstetrical services is provided when there is a continuation of coverage through Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or the conversion plan.

GENETIC TESTING AND COUNSELING

Genetic testing is covered when performed on the fetus using the following recognized tests:

- Alpha-fetoprotein (AFP), maternal serum
- Fetal chromosomal aneuploidy genomic sequence analysis panel, circulating cell-free fetal DNA (cfDNA) in maternal blood, (trisomy 13, 18 and 21), and sex chromosome aneuploidy (X, XXY, XYY, XXX) screening

Testing is covered for the following conditions when there is a family history of one of these conditions:

- Tay-Sachs disease
- Sickle cell anemia
- Fragile X syndrome - covered if there is a history of fragile X syndrome in another child. If there is a history of a child with mental retardation without a diagnosis of fragile X syndrome, the child (not the mother) should be tested

Amniocentesis is covered when the mother is age 35 or older.

Cytogenetic testing is covered if reasonable and necessary in accordance with Medicare guidelines.

Genetic counseling related to covered genetic testing services is considered a specialist consultation and is covered, subject to the applicable specialist consultation copayment.

The screening of newborns includes tandem mass spectrometry screening for fatty acid oxidation, amino acid, organic acid disorders, and congenital adrenal hyperplasia. Women receiving prenatal care or who are admitted to a hospital for delivery must be given information regarding these disorders and the testing resources available to them.

Genetic testing performed on an adult (including parents), genetic counseling related to non-covered genetic testing services, or any genetic testing that is considered investigative, is not covered.

Maternal Mental Health Screening Requirement

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Licensed health care practitioners who provide prenatal or postpartum care for a patient should screen or offer to screen mothers for maternal mental health conditions.

Maternal mental health condition means a mental health condition that occurs during pregnancy, the postpartum period, or interpregnancy and includes, but is not limited to, postpartum depression.

Providers serving Health Net members can use one of the following screening tools, as appropriate to the member's plan:

- Patient Health Questionnaire-2 (PHQ-2)
- Patient Health Questionnaire-9 (PHQ-9)
- Edinburgh Postnatal Depression Scale

You can refer members with a positive screen to Health Net's Case Management Department for further assistance with the member's mental health needs.

Pregnancy Program

Health care service plans and health insurers must develop a maternal mental health program. The program must be consistent with sound clinical principles and processes.

Health Net offers a pregnancy program to pregnant commercial and Medi-Cal members. The program provides customized support and care needed for a healthy pregnancy and baby. It helps pregnant members access medical care, educates them about their health care needs and assists with social needs and concerns. The program uses the Edinburgh Postnatal Depression Scale to assess for mental health needs of pregnant members and facilitates referrals to a mental health specialist as needed.

Refer members to the pregnancy program by contacting the Case Management Department.

Pediatric Services

Provider Type: Physicians | Participating Physician Groups (PPG) (does not apply to HSP)

Health Net covers newborns or adoptees of the subscriber or spouse automatically for the first 30 days of life, if the plan provides for dependent coverage.

Coverage after 30 days is contingent on the subscriber enrolling the eligible newborn through the subscriber's employer as a family member within 30 days following birth or placement, assuming the subscriber's employer has dependent coverage to insure the spouse, dependents or members of the immediate family. The child is then eligible with no lapse in coverage.

If the child is not added to the plan within 30 days from birth, the child is no longer covered and any services incurred after the 30th day are the financial responsibility of the child's parent or guardian.

Surrogacy

Provider Type: Physicians | Participating Physician Groups (PPG)

Services for pregnancies that result under a surrogate parenting agreement are covered only when the surrogate is a Health Net member. When compensation is obtained for the surrogacy, Health Net or the participating provider has a lien on such compensation to recover its medical expense.

Compensation is defined as remuneration over and above what the surrogate mother would have received if the pregnancy had not taken place.

A surrogate parenting agreement is one in which a woman agrees to become pregnant with the intent of surrendering custody of the child to another person. A participating provider aware that a member is pregnant on the basis of having entered into a surrogate mother agreement should advise the member that Health Net benefits are available for services incurred for that pregnancy. However, when compensation is obtained for the surrogacy, Health Net or the participating provider has a lien on such compensation to recover its medical expense.

Pregnancy Termination

Provider Type: Physicians | Participating Physician Groups (PPG)

Pregnancy terminations provided by a participating provider are covered on most plans.

Care for complications of pregnancy and abortions prescribed by a participating provider are covered on most plans.

Effective January 1, 2023, physicians and other providers cannot impose cost-sharing for abortion and abortion-related services in accordance with Senate Bill 245 (the Abortion Accessibility Act). To ensure coding accuracy, Health Net has put together a list of abortion-related diagnosis codes, ICD-10-CM Codes for Abortion-Related Services (PDF). Providers must bill applicable abortion and abortion-related diagnosis codes in the primary/principal position on the claim to comply with providing these services at no cost-share to members.

Medical Social Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information on medical social services.

Select any subject below:

- Coverage Explanation

Coverage Explanation

Provider Type: Physicians | Participating Physician Groups (PPG) (does not apply to HSP)

Medical social services provided to members dealing with the physical, emotional and economic effects of illness or disability are covered. Medical social services include pre- and post-hospital planning, member education programs, referral to services provided through community health and social welfare agencies, and family counseling.

Nuclear Medicine

Provider Type: Physicians | Ancillary | Participating Physician Groups (PPG) (does not apply to HSP)

Nuclear medicine, considered part of radiology, is a branch of medicine that uses radioactive materials in treatment and diagnosis of disease.

Nuclear medicine treatment may be covered, depending on the member's coverage. Some plans may require an inpatient stay copayment. Refer to the member's Evidence of Coverage (EOC) for more information. Refer to the specific plan chart in the Schedule of Benefits.

Obesity

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Obesity is defined as an excess of body fat. Body mass index (BMI) is a measure of body weight relative to height. BMI can be used to determine if people are at a healthy weight, overweight or obese. An adult member whose BMI is 25 to 29.9 is considered overweight and a BMI of 30 or more is considered obese. Children of the same age and sex, with a BMI at or above the 85th percentile and lower than the 95th percentile is defined as overweight. Considerations for obesity is having a BMI at the 95th percentile or above.

Obesity is a treatable medical condition. Treatment of this condition varies depending on the severity of the members' condition.

Coverage

The primary care physician (PCP) or attending provider may recommend a diet plan for the member to follow and, if medically appropriate, the PCP may refer the member to a dietitian or a provider who specializes in weight-loss management. These services are covered as specialist consultation services. In cases of extreme morbid obesity, other treatments, such as pharmaceutical and surgical services, may be covered.

Health Net does not provide coverage for diet programs, such as Weight Watchers®. Gym memberships and exercise programs are also not covered under Medi-Cal.

Resources

Medi-Cal members are eligible to receive weight control resources through the Health Education Department. Resources include:

- Fit Families for Life program - Mailed educational self-guided resource with nutrition tips, exercise band and cookbook to help families and children eat healthy and stay active. Physical activity videos are available online.
- Healthy Habits for Healthy People Program - Nutrition and physical activity resource for older adults. Includes a workbook, cookbook and exercise band. Physical activity videos are available online.

Providers may refer members interested in these resources via the Fit Families for Life Referral form – Health Net (PDF), Fit Families for Life Referral form – Community Health Plan of Imperial Valley (PDF) or Fit Families for Life Referral form – CalViva Health (PDF). Contact the Health Education Department for more information.

The following information does not apply to Medi-Cal

All participating physician groups (PPGs) or attending providers offer patient education programs, including weight management. For more information regarding Health Net's weight loss interactive tools, discounts and online education programs, refer to the Decision Power® program.

For more information on, select any subject below:

Bariatric Surgery Services

Bariatric Surgery Services

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG)

Health Net covers bariatric surgical procedures and services when medically appropriate in accordance with Health Net's Bariatric Surgery National Medical Policy. This includes the treatment of morbid obesity, including abdominoplasty or lipectomy, and is authorized by Health Net and performed by Health Net Bariatric Performance Centers (PDF).

Outpatient Services

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

This section contains general member benefit information on outpatient services.

Select any subject below:

- Coverage Explanation
- Alternative Birth Centers
- Ambulatory Surgical Centers
- Office Visit

- Outpatient Hospital Services and Supplies

Coverage Explanation

Provider Type: Physicians | Participating Physician Groups (PPG)

Outpatient services and supplies within the participating physician group (PPG) service area or Health Net's service area (if the member is not affiliated with a PPG) are covered. Copayments, coinsurance or deductibles are required on some plans. Refer to the Schedule of Benefits and Summary of Benefits and the members' Evidence of Coverage (EOC) or Certificate of Insurance (COI) for services received in the outpatient department of a hospital, emergency room, urgent care center, ambulatory surgical center (ASC), or alternative birth center (ABC).

Alternative Birth Centers

Provider Type: Physicians | Participating Physician Groups (PPG)

Health Net requires alternative birth centers (ABCs) to meet the following eligibility criteria:

- Be accredited by either the Accreditation Association for Ambulatory Care or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- Maintain a transfer agreement with a nearby acute-care hospital
- Bill charges on a UB-04 billing form
- Bill with an all-inclusive global fee

Ambulatory Surgical Centers

Provider Type: Physicians | Participating Physician Groups (PPG)

An ambulatory surgical center (ASC) is a facility other than a medical or dental office that performs outpatient surgery. It is generally required to be licensed as a freestanding outpatient clinic and meet all requirements of a clinic providing ambulatory surgical services.

Office Visit

Provider Type: Physicians | Participating Physician Groups (PPG)

Office visits to a physician, physician assistant (PA) and nurse practitioner (NP), and specialist consultations at a participating physician group (PPG), are covered on all Health Net plans. Specialist consultations are covered when referred by the member's primary care physician (PCP).

Well-Woman Self Referrals

The well-woman self-referral benefit allows female members to self-refer to an obstetrician/gynecologist (OB/GYN) within the member's selected PPG for obstetrical and gynecological physician services. Services received as part of a well-woman visit are considered an OB/GYN self-referral under the specialist consultation visit and the PPG may establish reasonable requirements for the OB/GYN to communicate with a member's PCP regarding the member's condition, treatment and any need for follow-up care.

Coverage Explanation

Office visits, consultations with a participating provider, or any necessary referrals for care by a provider other than the member's primary care physician (PCP) are covered and subject to the scheduled copayments.

Refer to the plan chart in the Schedule of Benefits and Summary Benefits for the standard benefit and copayments for office visits if applicable.

Outpatient Hospital Services and Supplies

Provider Type: Physicians | Participating Physician Groups (PPG)

The participating provider decides under what circumstances the outpatient department is used (excluding lab and X-ray procedures performed solely for diagnostic purposes and not in conjunction with a surgery or emergency).

Periodic Health Evaluations

Provider Type: Physicians | Participating Physician Groups (PPG)

Coverage for periodic health evaluations and diagnostic preventive procedures is based on recommendations published by the United States Preventive Services Task Force (USPSTF), Centers for Disease Control and Prevention (CDC). They include female breast and pelvic exams, Pap smears, blood pressure checks, periodic check-ups, routine preventive care, newborn care office visits, and well-baby care.

Annual cervical cancer screenings are covered, which include Pap smear and the option of any cervical cancer test approved by the U.S. Food and Drug Administration (FDA) upon referral of the member's physician, nurse practitioner or certified nurse midwife, or by self-referral to an OB/GYN or family practice physician who provides such services within the member's participating physician group (PPG). In accordance with California

legislation SB 1245 (ch.482, 2006), annual cervical cancer screening must also include coverage for FDA-approved human papillomavirus (HPV) screening.

Physicians Visit

Provider Type: Physicians | Participating Physician Groups (PPG)

Physician visits to a member's home (if the member is homebound), or to a hospital, skilled nursing facility (SNF) or convalescent home (if the member is confined in such a facility) located inside the participating physician group (PPG) or primary care physician's (PCPs) service area, are covered and subject to scheduled copayments if applicable. Attending participating providers determine appropriate accessibility and courses of treatment.

Homebound Members

Physician visits to a member's home may be covered when an eligible member is homebound. Refer to Home Health Care services for detailed information on Home-Bound Determination.

Home Health Care

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

Intermittent home health care is defined as those medical services customarily provided to members in their place of residence.

Members affiliated with a fee-for-service shared risk participating physician group (PPG) must use a Health Net participating home health care agency. Dual risk or global risk members affiliated with a PPG must use the PPG’s participating home health care agency.

Home Health Care Services

Home health care services in the member's home are provided by a registered nurse (RN); licensed vocational nurse (LVN); tech nurse, pediatric RN; licensed physical, occupational or speech therapist; MSW; or home health aid. These services may include, but are not limited to part-time, skilled nursing services, medical social services, rehabilitation therapy (including physical, speech and occupational), and cardiac rehabilitation therapy. These services are subject to the conditions and limitations in the member's Evidence of Coverage (EOC) or Cal MediConnect Member Handbook.

The following are additional components of home health care:

- Part-time home health aid services - Coverage for medically necessary home health care provided by a home health aid is authorized only in conjunction with skilled nursing services provided by a certified licensed RN, LVN, tech nurse, pediatric RN, physical or speech therapist, or MSW. The home health aid provides personal care to the member. Custodial care is not covered.
- Medical supplies - Routine supplies, because of their specific therapeutic or diagnostic characteristics, are essential in enabling home health care staff to provide effective care. Home health care covers the medical supplies and services needed to provide the skilled care.

Home health care services are in place of continued hospitalization, confinement in a skilled nursing facility, or outpatient services provided outside of the member's home.

Home health care services that can be safely and effectively performed or self-administered by the average, unlicensed, non-medical person without direct supervision of a licensed nurse are not skilled nursing services, even though a licensed nurse may provide the service.

Service Providers

Once authorized by the delegated participating physician group (PPG), primary care physicians (PCPs) may refer members for home health services through Health Net's directly-contracting home health providers.

Medicare Advantage (MA) Violet PPO plan members may use an in-network or out-of-network provider depending upon the desired level of coverage.

Providers must reference the Division of Financial Responsibility (DOFR) for the agreement governing the relationship to ensure services are directed to the appropriate home health providers.

Homebound Determination

A member is considered homebound if the following criteria are met:

- The member must either, because of illness or injury, need the aid of supportive devices, such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence; or have a condition that makes leaving their home medically contraindicated.

If the member meets any of the above criteria, then they must also meet both requirements as follows:

- Inability to leave home, and leaving home requires a considerable and taxing effort.

If the member does leave home, they are considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive health care treatment. Absences attributable to the need to receive health care treatment include, but are not limited to:

- attendance at adult day centers to receive medical care.
- ongoing outpatient kidney dialysis.
- outpatient chemotherapy or radiation therapy.

The physician requesting the home health services determines the homebound criteria. Obstetric (OB) criteria do not qualify as homebound. Women and newborns in the immediate postpartum phase may require skilled observation and evaluation. The following selection criteria apply:

- Members who have had a caesarean section and were discharged from the hospital within 96 hours after delivery are eligible for one home health care visit at the attending physician's request. Authorization is not required. Requests for visits to members discharged after 96 hours are evaluated on a case-by-case basis for medical necessity.
- Members who delivered vaginally and were discharged from the hospital within 48 hours after delivery are eligible for one home health visit at the attending physician's request. Authorization is not required. Requests for visits for members discharged after 48 hours are evaluated on a case-by-case basis for medical necessity.

Additionally, to receive home health care services, skilled nursing care must be appropriate for the medical treatment of a condition, illness, disease, or injury, or home health care services are part-time and intermittent in nature; for example, a visit lasts up to four hours in duration every 24 hours.

Occasional absences from the home to attend, for example, a family reunion, funeral, graduation, or other infrequent or unique event do not necessitate a determination that the member is not homebound if:

- absences are infrequent.
- absences are of relatively short duration.
- absences do not indicate that the member has the capacity to obtain the health care provided outside rather than in the home.

Exclusions and Limitations

The following are not covered (some may be available through Community Supports Services, Health Net Community Supports Resources):

- food, housing, homemaker services, and home-delivered meals.
- supportive environmental equipment, such as handrails, ramps, and similar appliances and devices (not an exclusion for Cal MediConnect members).
- services not deemed to be medically necessary by the PPG, PCP or Health Net.
- exercise equipment, gravitonic devices, treadmills, room air purifiers, air conditioners, and similar devices.
- any other equipment that is not considered by the Centers for Medicare & Medicaid Services (CMS) to be durable medical equipment (DME).

Authorization Guidelines

The participating provider prescribes treatment and the home health agency then proposes, develops and submits a treatment plan, signed by the physician, to the participating physician group (PPG) (for members affiliated with a PPG) for review and approval. For members affiliated with a PPG, the PPG is required to complete the Authorization for Treatment form for the member. The treatment plan summarizes the services provided, the member's progress, the member's response to treatment, and recommendations for continued service. The participating provider reviews the treatment plan at least every 60 days and signs it to verify that the services provided are medically necessary.

When determining the appropriateness of home health services the following factors are considered:

- mental status of member

- types of services and equipment required (including frequency, duration, dressings, injections, and treatments)
- frequency of visits
- prognosis
- rehabilitation potential
- activities performed
- nutritional requirements
- medications and treatments (including amount, frequency and duration)
- homebound status
- any safety measures to protect against injury
- instructions for timely discharge or referral
- any other relevant items

Providers should initiate arrangements for home health services upon finalizing a hospitalized member's discharge plan.

Physician Certification

Medicare Part A, Part B and Part C (Medicare Managed Care) and Medi-Cal requires physician certification for home health services. A physician must certify that the medical and other covered health services provided by the home health agency were medically required. If the member's underlying condition or complication requires a registered nurse to ensure that essential non-skilled care is achieving its purpose and necessitates a registered nurse be involved in the development, management and evaluation of a patient's care plan, the physician must include a brief narrative describing the clinical justification of this need. This certification needs to be made only once where the member may require over a period of time the furnishing of the same item or service related to one diagnosis.

Physician Recertification

Additionally, at the end of a 60-day period, a decision must be made whether or not to recertify the member for a subsequent 60-day period. An eligible member who qualifies for a subsequent 60-day episode of care would start the subsequent 60-day period on day 61. The plan of care must be reviewed and signed by the physician every 60 days unless the member transfers to another home health agency or is discharged and returns to the same home health agency during the 60-day period.

Ongoing Care

Participating providers initiate home health care services as follows:

- The participating provider or designee contacts the home health or home medical equipment/ respiratory provider with orders for continuation of therapy and additional needs.
- The ancillary provider's staff communicates with the ordering physician about changes in the member's condition and questions regarding care or the need for extension or termination of services.
- The ancillary provider's staff cannot deny a service for being not covered without consulting the participating physician group's (PPG's) Utilization Management (UM) Department. The participating

provider communicates all denials to the ordering physician and the PPG's UM Department. The PPG's UM Department issues any denial letter to the member.
- The participating provider contacts the ordering physician to discuss ongoing care before authorized services come to an end.

For more information, select any subject below:
Skilled Nursing Services

Preventive Services

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

This section contains general member benefit information on preventive care services.

Select any subject below:

- Breast Cancer Susceptibility Gene Testing
- Hepatitis C Screening
- Mammography
- Preventive Services Guidelines

Breast Cancer Susceptibility Gene Testing

Provider Type: Physicians

Health Net covers breast cancer susceptibility gene (BRCA) testing as preventive care for high-risk members enrolled in non-grandfathered health plans.

For information on Health Net's criteria for BRCA testing, refer to Health Net's medical policy, Genetic Testing for BRCA1 and BRCA2, available on the Health Net provider website > Medical Policies under Resources for You.

Hepatitis C Screening

Provider Type: Physicians

Health Net covers hepatitis C virus (HCV) screening as preventive care for high-risk members enrolled in non-grandfathered health plans.

Mammography

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

Health Net of California, Inc. and Health Net Life Insurance Company (Health Net) cover conventional 2-D mammography for commercial members in accordance with the member's health plan policy and the Women's Preventive Services Guidelines – Health Resources & Services Administration.

Health Net covers 3-D mammography, also known as digital breast tomosynthesis (DBT), for HMO, Point of Service (POS), HSP, PPO, and EPO (commercial) plans. Claims codes affected by this change are listed below.

When administered as a preventive screening, this benefit is subject to the annual screening limit, and cost-shares do not apply. If DBT services are provided for diagnostic purposes outside of the annual screening, they do not require prior authorization, but are subject to the member's applicable cost-share.

Claims coding for DBT:

CPT Codes	Description
77061	Digital breast tomosynthesis; unilateral
77062	Digital breast tomosynthesis; bilateral
77063	Screening digital breast tomosynthesis, bilateral
HCPCS Codes	Description
G0279	Diagnostic digital breast tomosynthesis, unilateral or bilateral

Preventive Services Guidelines

Provider Type: Physicians | Participating Physician Groups (PPG)

Preventive care refers to services or measures taken to promote health and early detection or prevention of diseases and injuries, rather than treating or curing them. Preventive care includes, but is not limited to,

immunizations, medications, contraception, tobacco cessation treatment, examinations and screening tests tailored to an individual's age, health and family history.

Health Net provides coverage for preventive care in accordance with the requirements of the Affordable Care Act (ACA). According to the ACA, preventive care services must include the following:

- Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF).
- Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the HRSA.

As new preventive care recommendations/guidelines are released by the USPSTF, ACIP and HRSA, they will ultimately be added to our list of covered preventive care benefits. *Note: All newly released preventive care recommendations/guidelines must be applicable to group health plans and health insurance issuers for plan years (in the individual market, policy years) that begin on or after the date that is one year after the date the recommendation or guideline is issued.*

On our commercial individual & family, small and large group plans, with the exception of grandfathered plans[1], preventive care benefits obtained from an in-network provider are covered without member cost share (i.e., covered in full – without a deductible, coinsurance or copayment). Please keep in mind, certain covered services can be performed for preventive or diagnostic reasons (e.g., mammograms). Therefore, how such services are billed – preventive or diagnostic – will determine the applicable benefit category and cost share. Furthermore, if preventive and diagnostic services are performed during the same visit, cost share may apply to the latter (depending on the plan design).

Refer to the following websites for the most up-to-date information about preventive care coverage requirements:

- USPSTF
- CDC ACIP
  - Recommended Child and Adolescent Immunization Schedule (PDF)
  - Recommended Adult Immunization Schedule (PDF)
- HRSA
- HealthCare.gov

[1]Grandfathered plans are those that were in existence on March 23, 2010, and have stayed basically the same. Grandfathered plans are not required to provide all of the benefits and consumer protections required by the ACA. As such, Health Net's in-network preventive care, provided on these plans, does not have to be covered in full.

Prosthesis

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information on prostheses and orthotics.

Select any subject below:

Coverage Explanation

Provider Type: Physicians | Ancillary | Participating Physician Groups (PPG)

Prostheses are covered on most plans. Prostheses needs may be referred to any Health Net participating provider.

Prostheses and supplies include:

- Artificial limbs
- Artificial eyes
- Artificial larynx devices after a laryngectomy
- Breast prostheses
- Colostomy and ostomy supplies
- Contact lenses after cataract surgery
- C.V., midline and peripheral catheters
- Enteral supplies (including formula)
- Lmphedema sleeves and gloves
- Phenylketonuria (PKU) formulas and food products
- Tacheostomy supplies
- Ventilator supplies

When reconstructive breast surgery (after a medically necessary mastectomy) is performed, prescribed prostheses are covered and replaceable when no longer functional. In addition, prescribed prostheses are covered and replaceable when no longer functional if surgery to the healthy breast is performed to restore and achieve symmetry. Benefits for prostheses include two mastectomy bras each year. If the original mastectomy was not medically necessary, the cost of a new prosthetic is not covered.

Repair or replacement of prostheses is covered. Repair or replacement due to misuse or loss is not covered. Supplies required for prostheses maintenance are covered.

Formula is covered under the prostheses benefit as follows:

- When given by a feeding tube

- When given for severe metabolic disorders (for example, PKU), whether by mouth or a feeding tube (as outlined in Health and Safety Code 1374.56 and Insurance Code 10123.89)

Phenylketonuria

Provider Type: Physicians | Ancillary | Participating Physician Groups (PPG)

Health Net covers the testing and treatment of phenylketonuria (PKU). Treatment includes formulas and special food products that are part of a diet prescribed by a participating licensed physician and managed by a health care professional in consultation with a physician who specializes in the treatment of metabolic disease. Coverage is only required to the extent that the cost of necessary formulas and foods exceeds the cost of a normal diet.

According to Health and Safety Code 1374.56 and Insurance Code 10123.89, formula means an enteral product for use at home that is prescribed by a physician or nurse practitioner or ordered by a registered dietitian upon referral by a health care provider authorized to prescribe dietary treatments, as medically necessary for the treatment of PKU.

Special food products means a food that is both:

- Prescribed for treatment of PKU consistent with recommendations and best practices in care and treatment of PKU (it does not include a food that is naturally low in protein, but may include food that is specially formulated to have less than one gram of protein per serving).
- Used in place of normal food products, such as foods from the grocery store that are used by the general population.

For additional information regarding the coverage of treatment of PKU, refer to the Coverage Explanation document.

Rehabilitation Therapy

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information on rehabilitation therapy services.

Select any subject below:

- Coverage Explanation
- Exclusions and Limitations
- Home Heath Services
- Physical, Occupational or Speech Therapy Services Concurrent Review Forms

Coverage Explanation

Provider Type: Physicians | Ancillary | Participating Physician Groups (PPG)

Rehabilitation in an inpatient, outpatient or home health setting enables the member to achieve a high level of functional independence. Rehabilitation programs common to hospital settings (inpatient or outpatient) include:

- Amputee rehabilitation
- Brain injury rehabilitation
- Cardiac rehabilitation
- Coma stimulation
- Fracture rehabilitation
- General rehabilitation - Physical, speech and occupational therapy (may include the above and additional conditions)
- Pain management
- Pulmonary rehabilitation
- Spinal cord injury rehabilitation
- Stroke rehabilitation

If the member is affiliated with a participating physician group (PPG) and the PPG provides physical rehabilitation and educates the member medically and socially, a formal cardiac rehabilitation program is not necessary.

Rehabilitation programs are directed by a physician experienced or trained in rehabilitation and supported by rehabilitative nursing. The ancillary services of physical therapy (PT) and occupational therapy (OT) are necessary for all of the programs cited.

Psychological and social services should be provided depending on the member's need. In addition to these basic services, brain injury and stroke rehabilitation programs require speech therapy, and the pulmonary rehabilitation program requires respiratory therapy.

Exclusions and Limitations

Provider Type: Physicians | Ancillary | Participating Physician Groups (PPG)

Rehabilitation therapy (physical, speech and occupational) is not covered when such problems are the result of the following conditions. Note: This does not apply to members with Mental Health and Substance Use Disorders. In such cases, therapy that develops or restores functioning to the maximum extent practicable is considered medically necessary when rehabilitation or habilitation therapy criteria is met.

- Psychosocial speech delay (includes delayed language development)
- Syndromes associated with diagnosed disorders attributed to perceptual and conceptual dysfunctions
- Attention deficit disorders (ADD) and associated behavior problems
- Developmental articulation and language disorders (such as stuttering and lisping)

Home Health Services

Provider Type: Physicians | Ancillary | Participating Physician Groups (PPG)

To receive home health services, a member must be confined to the home, under the care of a participating provider and be in need of physical therapy (PT), respiratory therapy (RT), speech therapy (ST), occupational therapy (OT), or nursing services.

These services must relate directly and specifically to an active treatment plan written by the participating provider after the physician consults with a qualified therapist. The therapy must be reasonable and necessary to the treatment of the member's illness or injury.

Physical, Occupational or Speech Therapy Services Concurrent Review Forms

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

Providers must use the Urgent Request for Continuing Occupational, Physical or Speech Therapy (PDF) concurrent review form for HMO/POS, PPO, EPO, and Medicare Advantage members continuing physical, occupational or speech therapy and home health services. Completed forms must be faxed to the Health Net Prior Authorization Department.

Routine Physical Exam

Provider Type: Physicians | Participating Physician Groups (PPG)

Coverage for a routine physical examination is optional coverage that an employer group may purchase. Routine physical examinations differ from periodic health evaluations, which are covered by all plans.

Routine physical exams requested by the member without medical condition indications, along with any related X-ray and laboratory procedures ordered or approved by the physician, may be covered. X-ray and laboratory procedures may be subject to a calendar-year deductible if they are not billed and coded in relation to a routine physical examination. Examinations are subject to scheduled copayments.

Routine physical examination coverage allows the member to request services not otherwise medically indicated. Refer to the specific plan in the Schedule of Benefits for the number of routine physical examinations based on the member's age.

A routine physical examination is one that is not physician-directed and is done for the purpose of checking a member's general health in the absence of symptoms. Examples include exams taken to obtain or maintain

employment, licenses or insurance, or exams administered at the request of a third party, such as a school, camp or sports-affiliated organization.

Assistance with completing any related forms is not covered. The only exception is completion of a Special Supplemental Nutrition Program for Women, Infants and Children (WIC) Referral form. Refer to the Referrals to WIC discussion for additional information.

Second Opinion by a Physician

Provider Type: Physicians | Participating Physician Groups (PPG)

All requests for a second opinion meeting the California Health and Safety Code Section 1383.1 and 1383.5 speaks about needing a policy, the second opinion requirements are noted in 1383.5 require health plans to allow members to obtain second opinions in any of the following situations:

- Member questions the reasonableness or necessity of recommended surgical procedures
- Member questions a diagnosis or plan of care for a condition that threatens loss of life, limb, bodily function, or substantial impairment, including a serious chronic condition
- Clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating physician is unable to diagnose the condition, and the member requests an additional diagnosis
- Treatment plan is in progress, but is not improving the member's medical condition within an appropriate period of time given the diagnosis and plan of care
- Member has attempted to follow the plan of care or has consulted with the initial provider with serious concerns about the diagnosis or plan of care

Second opinion consultations include a history, an examination and a medical decision of some complexity. They do not include additional tests, which have to be approved separately.

Office visits, consultations with a participating physician, or a referral to a physician or qualified professional provider necessary for obtaining a second opinion, are covered.

Out-of-Network Requests

Members who initiate a request for a second or third opinion are limited to in-network providers, except where appropriate in-network providers are not accessible.

If the member refuses to see an in-network provider and is requesting an out-of-network provider, all requests for a second opinion (meeting the California Health and Safety code definition) from a non-participating provider, should be directed to the Health Net Member Services Department.

Second Opinion Referral Responsibilities

Health Net and delegated participating physician groups (PPGs) provide timely referral for a second opinion consultation by an appropriately qualified health care professional when the second opinion is requested by a member or the member's physician. An appropriately qualified health care professional is a primary care physician (PCP) or specialist acting within the PCP's or specialist's scope of practice and possessing clinical background, training and expertise related to the particular illness, disease or other condition associated with the request for a second opinion. Second opinion referrals are approved for a one-time-only consultation. All tests, lab and X-ray services must be directed back to the member's PPG or PCP for coordination. All care must be performed or authorized by the PPG or PCP in order to be covered. There are few, if any, circumstances under which second opinion requests should be denied.

PPGs delegated for utilization management (UM):

- Provide second opinions by an appropriately qualified health care professional (of the same or equivalent specialty) of the member's choice, from the PPG's network
- Make every effort to accommodate the member within the PPG network
- Must consider all participating specialists for second opinion referrals
- Should instruct members who request an out-of-network second opinion and refuse to accept redirection in-network, to contact the Health Net Member Services Department for further assistance.

Health Net:

- Authorizes second opinions from appropriately qualified health care professional (of the same or equivalent specialty) of the member's choice from Health Net's network when appropriate
- May limit referrals to its network providers if criteria for appropriately qualified health care professionals are met within the network. Health Net authorizes a second opinion by an appropriately qualified out-of-network health care professional when no participating Health Net provider is available

Support for Disabled Members

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information about support for disabled members.

Select any subject below:

- Americans with Disabilities Act of 1990
- Auxiliary Aids and Services
- Effective Communication
- Financial Responsibility

Americans with Disabilities Act of 1990

Provider Type: Physicians (does not apply to Cal MediConnect) | Hospitals | Participating Physician Groups (PPG) (does not apply to HSP) | Ancillary

Health Net and its participating providers do not discriminate against members who have physical disabilities. The Americans with Disabilities Act of 1990 (ADA) requires that places of public accommodation, including hospitals and medical offices, provide auxiliary aids and services (for example, an interpreter for deaf members) to disabled members. Health Net's policy describes nondiscrimination toward members with physical disabilities and the participating providers' responsibility to provide needed auxiliary aids and services.

Auxiliary Aids and Services

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

Participating providers are required to take steps to ensure that no person with a disability is excluded, denied services, segregated, or otherwise treated differently. Health Net provides no-cost aids and services to people with disabilities to communicate effectively, such as qualified Sign Language interpreters, closed captioning interpreters, video remote interpreters, and written information in other formats (large print, audio, accessible electronic formats and additional formats), upon request and at no cost for members with disabilities.

Providers can request interpreter support for members, including auxiliary aids and services, by calling the Health Net Provider Services Department.

Effective Communication

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

Participating providers must communicate with members effectively and make verbally delivered information available to people with hearing impairments. Use of the most advanced technology is not required, as long as effective communication is ensured.

When a member requests a specific auxiliary aid or service for effective communication, the provider must evaluate the request and determine how to ensure effective communication. The ultimate decision about what measures should be taken to facilitate communication rests with the health care provider.

Financial Responsibility

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

Under federal regulations promulgated for use under the Americans with Disabilities Act of 1990 (ADA), participating providers bear the financial responsibility when auxiliary aids or services for the hearing impaired (such as an interpreter) are necessary to ensure effective communication with a member, unless this creates an undue burden or fundamentally alters the nature of the goods, services or operation.

Undue Burden

An undue burden is a significant difficulty or expense. Several factors may be relevant when determining whether providing an auxiliary aid or service is an undue burden, including:

- Nature and cost.
- Overall financial resources of the site or sites involved; the number of employees at the site; the effect on expenses and resources; legitimate safety requirements necessary for safe operation, including crime prevention measures; or any other negative effect on the operation of the site.
- The geographic separateness, and the administrative or fiscal relationship of the site or sites in question, to any parent corporation or entity.
- The overall financial resources of any parent corporation or entity; the overall size of the parent corporation or entity with respect to the number of its employees; and the number, type and location of its facilities.
- The type of operation or operations of any parent corporation or entity, including the composition, structure and functions of the workforce of the parent corporation or entity.

Surgery, Surgical Supplies, and Anesthesia

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information for surgery, surgical supplies and anesthesia.

Select any subject below:

- Coverage Explanation
- Exclusions and Limitations

Coverage Explanation

Provider Type: Physicians | Hospitals

When arranged and authorized by Health Net, surgery and anesthesia are covered on all plans. Surgical services, including pre- and post-operative care, in an inpatient or outpatient surgery center or hospital are covered. This includes the services of the surgeon or specialist, assistant, and anesthetist or anesthesiologist, including administration of anesthetics in conjunction with surgical services in the hospital.

The services of a Doctor of Dental Surgery (DDS) are covered if this specialty is necessary for the medical procedure.

Surgical supplies are covered when billed by the hospital in connection with an authorized hospital admission, outpatient surgery, renal dialysis, or emergency.

Refer to the Schedule of Benefits for specific plan coverage information.

Exclusions and Limitations

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG)

Surgical dressings are therapeutic and protective coverings applied directly to lesions either on the skin or opening to the skin required as a result of a surgical procedures performed by a physician are primary dressings and are covered. Surgical dressings for outpatient surgery, with the exception of primary dressings, are not covered.

TMJ

Provider Type: Physicians | Participating Physician Groups (PPG) | Ancillary

Temporomandibular joint (also known as TMD or TMJ) disorder commonly causes headaches, tenderness of the jaw muscles, tinnitus, or facial pain. These symptoms often occur when chewing muscles and jaw joints do not align correctly. When medically necessary and prior authorized, treatment of TMJ is covered.

Covered Services

Coverage of TMJ is limited to the following:

- Surgical procedures to correct abnormally positioned or improperly developed bones of the upper or lower jaw when such procedures are medically necessary.

- Custom-made oral appliances (intra-oral splint or occlusal splint) and surgical procedures to correct TMD or TMJ disorders are covered if medically necessary.

Health Net of California Inc. covers orthognathic surgery for specific conditions. Refer to the National Medical Policy on Orthognathic Surgery on the Health Net provider website for additional information.

Exclusions and Limitations

Spot grinding, restorative or mechanical devices, orthodontics, inlays or onlays, crowns, bridgework, dental splints, dental implants, or other dental appliances to treat dental conditions or dental conditions related to TMD or TMJ disorders are not covered.

For more information, select any subject below:

- Payment

Payment

Provider Type: Physicians | Ancillary | Participating Physician Groups (PPG)

The participating provider refers the member to their participating dentist or oral surgeon for medically necessary custom-made temporomandibular joint (TMJ) appliances (for example, occlusal splints) or medically necessary surgeries.

When items or services are covered under the member's benefit plan, claims responsibility for TMJ orthotics and services, including surgical services, are determined according to the Provider Participation Agreement (PPA) and the Division of Financial Responsibility (DOFR).

Transgender Services

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

Medically necessary transgender services for treatment of gender identity disorder (GID) are covered benefits for Health Net members. Refer to the most current Standards of Care (SOC) and guidance located on the World Professional Association for Transgender Health (WPATH) website at www.wpath.org for clinical guidance. Additional clinical information is located on the Health Net provider website, under Resources for you, select *Medical Policies > Gender Affirming Procedures (PDF)*.

Transgender services refer to the treatment of GID, which may include the following:

- Consultation with transgender service providers.
- Transgender services work-up and preparation.
- Psychotherapy.

- Continuous hormonal therapy.
- Laboratory testing to monitor hormone therapy.
- Gender reassignment surgery that is not cosmetic in nature.

Medically Necessary/Reconstructive Surgery

No categorical exclusions or limitations apply to coverage for the treatment of GID. Each of the following procedures, when used specifically to improve the appearance of an individual undergoing gender reassignment surgery or actively participating in a documented gender reassignment surgery treatment plan, must be evaluated to determine if it is medically necessary reconstructive surgery to create a normal appearance for the gender with which the member identifies. Prior to making a clinical determination of coverage, it may be necessary to consult with a qualified and licensed mental health professional and the treating surgeon.

- Abdominoplasty
- Blepharoplasty
- Breast augmentation
- Electrolysis
- Facial bone reduction
- Facial feminization
- Hair removal
- Hair transplantation
- Liposuction
- Reduction thyroid chondroplasty
- Rhinoplasty
- Subcutaneous mastectomy
- Voice modification surgery

Reconstructive surgery is "surgery performed to correct or repair abnormal structures of the body... to create a normal appearance to the extent possible." (Insurance Code Section 10123.88(c)). In the case of transgender patients, "normal appearance" is to be determined by referencing the gender with which the patient identifies.

Cosmetic surgery is "surgery that is performed to alter or reshape normal structures of the body in order to improve appearance." (Insurance Code Section 10123.88(d)).

This section clarifies how Health Net administers benefits in accordance with the WPATH, SOC, Version 7. Provided a patient has been properly diagnosed with gender dysphoria or GID by a mental health professional or other provider type with appropriate training in behavioral health and competencies to conduct an assessment of gender dysphoria or GID, particularly when functioning as part of a multidisciplinary specialty team that provides access to feminizing/masculinizing hormone therapy, certain options for social support and changes in gender expression are considered to help alleviate gender dysphoria or GID.

For example, with respect to hair removal through electrolysis, laser treatment, or waxing, the WPATH clarifies that patients with the same condition do not always respond to, or thrive, following the application of identical treatments. Treatment must be individualized, such as with the various hair removal techniques, and medical necessity should be determined according to the judgment of a qualified mental health professional and referring physician. The documentation to support the medical necessity for hair removal should include three essential elements:

1. A properly trained (in behavioral health) and competent (in assessment of gender dysphoria) professional has diagnosed the member with gender dysphoria or GID.

2. The individual is under feminizing hormonal therapy.
3. The medical necessity for hair removal has been determined according to the judgment of a qualified mental health professional and the referring physician.

If any element remains to be satisfied before medical necessity can be determined, the individual should be directed to an appropriate network participating provider for consultation or treatment.

Requesting Services

Prior authorization is required for transgender services. Providers must submit clinically relevant information for medical necessity review with prior authorization request. Members may select an available transgender surgery specialist from Health Net's network. To find out which providers contract with Health Net to perform services in conjunction with transgender reassignment surgery, or if Health Net contracts with additional transgender reassignment surgeons, contact the Health Net Provider Services Department.

Transplants

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information on transplant evaluations and services.

Select any subject below:

- Overview
- Compliance for Transplant Performance Centers Standardized Process
- Injectable Transplant Medication
- Health Net Transplant Performance Centers

Overview

Provider Type: Physicians | Participating Physician Groups (PPG)

Prior Authorization

The following transplants are covered when prior authorization is obtained and when medically necessary:

- Cornea
- Heart
- Heart and lung
- Intestine
- Kidney

- Kidney and pancreas
- Pancreas
- Liver
- Lung (single or double)
- Allogeneic stem cell transplants
- Autologous stem cell transplants

Solid Organ Transplant Review Procedure

All covered transplant services must be provided by a Health Net Transplant Performance Center (Center). Transplant service requests are evaluated on a case-by-case basis and must be prior authorized through Health Net or the delegated participating provider group (PPG).

PPG Procedures

Delegated PPGs use the following procedure for reviewing requests for delegated transplant services:

1. The treating physician or transplant center (requestor) submits a request for transplant services to the delegated PPG.
2. If Health Net receives a request directly from a treating physician or transplant center for a delegated transplant service, the requestor is referred to the delegated PPG.

The following applies to all non-delegated PPGs

For non-delegated PPG members, all major organ and bone marrow transplant (both allogenic stem cell and autologous stem cell) requests must be submitted by the transplant service provider directly to the Centene Centralized Transplant Unit (CTU) for review. Requests received from the primary care physician (PCP), specialist or PPG will be returned, and the requestor will be informed to have the transplant center submit the request.

A PCP, specialist or non-delegated PPG who identifies a member as a potential candidate for transplant services must provide applicable medical records to a Health Net Transplant Performance Center (Center) for transplant evaluation. The Center must submit a prior authorization request for the evaluation to the Centene CTU through the provider portal, or via fax directly to the CTU at 833-769-1142. On receipt of a request for a transplant, the CTU contacts the Center to request any necessary medical records to complete the clinical review. Once complete medical records are received, a review is performed to establish medical necessity. If approved, the Center is notified and provided an authorization number for the evaluation.

Once a member has completed an evaluation and is approved by the Center for transplant, the Center must submit a prior authorization request for listing to the Centene CTU through the provider portal, or via fax directly to the CTU at 833-769-1142. On receipt of a request for a listing, the CTU contacts the provider to request any necessary medical records to complete the clinical review. Once complete medical records are received, a review is performed to establish medical necessity. If approved, the transplant center is notified and provided an authorization number.

If the request meets medical necessity, but the requesting transplant center is not a Health Net Transplant Performance Center, the member may be redirected to a Health Net Transplant Performance Center.

CAR-T cell therapy, corneal transplant, tissue transplant, pancreatic islet cell auto-transplant after pancreatectomy, or parathyroid auto-transplant after thyroidectomy requests must be submitted directly to Health Net.

It is the member's PCP's, attending physician's or the PPG's (as applicable) responsibility to authorize medical care prior to a transplant. This includes maintenance care for the member prior to the transplant.

The transplant program covers the professional and institutional costs of solid organ, cornea and stem cell transplants for members when medically necessary and not considered experimental or investigative.

For transplants deemed to be medically necessary, the transplant case rate for solid organ transplants begins either one day prior to the transplant or the day of the transplant (depending on the Transplant Performance Center). For stem cell transplants, the transplant case rate begins at the onset of the preparative regimen, which may be either high-dose chemotherapy, radiation therapy or a combination. Pre-transplant evaluation services are excluded from the global case rate. This is defined as diagnostic services and specialty consultations required to evaluate a Health Net member for transplant program acceptance as an established candidate for a transplant. Coverage for pre-transplant expenses would be based on the participating physician group (PPG) Division of Financial Responsibility (DOFR) matrix determination as described in the PPG *Provider Participation Agreement* (*PPA*), or fee for service as applicable based on the member's plan. If the provider refers a transplant case to a facility that is not a Health Net-designated Transplant Performance Center, the transplant-related claims are processed based on the standard PPG DOFR matrix, not the transplant DOFR matrix.

Allogeneic Stem Cell

The following transplant services are covered by transplant case rate contracts:

- Donor searches - Donor searches include outside search and donor procurement services. Unrelated searches and stem cell acquisition are done and priced separately through the National Marrow Donor Program (NMDP) or Stemcyte. Unrelated donor matches may require new, advanced technology using molecular matching. Related donor searches are done by the approved transplant facility. Related or unrelated donor searches are covered on all product lines.
- Transplant event (This phase starts with initiation of the preparative regimen, which may be included: high-dose chemotherapy, radiation therapy or a combination) - The preparative regimen may be performed inpatient or outpatient depending on the transplant facility case protocol. This includes institutional, professional and ancillary services related to the transplant.
- Professional fees - Includes all inpatient and outpatient services beginning at the onset of the preparative regimen prior to stem cell transplants through the case rate period.
- Institutional fees - Includes all inpatient and outpatient services, including room and board, for services beginning with the onset of the preparative regimen with high-dose chemotherapy, radiation therapy or a combination for stem cell transplants through the case rate period as specified by the transplant facility contract.
- Post-transplant services - Includes all institutional, professional, ancillary, and pharmaceutical services required after inpatient discharge, except for those medications covered through the member's outpatient pharmacy benefits. Some exclusions apply based on the transplant facility contract limits.

Autologous Stem Cell

The following transplant services are covered by a transplant case rate contract:

- Stem cell acquisition and collection or apheresis - Includes all institutional, professional and ancillary services required to retrieve and store stem cells.

- Transplant event - This phase involves initiation of high-dose therapy with chemotherapy, radiation therapy or a combination followed by the stem cell rescue or re-infusion - Includes institutional, professional and ancillary services related to this treatment. High-dose therapy may be performed inpatient or outpatient depending on transplant facility case protocol. The transplant event may be as inpatient or outpatient depending on the transplant facility protocol.
- Professional fees - Includes all inpatient and outpatient services beginning at the onset of high-dose chemotherapy, radiation therapy or combination of these prior to the stem cell transplants through the specified case rate period per transplant facility contract.
- Institutional fees - Includes all inpatient and outpatient services, including room and board, for services beginning with the onset of the preparative regimen with high-dose chemotherapy, radiation therapy or combination of these for stem cell transplants through the case rate period as specified by the transplant facility contract.
- Post-transplant services - Includes all institutional, professional, ancillary, and pharmaceutical services required after inpatient discharge, except for those medications covered through the member's outpatient pharmacy benefits. Some exclusions apply based on the transplant facility contract limits.

Solid Organs

The following are covered for solid organ transplants and related services:

- Donor search, organ acquisition or procurement services, histocompatibility services, donor services (for example, identifying prospective donors), and United Network for Organ Sharing (UNOS) fees - Unrelated donor searches are covered across all product lines and require prior authorization from Health Net's transplant care managers before beginning the search.
- Transplant of solid organ:
    - Professional fees - May include inpatient and outpatient services beginning either one day prior to the transplant or the date of transplant (depending on the Transplant Performance Center case rate contract provision) for solid organ transplants through the case rate period. Professional services include:
        - Any and all professional services.
        - Consultations including any services rendered by a transplant surgeon for the transplant operation.
        - Post-operative inpatient care and outpatient care.
        - Assistant surgeon and physician assistant for operation and post-operative care.
        - Anesthesiologist services (professional component).
        - Hepatologist for pre- and post-operative inpatient care.
        - Pathologist (professional component) of clinical and anatomical lab testing.
        - Radiologist for professional component of X-rays.
        - Immunologist for the professional component of histocompatibility.
    - Institutional fees - May include inpatient and outpatient services, including room and board, for services beginning either the day prior to the transplant or the date of transplant (depending on the Transplant Performance Center case rate contract provision) of solid organs through the case rate period.
- Re-transplant - Covered if medically necessary and reimbursed according to the terms of the transplant case rate contract with the transplant performance center facility.
- Transplant-related services during the case rate period - May not be covered under the transplant case rate contract depending on the Transplant Performance Center contract provision. Except for medications covered by a member's outpatient pharmacy benefit, post-discharge care includes all

transplant-related care, including inpatient and outpatient services (for example, laboratory, radiology, home health care, and durable medical equipment (DME)), all transplant-related medications, including a medication supply for up to 30 days after discharge. Medications that are transplant-related and covered by the member's outpatient pharmacy benefit are not covered under the transplant case rate.

Coverage Exclusions

Post-transplant care for current Health Net members is not covered under the transplant case rate contract if the transplant procedure was not pre-approved by Health Net and performed at a facility that is not a Health Net Transplant Performance Center. The transplant case rate contract does not cover post-transplant care for members who had a transplant prior to their Health Net effective date or outside their Health Net coverage period.

Any transplant considered experimental or investigative is not covered, except as referenced under the Group Exceptions section for members covered under the Federal Employee Health Benefits Program (FEHBP), or when approved through an independent review organization or third-party reviewer.

The following services are not covered under the stem cell transplant case rate contract:

- Non-transplant related services.
- Any chemotherapy or radiation therapy (for example, induction, consolidation or adjuvant) performed prior to high-dose chemotherapy is excluded from the case rate and processed according to the standard PPG Division of Financial Responsibility (DOFR) matrix. If it is determined to be a health plan risk, payment is based on current Health Net Provider Participation Agreement (PPA) rates.

Payment

The Health Net transplant program covers transplant services at Health Net Transplant Performance Centers (PDF). If a Transplant Performance Center authorizes and coordinates care for services rendered through the PPG, reimbursement is based on the rates included in the Health Net Provider Participation Agreement (PPA).

Out-of-Area Claims

Health Net is responsible for out-of-area claims for transplant-related services that occur out of the member's typical travel patterns between home and the transplant center in the course of receiving transplant-related services. If these services are not transplant-related and do not meet the out-of-area emergency criteria, the services are the member's responsibility.

Payment for Services Not Related to the Transplant Procedure

If the member requires inpatient or outpatient hospital services for an injury or underlying illness that is not transplant-related, these services are processed according to the PPA with the PPG or service institution.

Transplant Case Rate Contract

The following information applies only to participating physician groups (PPGs).

The transplant case rate contract includes the professional and institutional costs of medically necessary, non-experimental and non-investigative solid organ, cornea and stem cell transplants, as well as all transplant-related medications, including a medication supply for up to 30 days after discharge. Health Net covers transplants at its Transplant Performance Centers (PDF). These centers operate transplant programs based on a case rate.

For stem cell transplants, donor searches and charges related to the collection and storage of stem cells may not be included in the case rate. This determination is based on the Transplant Performance Center contract provision.

For solid organ transplants, donor searches and organ acquisitions may or may not be included in the case rate. This determination is based on the Transplant Performance Center contract provision.

The transplant case rate is defined by those services provided during the transplant case rate period. If a member is admitted for any other reason prior to the transplant procedure, services rendered are not included in the transplant case rate.

For transplants determined medically necessary, coverage under the case rate contract begins based on the following:

- For a solid organ transplant, the case rate period begins either one day prior to the transplant procedure or the day of transplant (depending on the Transplant Performance Center contract provision).
- For an outpatient stem cell transplant, the case rate period begins on the day of high-dose chemotherapy or radiation therapy and extends to the transplant admission until the specified case rate period based on the Transplant Performance Center contract provision.
- For an inpatient stem cell transplant, the case rate period begins on the day when the preparative regimen with high-dose chemotherapy, radiation therapy or a combination is initiated and ends on the specified case rate period based on the Transplant Performance Center contract provision.

Case Rate Exclusions

Medical services necessary for the maintenance of the member while waiting for a transplant are subject to the participating physician group's (PPG's) authorization and are not covered under the transplant case rate. These services are processed based on the PPG Division of Financial Responsibility (DOFR) matrix, and reimbursement is based on the rates included in the Health Net *Provider Participation Agreement (PPA)*. For example:

- Services not directly related to transplant care are not covered under the transplant case rate.
- Outpatient pharmacy charges and take-home medications, otherwise covered by the Health Net pharmacy program, are not covered under the transplant case rate.
- Pre-transplant evaluations are not included in the case rate.

Compliance for Transplant Performance Centers Standardized Process

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG)

Designated Transplant Network Participation

Health Net will designate certain transplant programs as “center of excellence” programs (“Tier 1”). In order to be designated a center of excellence, a program must meet minimum volume, outcome and quality criteria, which Health Net may modify from year to year at its discretion. Information regarding the transplant program(s) will be required from the provider on an annual basis to confirm tier status. Health Net may include transplant programs without the center of excellence designation in a network where additional consideration may be warranted (“Tier 2”), including but not limited to a covered person’s access/choice or if the provider can document exceptional circumstances that would mitigate an individual metric. Health Net will consider these factors, in combination with the transplant program criteria and other factors, to reach a determination on a program’s eligibility to provide transplant services without center of excellence designation. Transplant programs may, at Health Net’s sole discretion, move from one tier to the other on an annual basis, depending upon the data and performance of the transplant program from year to year.

Annual Transplant Program Review

The provider shall comply with Health Net’s annual transplant program review process and shall provide to Health Net, or its designee, such transplant program information and data on an annual basis as necessary, for Health Net to complete its annual review of the provider’s transplant program(s). The provider acknowledges that the provider’s failure to provide information in connection with such annual review process within 30 days of the request may result in suspension of the provider’s transplant programs from participation in the network. Health Net shall provide the provider with 30 days prior written notice in the event of the suspension of any transplant program.

Data Submission

The provider will submit transplant program performance data relating to all transplant services provided by the provider (whether to covered persons or other individuals), including but not limited to volume and outcomes, to the appropriate national reporting agency on each transplant program in accordance with the required reporting schedule. Health Net shall access and utilize the reported data. In the event Health Net determines that it requires additional information, such information will be requested from the provider. The provider shall respond to such request within 30 days.

Transplant Program Change Notification

The provider shall notify Health Net of any changes in the provider’s transplant program(s) and/or medical team. Health Net shall be notified immediately of any changes that could impact the quality of the provider’s transplant program, including but not limited to the loss of transplant program surgeons, loss or suspension of Centers for Medicare & Medicaid Services (CMS) certification, shutdown of transplant program.

Performance Requirements

In the event Health Net determines that the provider did not maintain compliance with applicable network criteria, quality standards or other performance requirements, Health Net may require corrective action.

Required Accreditation

Hospital accreditation: The Joint Commission (TJC), NIAHO or local alternative.

Solid organ: CMS certification and member in good standing with United Network for Organ Sharing (UNOS).

Blood and Marrow: Accreditation by Foundation of Accreditation of Cellular Therapy (FACT) and certification by the National Marrow Donor Program (NMDP).

Two Levels of Participation –

- National Network – Program must meet or exceed minimum volumes and survival/outcomes criteria below and have all accreditations noted above.
- Regional Network – Program must have all accreditations noted above and be an active program for at least two years.

Volume Criteria

The minimum volume criteria required by adult-specific Transplant Performance Center programs is maintained. A combined volume is calculated for transplant performance centers that contract for both adult and pediatric populations.

Minimum Transplant Volume required per calendar year:

Transplant Type	Adult	Pediatric
Kidney	30	3
Liver	15	3
Heart	12	2
Lung	12	1
Pancreas or SPK	No minimum if kidney meets	N/A

Transplant Type	Adult	Pediatric
Intestinal/Small Bowel	3	1
Blood and Marrow	40 total, with at least 20 being allogeneic	10

Survival/Outcomes Criteria:

Solid Organ – Outcomes are reviewed for one-year graft survival, three-year patient survival, mortality rate while on the waitlist and offer acceptance ratio. They are measured as follows:

- Graft Survival – One-year Graft Survival Hazard Ratio Z-Score of the 95% Lower Credibility Limit to adjust for observed vs. expected survival rates as compared to transplant programs throughout the country.
- Patient Survival – Three-year Patient Survival Hazard Ratio Z-Score of the 95% Lower Credibility Limit to adjust for observed vs. expected survival rates as compared to transplant programs throughout the country.
- Waitlist Mortality – Waitlist time to mortality Hazard Ratio Z-Score of the 95% Lower Credibility Limit to compare experiences of transplant programs throughout the country.
- Offer Acceptance Ratio-Number of expected offers to number of accepted offers is equal to or exceeds 1.0.

Total final score must meet or exceed 2.0 to be considered for participation.

If a total score was given that includes each of the measurements above, then the programs that are in the top 55% of all programs of the same transplant type were deemed to have met the quality criteria and hence, eligible to be included in the national network.

Blood and Marrow –

Autologous: 100-day survival must be at least 90%.

Allogeneic: 100-day survival must be at least 60% and the actual one-year survival must be “similar to” or “above” the expected rate as reported on Bethematch.org (for NMDP).

All programs must meet for both autologous and allogeneic to be included in the national network.

Injectable Transplant Medication

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

An injectable transplant medication is an injectable immunosuppressive used specifically during the course of transplantation to prevent organ rejection. Refer to the Health Net Injectable Medication HCPCS/DOFR Crosswalk (PDF) table for a list of injectable transplant medications.

Health Net Transplant Performance Centers

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG)

Refer to the Health Net Transplant Performance Center (PDF) matrix, which lists the Transplant Performance Centers and programs by region, when referring Health Net members for a transplant procedure.

Participation in Health Net's transplant network follows the Evaluation Process Standards to meet industry-accepted standards.

Vision

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section provides general member benefit information for vision services.

Select any subject below:

- Overview
- EyeMed Vision Care

Overview

Provider Type: Physicians | Participating Physician Groups (PPG)

Vision examinations are covered, subject to the scheduled copayments. Coverage includes eye refractions and examinations for diagnosis or for correction of vision. Conventional glasses and contact lenses are not covered, unless the member's contract specifically provides for supplemental coverage with EyeMed Vision Care. Vision services, including an annual vision exam and eyewear, are covered for pediatric members under age 19 (until at least the end of the month in which the enrollee turns 19 years of age) enrolled in a Health Net plan that includes vision coverage, as required by the Affordable Care Act (ACA). Pediatric vision coverage is administered by Eyemed Vision Care. For a list of additional covered vision services for these members, refer to the member's Evidence of Coverage (EOC), Certificate of Insurance (COI) or Schedule of Benefits.

Intraocular lens implants to replace the organic eye lens are covered following cataract surgery. If an intraocular lens is not implanted following such surgery, then contact lenses or cataract eyeglasses are covered. Refer to the member's EOC, COI or Schedule of Benefits for specific plan information.

Exclusions and Limitations

Refer to the member's Evidence of Coverage (EOC), Certificate of Insurance (COI) or Schedule of Benefits for additional information.

EyeMed Vision Care

Provider Type: Physicians | Participating Physician Groups (PPG)

Health Net contracts with Centene Vision Services to provide vision benefits to Health Net members whose coverage includes vision plan benefits. Centene Vision Services sub-delegates benefit administration to EyeMed Vision Care. EyeMed provides benefits for a routine vision exam and/or eyewear through their network of optometrists, dispensing opticians and optometric laboratories for employer and union groups as well as individual members (not covered through an employer group). Benefit coverage and benefit administration varies by plan:

- Exam only
- Materials only
- Exam and materials

Depending upon the plan the routine vision examination may be covered through their participating physician group (PPG) or primary care physician (PCP) or through EyeMed.

If the member requires eyeglasses, a prescription is written and the member may purchase eyewear from a list of participating dispensing opticians in California.

The optician bills EyeMed Vision Care for reimbursement. If the member selects standard lenses and frames, they do not owe the dispensing optician. If more costly items are selected, members are required to pay the amount in excess of those specified in the Schedule of Allowances under the member's Evidence of Coverage (EOC), or Certificate of Insurance (COI). The HMO member is required to obtain eyewear services only through participating providers.

Eye Care Network Responsibilities

The PCP or PPG are not responsible for referring Health Net members to EyeMed Vision Care for a refraction examination when applicable; however, PCPs or PPGs should be aware of which members have this benefit so they can direct the member to contact EyeMed Vision Care when appropriate.

If the EyeMed Vision Care provider finds a medical problem during the refraction examination, the provider must refer the member back to the PCP or PPG. If the medical condition is considered acute or emergency, the provider must call the PPG and direct the member back to the PCP immediately or to a hospital emergency department, if appropriate. For non-emergency conditions, the provider prepares and sends a report to the PCP or PPG identifying the problem and instructs the member to follow up with their PCP for further evaluation and treatment.

A member with a Health Net vision plan can request an appointment for a vision examination through the PPG.

Criteria for Vision Services

Eyewear services is not covered by individual family plans (IFP).

The HMO member is required to obtain eyewear services through participating providers. Refer to the member's Evidence of Coverage (EOC), Certificate of Insurance (COI) or Schedule of Benefits for additional information or contact Health Net vision plan.

A member with a Health Net vision plan can request an appointment for a vision examination through the participating physician group (PPG).

X-Ray and Laboratory Services

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

This section contains general member benefit information on x-ray and laboratory services.

Select any subject below:

- Overview
- Diagnostic Procedures
- Laboratory Services
- Radiation Therapy

Overview

Provider Type: Physicians | Ancillary | Participating Physician Groups (PPG)

Medically necessary X-ray and laboratory procedures, services and materials are covered when ordered or approved by the participating provider.

Exclusions and Limitations

X-ray and laboratory procedures associated with routine physical examinations for insurance are not covered on most plans. These procedures are also not covered when obtained for licensing, employment, school, camp, or other non-preventive purposes. On plans that cover routine physical examinations, the exam itself and any related X-ray and laboratory procedures are covered; however, completion of any related forms is not.

Additionally, premarital blood tests are not covered.

Diagnostic Procedures

Provider Type: Physicians | Participating Physician Groups (PPG) | Ancillary

Health Net has an agreement with Evolent Specialty Services, Inc. to provide utilization management (UM) services, including prior authorization determinations for certain advanced and cardiac imaging for fee-for-service (FFS) members.

Evolent Specialty Services Agreement

Evolent Specialty Services Agreement provides UM determinations for the following outpatient imaging procedures:

- Advanced imaging:
  - Computed tomography (CT)/computed tomography angiography (CTA)
  - Magnetic resonance imaging (MRI)/magnetic resonance angiography (MRA)
  - Positron emission tomography (PET) scan
- Cardiac imaging:
  - Coronary computed tomography angiography (CCTA)
  - Myocardial perfusion imaging (MPI)
  - Multigated acquisition (Muga) scan
  - Stress echocardiography
  - Transthoracic echocardiography (TTE)
  - Transesophageal echocardiography (TEE)

Exceptions

Health Net retains responsibility for UM determinations for these services.

- Emergency room radiology services

Laboratory Services

Provider Type: Physicians

Quest Diagnostics® and LabCorp® are Health Net's preferred providers are Health Net's preferred provider for laboratory services for the following lines of business:

- Point of Service (POS)
- PPO
- EPO
- Fee-for-service (FFS):
  - HMO

- Medicare Advantage (MA)
- Medi-Cal

Quest Diagnostics is the world's leading provider of diagnostic testing, information and services, and offers:

- Convenient access to testing services with over 400 Quest Diagnostics Patient Service Center (PSC) locations in California, in addition to an online PSC locator and appointment scheduling function to minimize wait times.
- Access to more than 3,000 clinical, esoteric and anatomic pathology tests performed at one of Quest Diagnostics' testing facilities.
- Industry-leading standards of quality, integrity and clinical excellence, providing the greatest level of consistency and security for providers' practices.
- Consultation services with more than 800 physician and clinical specialists for rare or difficult test results.
- 24-hour-a-day, seven-day-a-week access to electronic laboratory orders and results, and other office solutions through Care360® Labs & Meds.
- Electronic prescription capability to order and renew prescriptions.
- Patient-friendly reports that help easily explain test results.

Radiation Therapy

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

eviCore healthcare is responsible for the prior authorization process for radiation therapy for all members*. Physicians and specialty providers can request prior authorization by contacting eviCore healthcare.

*Health Net continues to review radiation therapy requests for Direct Network HMO (including Ambetter HMO) until Department of Managed Healthcare (DMHC) approval is received.

Claims and Provider Reimbursement

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section describes claims and provider reimbursement

Select any subject below:

- Remittance Advice and Explanation of Payment System
- Accessing Claims on Health Net Provider Portal
- Adjustments
- Balance Billing
- Billing and Submission
- Capitated Claims and Billing Information

Remittance Advice and Explanation of Payment System

Provider Type: Hospitals

The remittance advice (RA) and explanation of payment (EOP) system communicates Health Net's claims resolution and outcomes to participating hospitals. This automated system consolidates claim payments to providers and recognizes and recovers any overpayment allowed under the provider's contract.

Hospitals receive a RA and EOP from Health Net when any of the following occurs:

- Health Net pays, denies or contests a claim for services provided to a Health Net member
- For Medicare employer groups withholds a payment to recover a previous overpayment. A RA and EOP overpayment detail notification is sent to the provider. This notification does not apply to individual Medicare or Special Needs Plan (SNP) providers.

A RA and EOP notification lists payments Health Net makes to hospitals claim by claim. It is composed of the following:

- Subscriber identification number
- Patient name
- Patient account number - recorded on the CMS-1500 or UB-04
- Health Net claim identification (ID) number
- Service dates
- Total billed
- Contract adjustment
- Amount paid - same as contract adjustment
- Total claims payable
- Total check amount - total claims payable

Hospitals must carefully review all RA and EOP notifications to verify payments and denials. Health Net does not send letters on initial claim denials. Questions regarding RA and EOP notifications must be directed to the Provider Services Center.

Accessing Claims on the New Health Net Portal

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) (does not apply to HSP) | Ancillary

To obtain step-by-step guidance on how to access the claims and more on Health Net's provider portal download the Save Time Navigating the Provider Portal (PDF), Save Time Navigating the Provider Portal – Community Health Plan of Imperial Valley (PDF), Save Time Navigating the Provider Portal – CalViva (PDF) or Save Time Navigating the Provider Portal – WellCare by Health Net booklet.

- Accessing member claims
- Submitting professional claims
- Submitting institutional claims
- Viewing claims
- View details of individual claims
- Correct claims
- Copy claims
- Saved claims
- Submitted claims
- Batch claims
- Viewing submitted batch claims
- Payment history
- Explanation of payment details
- Downloading the explanation of payment
- Claims audit tool

Adjustments

Provider Type: Physicians | Ancillary

If a participating provider believes that a claim was processed inaccurately and wants to request an adjustment, the claim may be resubmitted to Health Net requesting reconsideration of the claim by following the provider dispute resolution process.

Balance Billing

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

Balance billing is strictly prohibited by state and federal law and Health Net's Provider Participation Agreement (PPA).

Balance billing occurs when a participating provider bills a member for fees and surcharges above and beyond a member's copayment and coinsurance responsibilities for services covered under a member's benefit program, or for claims for such services denied by Health Net or the affiliated participating physician group (PPG). Participating providers are also prohibited from initiating or threatening to initiate a collection action against a member for non-payment of a claim for covered services. Participating providers agree to accept Health Net's fee for these services as payment in full, except for applicable copayments, coinsurance, or deductibles.

Dual Special Needs Plan (D-SNP) members are not subject to copayments, so providers must not charge D-SNP members coinsurance, copayments, deductibles, financial penalties, or any other amount due to their Medi-Cal eligibility. Any amounts non-covered by the Medicare payment/reimbursement must be sent for secondary payment to the member's Medi-cal managed care plan (MCP) or directly to the Department of Health Care Services (DHCS) if not assigned to a Medi-cal MCP for that date of service.

Providers can verify the member's Medi-cal MCP by checking the Medi-Cal Automated Eligibility Verification (PDF) .

Providers can refer to the Verifying and Clearing Share-of-Cost section for information regarding D-SNP members' share of cost (SOC) responsibility for certain services.

Participating providers may bill a member for non-covered services when the member is notified in advance that the services to be provided are not covered and the member, nonetheless, requests in writing that the services be rendered. A participating provider who exhibits a pattern and practice of billing members will be contacted by Health Net and is subject to disciplinary action.

Billing and Submission

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information on claims billing and submission.

Select any subject below:

- Claims Receipt Acknowledgement
- Claims Submission
- Claims Submission Requirements
- Clinical Information Submission
- CMS-1500 Billing Instructions
- Hospital Acquired Conditions
- Trauma Services
- UB-04 Billing Instructions
- Workers' Compensation

Claims Receipt Acknowledgement

Provider Type: Physicians | Ancillary | Hospitals

Health Net provides an acknowledgement of claims receipt, whether or not the claims are complete, within two business days for electronically submitted claims. For paper claims, Health Net provides an acknowledgement of claims receipt within 15 business days of receipt for HMO, Medi-Cal, PPO, and EPO. If a paper claim is paid or denied within 15 days, the Remittance Advice (RA) is considered an acknowledgement of claims receipt. A provider may obtain acknowledgement of claim receipt in the following manner:

HMO, PPO, EPO, and HSP claims: Electronic fax-back confirmation of claims receipt through the Health Net Provider Services Center interactive voice response (IVR) system, via a paper acknowledgement report mailed within 14 days of claims receipt and on the Health Net provider portal.

Medi-Cal claims: Confirmation of claims receipt through the provider portal of Health Net's website and by calling the Medi-Cal Provider Services Center, Community Health Plan of Imperial Valley Provider Services Center or CalViva Health Provider Services Center.

Claims received from a provider's clearinghouse are acknowledged directly to the clearinghouse in the same manner and time frames noted above.

Date of Receipt definition: Date of receipt is the business day when a claim is first delivered, electronically or physically, to Health Net's designated address.

Claims Submission

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) |Ancillary

Providers must use correct coding to ensure prompt, accurate processing of claims. Physicians should use CMS-1500 forms and CPT or HCPCS coding, as indicated in the Provider Participation Agreement (PPA). Hospitals use UB-04 (CMS-1450) form and current UB coding, including CPT, DRG, HCPCS, and ICD-10.

If the provider has more than one tax identification number, use the tax identification number under which the PPA has been signed and also include the National Provider Identifier (NPI) number. Claims cannot be processed without these identifying numbers.

The physician's name must be listed in the Referring Physician box on the claim form only if the member has received a referral from the primary care physician (PCP). Claims submitted with a physician's name in the Referring Physician box are processed at the Tier 1 (HMO) coverage level. Members accessing Tier 2 or Tier 3 coverage levels do not have a referral form from the PCP and the claim form needs to accurately reflect this.

Submit Health Net claims within 120 calendar days from the date of service to the Health Net commercial claims address (PPO). Do not send claims to members unless the member has agreed, in writing, to take financial responsibility for a non-covered service.

Claims Submission Requirements

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) |Ancillary

Health Net encourages providers to submit claims electronically. Paper submissions are subject to the same edits as electronic and web submissions.

All paper claims sent to the claims office must first pass specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected or denied. Claims missing the necessary requirements are not considered clean claims and will be returned to providers with a written notice describing the reason for return. Nonstandard forms include any that have been downloaded from the Internet or photocopied, which do not have the same measurements, margins, and colors as commercially available printed forms.

Refer to un-clean claims for more information.

Acceptable Forms

For paper claims, Health Net only accepts the Centers for Medicare & Medicaid Services (CMS) most current:

- CMS-1500 form - complete in accordance with the guidelines in the National Uniform Claim Committee (NUCC) 1500 Claim Form Reference Instruction Manual, updated each July.
- CMS-1450 (UB-04) form - complete in accordance to UB-04 Data Specifications Manual, updated each July.

Other claim form types will be upfront rejected and returned to the provider. Providers should adhere to the claims submission requirements below to ensure that submitted claims have all required information, which results in timely claims processing.

Electronic Claims

For fastest delivery and processing, claims can be submitted electronically using the HIPAA 5010 standard 837I (005010X223A2) and 837P (005010X222A1) transaction. Each claim submitted must include all mandatory elements and situational elements, where applicable. Secondary COB claims can be sent electronically with all appropriate other payer information and paid amounts.

Paper Claims

Paper claim forms must be typed in black ink with either 10 or 12 point Times New Roman font, and on the required original red and white version to ensure clean acceptance and processing. Claims submitted on black and white, handwritten or nonstandard forms will be rejected and a letter will be sent to the provider indicating the reason for rejection. To reduce document handling time, providers must not use highlights, italics, bold text, or staples for multiple page submissions. Copies of the form cannot be used for submission of claims, since a copy may not accurately replicate the scale and optical character recognition (OCR) color of the form.

Health Net only accepts claim forms printed in Flint OCR Red, J6983 (or exact match) ink and does not supply claim forms to providers. Providers should purchase these forms from a supplier of their choice.

Professional Claims

Providers billing for professional services and medical suppliers must complete the CMS-1500 (02/12) form. The form must be completed in accordance with the guidelines in the National Uniform Claim Committee (NUCC) 1500 Claim Form Reference Instruction Manual Version 5.0 7/17 at www.nucc.org. Paper claims follow the same editing logic as electronic claims and will be rejected with a letter sent to the provider indicating the reason for rejection if non-compliant.

Institutional Claims

Providers billing for institutional services must complete the CMS-1450 (UB-04) form. The form must be completed in accordance with the National Uniform Billing Committee (NUBC) Official UB-04 Data Specifications Manual 2018 at www.nubc.org. Paper claims follow the same editing logic as electronic claims and will be rejected with a letter sent to the provider indicating the reason for rejection if non-compliant.

Medicare Billing Instructions

Medicare CMS-1500 and completion and coding instructions, are available on the CMS website at www.cms.gov.

Mandatory Items for Claims Submission

Refer to CMS-1500 Billing instructions or UB-04 Billing Instructions as applicable for complete description and required or conditional fields.

Reference guide for commonly submitted items

Form Fields	Electronic	CMS-1500	UB-04
Billing provider tax ID	Loop 2010AA REF segment with TJ qualifier	Box 25	Box 5
Billing provider name, address and NPI	Loop NM109 with XX qualifier	Box 33	Box 1

Form Fields	Electronic	CMS-1500	UB-04
Subscriber (name, address, DOB, sex, and member ID required)	2000B and 2010BA	Subscriber box 1a, 4, 7, 11	Box 58 and 60
Provider taxonomy		Box 33B and Box 24	Box 57
Patient (name, address, DOB, sex, relationship to subscriber, status, and member ID)	2000C and 2010CA	Patient box 2, 3, 5, 6, 8	Box 8, 9, 10, 11
Principal diagnosis and additional diagnoses	Loop 2300 HI segment qualifier BK (ICD9) or ABK (ICD10)	Box 21	Box 66
Diagnosis pointers (up to 4)	Loop 2410 SV107	Box 24E (A-L)	N/A
Referring provider with NPI	Loop 2300 NM1 with DN qualifier	Box 17	N/A
Attending provider with NPI	Loop 2300 NM1with DN qualifier	N/A	Box 76
Rendering provider	Loop 2300 NM1 with 82 qualifier (if differs from billing provider)	NPI in Box 24J	N/A
Service facility information	Loop 2310C or 2310E NM1 with 77 qualifier (if differs from billing provider)	Box 32	N/A
Procedure code	Loop 2400 SV segment	Box 24D	Box 44 if applicable

Form Fields	Electronic	CMS-1500	UB-04
NDC code	Loop 2410 LIN segment with N4 qualifier. Must include mandatory CTP segment.	Box 24D shaded	Box 43
UPN	Loop 2410 LIN segment with appropriate UP, UK, UN qualifier. Must include mandatory CTP segment.	Box 24D shaded	Box 43
Value codes (for accommodation codes, share of cost, etc.)	Loop 2300 HI segment with qualifier BE	N/A	Box 39, 40, 41
Condition codes	Loop 2300 HI segment with qualifier BG	N/A	Box 18-28
COB-other subscriber or third party liability	Loop 2320, 2330A and 2330 B	Box 9, if applicable (requires paper EOB from other payer), 10, 11	Box 50-62 (requires paper EOB from other payer)
Claim DOS	Loop 2400 DTP segment with 472 qualifier	Box 24A	Box 45 for outpatient when required
Claim statement date	Loop 2300 with 434 qualifier	N/A	Box 6 from and through

Claims Rejection Reasons and Resolutions

The following are some claims rejection reasons, challenges and possible resolutions.

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
01	Member's DOB is missing or invalid	Enter the member's 8-digit date of birth (MM/DD/YYYY)	CMS-1500 box 3 UB-04 box 10	Section 2 [1]Non-standard submission or equivalent
02	Incomplete or invalid member information	Enter the member's Health Plan member identification (ID) for Commercial and Medicare or Client Identification Number (CIN) for Medi-Cal. Social Security number (SSN) should not be used. Check eligibility online, electronically, or refer to the member's current ID card to determine ID numbers	CMS-1500 box 1a UB-04 box 60	Section 2 [1]Non-standard submission or equivalent
06	Missing/invalid tax ID	Include complete 9-character tax identification number (TIN)	CMS-1500 box 25 UB-04 box 5	Section 1a [1]Non-standard submission or equivalent
17	Diagnosis indicator is missing POA indicator is not valid DRG code is not valid	Ensure 9/0 ("9" for ICD-9 or "0" for ICD-10) appears in field 66 for all claims. Ensure present on admission (POA) indicators	UB-04 box 66-70 UB-04 box 71	Section 3 [1]Non-standard submission or equivalent

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
		are valid when billed. Ensure a valid DRG code is used in field 71. POA valid values are: Y – Diagnosis was present at time of inpatient admission. N – Diagnosis was not present at time of inpatient admission. Leave blank if cannot be determined		
75	The claim(s) submitted has missing, illegible or invalid value for anesthesia minutes	When box 24 is completed, then box 24G must be completed as well	CMS-1500 box 24D and 24G	N/A
76	Original claim number and frequency code required	When submitting a corrected claim, for UB-04 box 64 and CMS-1500 box 22, you must reference the original claim. Claim numbers can be found on your Remittance Advice (RA)/ Explanation of Payment (EOP)	CMS-1500 box 22 UB-04 box 4 and 64	Section 4 [1]Non-standard submission or equivalent

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
		or check claims status online. Do not include punctuation, words or special characters before or after the claim number. Submission ID from a reject letter is not a valid claim number. If not using frequency codes 7 or 8 leave boxes 64 and 22 blank. Submit contested claims to Medi-Cal Provider Contested Claims.		
77	Type of bill or place of service invalid or missing	Enter the appropriate type of bill (TOB) code as specified by the NUBC UB-04 Uniform Billing Manual minus the leading “0” (zero). A leading “0” is not needed. Digits should be reflected as follows: 1st digit – Indicating the type of facility 2nd digit –	UB-04 box 4	N/A

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
		Indicating the type of care 3rd digit – Indicating the bill sequence (frequency code)		
87	One or more of the REV codes submitted is invalid or missing	Include complete 4-digit revenue code	UB-04 box 42	N/A
92	Missing or invalid NPI	Enter provider's 10-character National Provider Identifier (NPI) ID	CMS-1500 box 24J and 33A UB-04 box 56	Section 1b [1]Non-standard submission or equivalent
A5	NDC or UPIN information missing/invalid	Providers must bill the UPIN qualifier, number, quantity, and type or National Drug Code (NDC) qualifier, number, quantity, and unit/basis of measure. If any of these elements are missing, the claim will reject	CMS-1500 box 24D UB-04 box 43	N/A
A7	Invalid/missing ambulance point of pick- up ZIP Code	When box 24 D is completed, include the pickup/drop off address in attachments	CMS-1500 box 24 or box 32. Medicare claims require a point of pickup (POP) ZIP in box 23 in addition to the addresses in 24	N/A

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
			shaded area or box 32	
A9	Provider name and address required at all levels	Include complete provider billing address including city, state and ZIP Code	CMS-1500 box 33 UB-04 box 1	Section 1a [1]Non-standard submission or equivalent
AK	Original claim number sent when the claim is not an adjustment	When submitting an initial claim, leave CMS 1500 box 22 and UB-04 box 64 blank. Any values entered in these boxes will cause a claim to reject.	CMS-1500 box 22 UB-04 box 64	Section 4 [1]Non-standard submission or equivalent
C8	Valid POA required for all DX fields	Do not include the POA of 1. The valid values for this field are Y or N or blank. (for description see Reject code 17)	UB-04 box 67–67Q and 72A–72C	N/A
B7	Review NUCC guidelines for proper billing of the CMS-1500 versions (08/05) and (02/12). Claims will be rejected if data is not submitted and/or formatted appropriately	Only CMS-1500 02/12 version is accepted	N/A	N/A

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
C6	Other Insurance fields 9, 9a, 9d, and 11d are missing appropriate data	If the member has other health insurance, box 9, 9a and 9d must be populated, and box 11d must be marked as yes. If this is not provided, the claim will be rejected	CMS-1500 box 9, 9a, 9d and 11d	N/A
AV	Patient's reason for visit should not be used when claim does not involve outpatient visits	Include patient reason for visit for bill type 013x, 078x, and 085x (outpatient) when Type of Admission/Visit (Box 14) is 1 (emergency), 2 (urgent) or 5 (trauma) and revenue code 045x, 0516 or 0762 are reported. Otherwise, do not populate	UB-04 box 70a, b, c	N/A
HP	ICD-10 is mandated for this date of service	Submit with the ICD indicator of 9/0 on both UB-04 and CMS-1500 claim forms according to the 5010 Guidelines requirement to bill this information. (for	CMS-1500 box 21 UB-04 box 66	N/A

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
		description see Reject code 17)		
RE	Black/white, handwriting or nonstandard format	Use proper CMS-1500 or UB-04 form typed in black ink in 10 or 12 point Times New Roman font	N/A	N/A

[1]This is not a standard claim form like the CMS-1500 or the UB-04 claim forms; used to bill ECM and Community Supports services only.

Clinical Information Submission

Provider Type: Physicians | Participating Physician Groups (PPG)

Health Net routinely requires Medicare employer groups to include clinical information at the time of claim submission as follows:

- Evaluation and Management Services (E&M) - There are general principles of medical record documentation that are applicable to all types of medical and surgical services in all settings. While E&M services vary in several ways, such as the nature and amount of physician work required, the following general principles help ensure that medical record documentation for all E&M services is appropriate. The diagnosis and treatment codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

The documentation of each patient encounter should include the following:

- Reason for the encounter and relevant history, physical examination findings, and any prior and additional diagnostic test results.
- Assessment, clinical impression or diagnosis.
- Medical plan of care.
- Date and legible identity of the observer.
- Any additional relevant information.

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill higher level of evaluation and management service when a lower level of service is warranted.

Health Net reserves the right to request clinical records before or after claim payment to identify possible fraudulent or abusive billing practices, as well as any other inappropriate billing practice not consistent or

compliant with the American Medical Association (AMA) CPT codes or guidelines, provided there is evidence such an investigation is warranted.

CMS-1500 Billing Instructions

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

All claims from participating providers that are Health Net's responsibility must be submitted to Health Net Medi-Cal claims within 180 days from the last day of the month of the date services were rendered. Medicare Advantage, EPO, HMO, HSP and PPO participating providers must be submitted claims to Health Net within 120 days from the date services were rendered, unless a different time frame is stated in the providers' contract. Health Net accepts claims submitted on the standard CMS-1500 and computer generated claims using these formats.

Field number	Field description	Instruction or comments	Required, conditional or not required
1	Insurance program identification	Check only the type of health coverage applicable to the claim. This field indicated the payer to whom the claim is being field. Enter "X" in the box noted "Other"	Required
1a	Insured identification (ID) number	The nine-digit identification number on the member's ID card	Required
2	Patient's name (Last name, first name, middle initial)	Enter the patient's name as it appears on the member's ID. card. Do not use nicknames	Required
3	Patient's birth date and sex	Enter the patient's eight-digit date of birth (MM/DD/YYYY), and mark the appropriate	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		box to indicate the patient's sex/gender. M= Male or F= Female	
4	Insured's name	Enter the subscriber's name as it appears on the member's ID card	Conditional - Needed if different than patient
5	Patient's address (number, street, city, state, ZIP code) Telephone number (include area code)	Enter the patient's complete address and telephone number, including area code on the appropriate line. First line - Enter the street address. Do not use commas, periods, or other punctuation in the address such as 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line - In the designated block, enter the city and state. Third line - Enter the ZIP code and telephone number. When entering a nine-digit ZIP code (ZIP +4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number such as (803)5551414. Note: Patient's telephone does not exist in the electronic	Conditional

Field number	Field description	Instruction or comments	Required, conditional or not required
		837 Professional 4010A1	
6	Patient's relationship to insured	Always mark to indicate self if the same	Conditional - Always mark to indicate self if the same
7	Insured's address (number, street, city, state, ZIP code) Telephone number (include area code)	Enter the insured's complete address and telephone number, including area code on the appropriate line. First line - Enter the street address. Do not use commas, periods, or other punctuation in the address such as 123 N Main Street 101 instead of 123 N. Main Street, #101. Second line - In the designated block, enter the city and state. Third line - Enter the ZIP code and telephone number. When entering a nine-digit zip code (ZIP + 4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number such as (803)5551414. Note: Patient's telephone does not exist in the electronic	Conditional

Field number	Field description	Instruction or comments	Required, conditional or not required
		837 Professional 4010A1	
8	Reserved for NUCC	N/A	Not required
9	Other insured's name (last name, first name, middle initial)	Refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan. Enter the complete name of the insured	Conditional refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan
9a	Other insured's policy or group number	REQUIRED if field 9 is completed. Enter the policy of group number of the other insurance plan	Conditional REQUIRED if field 9 is completed. Enter the policy for group number of the other insurance plan
9b	Reserved for NUCC	N/A	Not required
9c	Reserved for NUCC	N/A	Not required
9d	Insurance plan name or program name	REQUIRED if field 9 is completed. Enter the other insured's (name of person listed in field 9) insurance plan or program name	Conditional REQUIRED if field 9 is completed
10 a, b, c	Is patient's condition related to:	Enter a Yes or No for each category/line (a, b and c). Do not enter a Yes and No in the same category/line. When marked Yes, primary insurance	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		information must then be shown in box 11	
10d	Claims codes (designated by NUCC)	When reporting more than one code, enter three blank spaces and then the next code	Conditional
11	Insured policy or FECA number	REQUIRED when other insurance is available. Enter the policy, group, or FECA number of the other insurance. If box 10 a, b or c is marked Y, this field should be populated	Conditional REQUIRED when other insurance is available
11a	Insured date of birth and sex	Enter the eight-digit date of birth (MM/DD/YYYY) of the insured and an X to indicate the sex (gender) of the insured. Only one box can be marked. If gender is unknown, leave blank	Conditional
11b	Other claims ID (Designated by NUCC)	The following qualifier and accompanying identifier has been designated for use: Y4 Property Casualty Claim Number For worker's compensation of property and casualty: Required if known.	Conditional

Field number	Field description	Instruction or comments	Required, conditional or not required
		Enter the claim number assigned by the payer	
11c	Insurance plan name or program number	Enter name of the insurance health plan or program	Conditional
11d	Is there another health benefit plan	Mark Yes or No. If Yes, complete field's 9a-d and 11c	Required
12	Patient's or authorized person's signature	Enter "Signature on File," "SOF," or the actual legal signature. The provider must have the member's or legal guardian's signature on file or obtain his/her legal signature in this box for the release of information necessary to process and/or adjudicate the claim	Conditional - Enter "Signature on File," "SOF," or the actual legal signature
13	Insured's or authorized person's signature	Obtain signature if appropriate.	Not required
14	Date of current: Illness (First symptom) or Injury (Accident) or Pregnancy (LMP)	Enter the six-digit (MM/DD/YY) or eight-digit (MM/DD/YYYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last	Conditional

Field number	Field description	Instruction or comments	Required, conditional or not required
		menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported. 431 Onset of Current Symptoms or Illness 484 Last Menstrual Period	
15	If patient has same or similar illness. Give first date.	Enter another date related to the patient's condition or treatment. Enter the date in the six-digit (MM/DD/YY) or eight-digit (MM/DD/YYYY) format	Conditional
16	Dates patient unable to work in current occupation	Enter the six-digit (MM/DD/YY) or eight-digit (MM/DD/YYYY)	Conditional
17	Name of referring physician or other source	Enter the name of the referring physician or professional (first name, middle initial, last name, and credentials)	Conditional - Enter the name of the referring physician or professional (first name, middle initial, last name, and credentials)
17a	ID number of referring physician	Required if field 17 is completed. Use ZZ qualifier for Taxonomy code	Conditional REQUIRED if field 17 is completed

Field number	Field description	Instruction or comments	Required, conditional or not required
17b	NPI number of referring physician	Required if field 17 is completed. If unable to obtain referring NPI, servicing NPI may be used	Conditional REQUIRED if field 17 is completed. If unable to obtain referring NPI, servicing NPI may be used
18	Hospitalization on dates related to current services		Conditional
19	Reserved for local use - new form: Additional claim information		Conditional
20	Outside lab/ charges		Conditional
21	Diagnosis or nature of illness or injury (related items A-L to item 24E by line). New form allows up to 12 diagnoses, and ICD indicator	Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD-10-CM diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field. Note: Claims missing or with invalid diagnosis codes will be rejected or denied for payment	Required - Include the ICD indicator
22	Resubmission code / original REF	For resubmissions or adjustments, enter the original claim number of the original claim.	Conditional - For resubmissions or adjustments, enter the

Field number	Field description	Instruction or comments	Required, conditional or not required
		New form - for resubmissions only: - Replacement of Prior Claim - Void/Cancel Prior Claim	original claim number of the original claim
23	Prior authorization number or CLIA number	Enter the authorization or referral number. Refer to the provider operations manual for information on services requiring referral and/or prior authorization. CLIA number for CLIA waived or CLIA certified laboratory services	If authorization, then conditional If CLIA, then required If both, submit the CLIA number Enter the authorization or referral number. Refer to the provider operations manual for information on services requiring referral and/or prior authorization. CLIA number for CLIA waived or CLIA certified laboratory services
24 A-G Shaded	Supplemental information	The shaded top portion of each service claim line is used to report supplemental information for: • NDC • Narrative description of unspecified codes • Contract rate • For detailed instructions and qualifiers refer	Conditional - The shaded top portion of each service claim line is used to report supplemental information for: NDC Narrative description of unspecified codes Contract rate

Field number	Field description	Instruction or comments	Required, conditional or not required
		to Appendix IV of this guide	
24A Unshaded	Dates of service	Enter the date the service listed in field 24D was performed (MM/DD/YYYY). If there is only one date, enter that date in the "From" field. The "To" field may be left blank or populated with the "From" date. If identical services (identical CPT/HCPC code(s)) were performed, each date must be entered on a separate line	Required
24B Unshaded	Place of service	Enter the appropriate two-digit CMS standard place of service (POS) code. A list of current POS codes may be found on the CMS website	Required
24C Unshaded	EMG	Enter Y (Yes) or N (No) to indicate if the service was an emergency	Not required
24D Unshaded	Procedures, services or supplies CPT/ HCPCS modifier	Enter the five-digit CPT or HCPCS code and two-character modifier, if applicable. Only one CPT or HCPCS and up to four	Required - Ensure NDC or UPIN is included if applicable

Field number	Field description	Instruction or comments	Required, conditional or not required
		modifiers may be entered per claim line. Codes entered must be valid for date of service. Missing or invalid codes will be denied for payment. Only the first modifier entered is used for pricing the claim. Failure to use modifiers in the correct position or combination with the procedure code, or invalid use of modifiers, will result in a rejected, denied, or incorrectly paid claim	
24 E Unshaded	Diagnosis code	In 24E, enter the diagnosis code reference letter (pointer) as shown in box 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. ICD-10-	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		CM diagnosis codes must be entered in box 21 only. Do not enter them in 24E. Do not use commas between the diagnosis pointer numbers. Diagnosis Codes must be valid ICD-10 codes for the date of service, or the claim will be rejected/denied	
24 F Unshaded	Charges	Enter the charge amount for the claim line item service billed. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line	Required
24 G Unshaded	Days or units	Enter quantity (days, visits, units). If only one service provided, enter a numeric value of one	Required
24 H Shaded	EPSDT (Family Planning)	Leave blank or enter "Y" if the services were performed as a result of an EPSDT referral	Conditional - Leave blank or enter "Y" if the services were performed as a result of an Early and Periodic Screening, Diagnostic and

Field number	Field description	Instruction or comments	Required, conditional or not required
			Treatment (EPSDT) referral
24 H Unshaded	EPSDT (Family Planning)	Enter the appropriate qualifier for EPSDT visit	Conditional - Enter the appropriate qualifier for EPSDT visit
24 I Shaded	ID qualifier	Use ZZ qualifier for taxonomy. Use 1D qualifier for ID, if an atypical provider	Required
24 J Shaded	Non-NPI provider ID#	Typical providers: Enter the provider taxonomy code that corresponds to the qualifier entered in box 24I shaded. Use ZZ qualifier for taxonomy code Atypical providers: Enter the provider ID number.	Required
24 J Unshaded	NPI provider ID	Typical providers ONLY: Enter the 10-character NPI of the provider who rendered services. If the provider is billing as a member of a group, the rendering individual provider's 10-character NPI may be entered. Enter the billing NPI if services are not provided by an individual (such as DME, independent lab, home health,	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		RHC/FQHC general medical exam)	
25	Federal Tax ID number SSN/EIN	Enter the provider or supplier nine-digit federal tax ID number, and mark the box labeled EIN	Required
26	Patient's account NO	Enter the provider's billing account number	Conditional - Enter the provider's billing account number
27	Accept Assignment?	Enter an X in the YES box. Submission of a claim for reimbursement of services provided to a recipient using state funds indicates the provider accepts assignment. Refer to the back of the CMS-1500 (02-12) claim form for the section pertaining to payments	Conditional - Enter an X in the YES box. Submission of a claim for reimbursement of services provided to a recipient using state funds indicates the provider accepts assignment
28	Total charge	Enter the total charges for all claim line items billed - claim lines 24F. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e., 10.00),	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		enter 00 in the area to the right of the vertical line.	
29	Amount paid	REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to the right of the vertical line	Conditional REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing
30	Balance due	REQUIRED when field 29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payer). Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole	Conditional REQUIRED when field 29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payer)

Field number	Field description	Instruction or comments	Required, conditional or not required
		number (i.e., 10.00), enter 00 in the area to the right of the vertical line	
31	Signature of physician or supplier including degrees or credentials	If there is a signature waiver on file, you may stamp, print, or computer-generate the signature; otherwise, the practitioner or practitioner's authorized representative MUST sign the form. If signature is missing or invalid, the claim will be returned unprocessed. Note: Does not exist in the electronic 837P	Required
32	Service facility location information	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the name and physical location. (PO box numbers are not acceptable here.) First line - Enter the business/facility/ practice name. Second line- Enter the street address. Do not use commas, periods, or other punctuation in	Conditional REQUIRED if the location where services were rendered is different from the billing address listed in field 33

Field number	Field description	Instruction or comments	Required, conditional or not required
		the address (for example, 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line - In the designated block, enter the city and state. Fourth line - Enter the ZIP code and telephone number. When entering a nine-digit ZIP code (ZIP + 4 codes), include the hyphen	
32a	NPI - Services rendered	Typical providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI of the facility where services were rendered.	Conditional Typical providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33.
32b	Other provider ID	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Typical providers: Enter the 2-character qualifier ZZ followed	Conditional REQUIRED if the location where services were rendered is different from the billing address listed in field 33

Field number	Field description	Instruction or comments	Required, conditional or not required
		by the taxonomy code (no spaces). Atypical providers: Enter the 2-character qualifier 1D (no spaces)	
33	Billing provider INFO & PH#	Enter the billing provider's complete name, address (include the ZIP + 4 code), and telephone number. First line -Enter the business/facility/ practice name. Second line - Enter the street address. Do not use commas, periods, or other punctuation in the address (for example, 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line - In the designated block, enter the city and state. Fourth line- Enter the ZIP code and telephone number. When entering a nine-digit ZIP code (ZIP + 4 code), include the hyphen. Do not use a hyphen or space as a separator within the	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		telephone number (i.e., (555)555-5555). NOTE: The nine digit ZIP code (ZIP + 4 code) is a requirement for paper and EDI claim submission	
33a	Group billing NPI	Typical providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI .	Required
33b	Group billing other ID	Enter as designated below the billing group taxonomy code. Typical providers: Enter the provider taxonomy code. Use ZZ qualifier. Atypical providers: Enter the provider ID number	Required

Hospital Acquired Conditions

Provider Type: Hospitals

Hospital-acquired conditions (HACs) are a set of hospital complications and medical errors that may cause severe consequences. They occur during a hospital stay (are not present at the time of admission) and can

reasonably be prevented through the application of appropriate evidence-based protocols. These events may result in more serious outcomes to the member, including loss of function, disability and death. Their occurrence may also prolong hospital stays.

Billing Instructions

Each HAC is to be reported on the claim and must be catalogued according to when it occurred. Like the Centers for Medicare & Medicaid Services (CMS), Health Net requests hospitals to submit inpatient hospital claims (UB-04/CMS 1450) with Present on Admission (POA) indicators. POA is defined as a condition that is present at the time the order for inpatient admission occured. Conditions that develop during an outpatient encounter, including in the emergency department or during observation or outpatient surgery, are included within the definition of POA conditions.

The POA indicator must be assigned to all ICD-10 diagnoses (primary and secondary diagnosis codes, as well as to external cause of injury codes) on all inpatient claims (UB-04/CMS 1450) for all lines of business. Categories and codes exempt from reporting include late effect codes, normal delivery, Z-codes, and certain external codes (for example, railway, motor vehicle, water transport, air transport, and space transport).

Refer to the current HAC ICD-10 codes available on the CMS website at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.html; select FY 2017 HOSPITAL ACQUIRED CONDITIONS LIST under Downloads. This list includes the HAC descriptions, codes and diagnoses, and is subject to change, as Health Net relies on guidance from CMS on these diagnoses. An HTML version of the ICD-10 HAC list is also available. Look for a link on the same page, titled Appendix I Hospital Acquired Conditions (HACS) List.

The following POA indicators should be submitted in field locator 67 of the UB-04/CMS 1450, and in segment K3 in the 2300 loop, data element K301 for the 837I electronic claim submission.

Indicator	Description
Y	Present at the time of inpatient admission
N	Not present at the time of inpatient admission
U	Documentation is insufficient to determine if condition is present on admission
W	Provider is unable to clinically determine whether condition was present on admission or not
1	Exempt from POA reporting (equivalent of a blank code on UB-04/CMS 1450 form). This code should rarely be used and every effort to

Indicator	Description
	determine the appropriate indicator must be made

The POA only applies to inpatient prospective payment systems (IPPS) hospitals. The following hospitals are exempt from the POA indicator:

- Critical access hospitals (CAHs)
- Long-term care hospitals (LTCHs)
- Maryland waiver hospitals
- Cancer hospitals
- Children's inpatient facilities
- Religious non-medical health care institutions
- Inpatient psychiatric hospitals
- Inpatient rehabilitation facilities
- Veterans Administration (VA)/Department of Defense (DOD) hospitals

Source: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/wPOA-Fact-Sheet.pdf

Quality Improvement HAC Program

Health Net's Quality Improvement (QI) HAC program is designed to encourage hospitals to improve patient safety by reducing or eliminating the occurrence of serious and costly errors in the provision of health care services. The QI HAC program supports improving hospital reporting and member awareness about hospital quality issues. The program also serves to more closely align Health Net practices with those of CMS and The Leapfrog Group, which represents purchasers and employer groups.

HAC Confirmation

Health Net's QI Department monitors claims submitted by the hospital after discharge for evidence of reported Not Present on Admission indicators of HACs. In accordance with the QI HAC Program, if a Health Net member experiences a HAC noted on the CMS website, Health Net requests that the admitting hospital take the following action:

- Determine if the event was potentially preventable and within the control of the hospital and the medical staff who provided care during the member's stay.
- Agree to refrain from billing or adjust billing to Health Net or the member for any charges associated with the HAC if it is determined that the HAC was preventable.
- Perform a root cause analysis and take measures to prevent recurrences as necessary.

HAC Notification

Health Net's QI Department notifies the hospital's QI Department director or whoever is responsible to confirm that the above actions were taken according to the instructions in the notification. The notification also allows the hospital to explain extenuating circumstances that preclude these actions from being taken. The hospital has 30 days to complete and fax-back the confirmation to Health Net's QI Department. Health Net may also address potential HACs through the plan's established potential quality of care issues (PQI) process.

Trauma Services

Provider Type: Hospitals

Hospitals billing Health Net for trauma admissions, trauma care or other trauma-related services must submit complete documentation with the UB-04 (CMS-1450) and the itemized claim form at the time of billing. Submission of complete trauma service records assists Health Net with timely claims processing and payment. Failure to submit the required documentation can lead to delay in claims processing or denial of the claim.

The following documents may be required when billing any trauma-related services (documents may be handwritten or transcribed):

- Emergency room (ER) report.
- Trauma activation/trauma team involvement (for example, members or specialties).
- Complete clinical hospital records, if admitted.
- Admitting notes.
- Emergency medical services (EMS or paramedic) record.
- ER attending physician's report.
- All additional reports from any other physician.

Documentation for inpatient admissions must include the above documents and the following:

- Admission history and physical.
- Discharge summary.
- Operating room reports, if applicable.
- Complete clinical hospital records.
- All additional reports from any other physician.

UB-04 Billing Instructions

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

All claims from participating providers that are Health Net's responsibility must be submitted to Health Net Medi-Cal claims within 180 days from the last day of the month of the date services were rendered. EPO, HMO, HSP, Medicare Advantage, and PPO participating providers must be submitted claims to Health Net within 120 days from the date services were rendered, unless a different time frame is stated in the providers' contract. Health Net accepts claims submitted on the standard CMS-1500 and UB-04 form and computer generated claims using these formats.

Field number	Field description	Instruction or comments	Required, conditional or not required
1	Unlabeled field	Line 1: Enter the complete provider name. Line 2: Enter the complete mailing address. Line 3: Enter the city, state, and ZIP +4 Codes (include hyphen). Note: The 9 digit ZIP (ZIP +4 codes) is a requirement for paper and EDI claims. Line 4: Enter the area code and telephone number **ALERT: Providers submitting paper claims should left-align data in this field.	Required
2	Unlabeled field	Enter the pay-to name and address	Not required
3a	Patient control no	Enter the facility patient account/control number	Not required
3b	Medical record number	Enter the facility patient medical or health record number	Required
4	Type of bill	Enter the appropriate type of bill (TOB) code as specified by the NUBC UB-04 Uniform Billing Manual minus the leading "0" (zero). A leading "0" is not needed. Digits should	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		be reflected as follows: 1st Digit - Indicating the type of facility. 2nd Digit - Indicating the type of care. 3rd Digit- Indicating the bill sequence (frequency code).	
5	Fed Tax No	Enter the nine-digit number assigned by the federal government for tax reporting purposes	Required
6	Statement covers period from/through	Enter begin and end, or admission and discharge dates, for the services billed. Inpatient and outpatient observation stays must be billed using the admission date and discharge date. Outpatient therapy, chemotherapy, laboratory, pathology, radiology, and dialysis may be billed using a date span. All other outpatient services must be billed using the actual date of service (MMDDYY).	Required
7	Unlabeled field	Not used.	Not required
8a	Patient name	8a - Enter the first nine digits of the identification number	Not required

Field number	Field description	Instruction or comments	Required, conditional or not required
		on the member's ID card.	
8b		Enter the patient's last name, first name, and middle initial as it appears on the ID card. Use a comma or space to separate the last and first names. Titles: (Mr., Mrs., etc.) should not be reported in this field. Prefix: No space should be left after the prefix of a name (e.g., McKendrick. H). Hyphenated names: Both names should be capitalized and separated by a hyphen (no space). Suffix: a space should separate a last name and suffix. Enter the patient's complete mailing address.	Required
9	Patient address	Enter the patient's complete mailing address. Line a: Street address Line b: City Line c: State Line d: ZIP code Line e: Country code (NOT REQUIRED)	Required - Except line 9e county code

Field number	Field description	Instruction or comments	Required, conditional or not required
10	Birthdate	Enter the patient's date of birth (MMDDYYYY)	Required - Ensure DOB of patient is entered and not the insured)
11	Sex	Enter the patient's sex. Only M or F is accepted	Required
12	Admission date	Enter the date of admission for inpatient claims and date of service for outpatient claims (MMDDYY)	Required for Inpatient claims. Leave blank for Outpatient claims. Exceptions: Type of bill codes 012x, 022x, 032x, 034x, 081x, and 082x require boxes 12–13 to be populated.
13	Admission hour	Enter the time using two-digit military time (00-23) for the time of inpatient admission or time of treatment for outpatient services. • 00 - 12:00 a.m. 01 - 1:00 a.m. • 02 - 2:00 a.m. 03 - 3:00 a.m. • 04 - 4:00 a.m. 05 - 5:00 a.m. • 06 - 6:00 a.m. 07 - 7:00 a.m. • 08 - 8:00 a..m 09 - 9:00 a.m. • 10 - 10:00 a.m. 11 - 11:00 a.m. • 12 - 12:00 p.m. 13 - 1:00 p.m.	Required for Inpatient claims. Leave blank for Outpatient claims. Exceptions: Type of bill codes 012x, 022x, 032x, 034x, 081x, and 082x require boxes 12–13 to be populated.

Field number	Field description	Instruction or comments	Required, conditional or not required
		• 14 - 2:00 p.m. 15 - 3:00 p.m. • 16 - 4:00 p.m. 17 - 5:00 p.m. • 18 - 6:00 p.m. 19 - 7:00 p.m. • 20 - 8:00 p.m. 21 - 9:00 p.m. • 22 - 10:00 p.m. 23 - 11:00 p.m.	
14	Admission type	Require for inpatient and outpatient admissions. Enter the one-digit code indicating the type of the admission using the appropriate following codes: • 1 - Emergency • 2 - Urgent • 3 - Elective • 4 - Newborn • 5 - Trauma	Required
15	Admission source	Required for inpatient and outpatient admissions. Enter the one-digit code indicating the source of the admission or outpatient service using one of the following codes. For type of admission 1,2,3, or 5: • 1 - Physician referral	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		• 2 - Clinic referral • 3 - Health maintenance referral (HMO) • 4 - Transfer from a hospital • 5 - Transfer from skilled nursing facility • 6 - Transfer from another health care facility • 7 - Emergency room • 8 - Court/law enforcement • 9 - Information not available For type of admission 4 (newborn): • 1 - Normal delivery • 2 - Premature delivery • 3 - Sick baby • 4 - Extramural birth • Information not available	
16	Discharge hour	Enter the time using two-digit military times (00-23) for the time of the inpatient or outpatient discharge. • 00 - 12:00 a.m. 01 - 1:00 a.m.	Conditional - Enter the time using two-digit military times (00-23) for the time of the inpatient or outpatient discharge

Field number	Field description	Instruction or comments	Required, conditional or not required
		• 02 - 2:00 a.m. 03 - 3:00 a.m. • 04 - 4:00 a.m. 05 - 5:00 a.m. • 06 - 6:00 a.m. 07 - 7:00 a.m. • 08 - 8:00 a.m 09 - 9:00 a.m. • 10 - 10:00 a.m. 11 - 11:00 a.m. • 12 - 12:00 p.m. 13 - 1:00 p.m. • 14 - 2:00 p.m. 15 - 3:00 p.m. • 16 - 4:00 p.m. 17 - 5:00 p.m. • 18 - 6:00 p.m. 19 - 7:00 p.m. • 20 - 8:00 p.m. 21 - 9:00 p.m. • 22 - 10:00 p.m. 23 - 11:00 p.m.	
17	Patient status	REQUIRED for inpatient and outpatient claims. Enter the two-digit disposition of the patient as of the "through" date for the billing period listed in field 6 using one of the following codes: • 01 - Routine discharge • 02 - Discharged to another short-term general hospital • 03 - Discharged to SNF	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		• 04 - Discharged to ICF • 05 - Discharged to another type of institution • 06 - Discharged to care of home health service organization • 07 - Left against medical advice • 09 - Discharged/ transferred to home under care of a home IV provider • 09 - Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims) • 20 - Expired or did not recover • 30 - Still patient (To be used only when the client has been in the facility for 30 consecutive days if payment is based on DRG) • 40 - Expired at home (hospice use only) • 41 - Expired in a medical facility (hospice use only) • 42 - Expired-place unknown	

Field number	Field description	Instruction or comments	Required, conditional or not required
		(hospice use only) • 43 - Discharged/ transferred to a federal hospital (such as a Veteran's Administration [VA] hospital) • 50 - Hospice-Home • 51 - Hospice-Medical Facility • 61 - Discharged/ transferred within this institution to a hospital-based Medicare approved swing bed • 62 - Discharged/ transferred to an Inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital • 63 - Discharged/ transferred to a Medicare certified long-term care hospital (LTCH) • 64 - Discharged/ transferred to a nursing facility	

Field number	Field description	Instruction or comments	Required, conditional or not required
		certified under Medicaid but not certified under Medicare • 65 - Discharged/ transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital • 66 - Discharged/ transferred to a critical access hospital (CAH)	
18-28	Condition codes	REQUIRED when applicable. Condition codes are used to identify conditions relating to the bill that may affect payer processing. Each field (18-24) allows entry of a two-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual	Conditional REQUIRED when condition codes are used to identify conditions relating to the bill that may affect payer processing
29	Accident state	N/A	Not required

Field number	Field description	Instruction or comments	Required, conditional or not required
30	Unlabeled Field	N/A	Not required
31-34 a-b	Occurrence code and occurrence date	Occurrence code: REQUIRED when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows for entry of a two-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence date: REQUIRED when applicable or when a corresponding occurrence code is present on the same line (31a-34a). Enter the date for the associated occurrence code in MMDDYY format	Conditional REQUIRED when occurrence codes are used to identify events relating to the bill that may affect payer processing
35-36 a-b	Occurrence SPAN code and Occurrence date	Occurrence span code: REQUIRED when applicable. Occurrence codes are	Conditional REQUIRED when occurrence codes are

Field number	Field description	Instruction or comments	Required, conditional or not required
		used to identify events relating to the bill that may affect payer processing. Each field (35-36a) allows for entry of a two-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence span date: REQUIRED when applicable or when a corresponding occurrence span code is present on the same line (35a-36a). Enter the date for the associated occurrence code in MMDDYY format.	used to identify events relating to the bill that may affect payer processing
37	Unlabeled field	REQUIRED for re-submissions or adjustments. Enter the DCN (document control number) of the original claim	Conditional REQUIRED for resubmissions or adjustments. Enter the DCN (document control number) of the original claim
38	Responsible party name and address	N/A	Not required

Field number	Field description	Instruction or comments	Required, conditional or not required
39-41 a-d	Value codes and amounts	Code: REQUIRED when applicable. Value codes are used to identify events relating to the bill that may affect payer processing. Each field (39-41) allows for entry of a two-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). Up to 12 codes can be entered. All "a" fields must be completed before using "b" fields, all "b" fields before using "c" fields, and all "c" fields before using "d" fields. For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Amount: REQUIRED when applicable or when a value code is entered. Enter the dollar amount for the associated value code. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199,999.99). Do not enter a dollar sign ($)	Conditional REQUIRED when value codes are used to identify events relating to the bill that may affect payer processing

Field number	Field description	Instruction or comments	Required, conditional or not required
		or a decimal. A decimal is implied. If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to the right of the vertical line	
42 Lines 1-22	REV CD	Enter the appropriate revenue codes itemizing accommodations, services, and items furnished to the patient. Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Enter accommodation revenue codes first followed by ancillary revenue codes. Enter codes in ascending numerical value	Required
42 Line 23	Rev CD	Enter 0001 for total charges.	Required
43 Lines 1-22	Description	Enter a brief description that corresponds to the revenue code entered in the service line of field 42	Required
43 Line 23	PAGE ___ OF ___	Enter the number of pages. Indicate the page sequence in the "PAGE" field and the total number of pages	Conditional - Enter the number of pages. (Limited to 4 pages per claim)

Field number	Field description	Instruction or comments	Required, conditional or not required
		in the "OF" field. If only one claim form is submitted, enter a "1" in both fields (i.e., PAGE "1" OF "1"). (Limited to 4 pages per claim)	
44 lines 1-22	HCPCS/Rates	REQUIRED for outpatient claims when an appropriate CPT/HCPCS code exists for the service line revenue code billed. The field allows up to nine characters. Only one CPT/HCPCS and up to two modifiers are accepted. When entering a CPT/ HCPCS with a modifier(s), do not use spaces, commas, dashes, or the like between the CPT/ HCPCS and modifier(s). Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Please refer to your current provider contract	Conditional REQUIRED for outpatient claims when an appropriate CPT/HCPCS code exists for the service line revenue code billed
45 Lines 1-22	Service date	REQUIRED on all outpatient claims. Enter the date of service for each	Conditional REQUIRED on all outpatient claims. Enter the date of

Field number	Field description	Instruction or comments	Required, conditional or not required
		service line billed (MMDDYY). Multiple dates of service may not be combined for outpatient claims	service for each service line billed (MMDDYY). Multiple dates of service may not be combined for outpatient claims
45 Line 23	Creation date	Enter the date the bill was created or prepared for submission on all pages submitted (MMDDYY).	Required
46 lines 1-22	Service units	Enter the number of units, days, or visits for the service. A value of at least "1" must be entered. For inpatient room charges, enter the number of days for each accommodation listed	Required
47 Lines 1-22	Total charges	Enter the total charge for each service line	Required
47 Line 23	Totals	Enter the total charges for all service lines	Required
48 Lines 1-22	Non-covered charges	Enter the non-covered charges included in field 47 for the revenue code listed in field 42 of the service line. Do not list negative amounts	Conditional - Enter the noncovered charges included in field 47 for the revenue code listed in field 42 of the service line. Do not list negative amounts

Field number	Field description	Instruction or comments	Required, conditional or not required
48 Line 23	Totals	Enter the total non-covered charges for all service lines	Conditional - Enter the total noncovered charges for all service lines
49	Unlabeled field	Not used	Not required
50 A-C	Payer	Enter the name of each payer from which reimbursement is being sought in the order of the payer liability. Line A refers to the primary payer; B, secondary; and C, tertiary	Required
51 A-C	Health plan identification number	N/A	Not required
52 A-C	REL information	REQUIRED for each line (A, B, C) completed in field 50. Release of Information Certification Indicator. Enter 'Y' (yes) or 'N' (no). Providers are expected to have necessary release information on file. It is expected that all released invoices contain 'Y'	Required
53	ASG. BEN.	Enter 'Y' (yes) or 'N' (no) to indicate a signed form is on file authorizing payment by the payer directly to	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		the provider for services	
54	Prior payments	Enter the amount received from the primary payer on the appropriate line	Conditional - Enter the amount received from the primary payer on the appropriate line when Health Net is listed as secondary or tertiary
55	EST amount due	N/A	Not required
56	National Provider Identifier or provider ID	REQUIRED: Enter providers 10-character NPI ID	Required
57	Other provider ID	Enter the numeric provider identification number. Enter the TPI number (non-NPI number) of the billing provider	Required
58	Insured's name	For each line (A, B, C) completed in field 50, enter the name of the person who carries the insurance for the patient. In most cases this will be the patient's name. Enter the name as last name, first name, middle initial	Required
59	Patient relationship	N/A	Not required

Field number	Field description	Instruction or comments	Required, conditional or not required
60	Insured unique ID	REQUIRED: Enter the patient's insurance ID exactly as it appears on the patient's ID card. Enter the insurance ID in the order of liability listed in field 50	Required
61	Group name	N/A	Not required
62	Insurance group no.	N/A	Not required
63	Treatment authorization code	Enter the prior authorization or referral when services require precertification	Conditional - Enter the prior authorization or referral when services require precertification
64	Document control number	Enter the 12-character original claim number of the paid/denied claim when submitting a replacement or void on the corresponding A, B, C line Applies to claim submitted with a type of bill (field 4), frequency of "7" (replacement of prior claim) or type of bill, frequency of "8" (void/cancel of prior claim). *Please refer to the reconsider/corrected claims section	Conditional - Enter the 12-character original claim number of the paid/denied claim when submitting a replacement or void on the corresponding A, B, C line reflecting Payer from field 50

Field number	Field description	Instruction or comments	Required, conditional or not required
65	Employer name	N/A	Not required
66	DX version qualifier	N/A	Required
67	Principal diagnosis code	Enter the principal/ primary diagnosis or condition using the appropriate release/ update of ICD-10-CM Volume 1 & 3 for the date of service	Required
67 A-Q	Other diagnosis code	Enter additional diagnosis or conditions that coexist at the time of admission or that develop subsequent to the admission and have an effect on the treatment or care received using the appropriate release/ update of ICD-10CM Volume 1 & 3 for the date of service. Diagnosis codes submitted must be valid ICD-10 Codes for the date of service and carried out to its highest level of specificity - 4th or 5th digit. "E" and most "V" codes are NOT acceptable as a primary diagnosis. Note: Claims with incomplete or invalid	Conditional - Enter additional diagnosis or conditions that coexist at the time of admission

Field number	Field description	Instruction or comments	Required, conditional or not required
		diagnosis codes will be denied	
68	Present on admission indicator		Required
69	Admitting diagnosis code	Enter the diagnosis or condition provided at the time of admission as stated by the physician using the appropriate release/ update of ICD-10-CM Volume 1 & 3 for the date of service. Diagnosis codes submitted must be valid ICD-10 codes for the date of service and carried out to its highest level of specificity - 4th or 5th digit. "E" codes and most "V" are NOT acceptable as a primary diagnosis. Note: Claims with missing or invalid diagnosis codes will be denied	Required
70	Patient reason code	Enter the ICD-10-CM code that reflects the patient's reason for visit at the time of outpatient registration. Field 70a requires entry; fields 70b-70c are conditional.	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		Diagnosis codes submitted must be valid ICD-10 codes for the date of service and carried out to its highest digit - 4th or 5th. "E" codes and most "V" codes are NOT acceptable as a primary diagnosis. NOTE: Claims with missing or invalid diagnosis codes will be denied	
71	PPS/DRG code	N/A	Not required
72 a, b, c	External cause code	N/A	Not required
73	Unlabeled field	N/A	Not required
74	Principal procedure code/date	CODE: Enter the ICD-10 procedure code that identifies the principal/primary procedure performed. Do not enter the decimal between the 2nd or 3rd digits of code; it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).	Conditional - Enter the ICD-10 procedure code that identifies the principal/primary procedure performed. Do not enter the decimal between the 2nd or 3rd digits of code; it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY)
74 a-e	Other procedure code date	REQUIRED on inpatient claims when a procedure is	Conditional REQUIRED on inpatient claims when

Field number	Field description	Instruction or comments	Required, conditional or not required
		performed during the date span of the bill. CODE: Enter the ICD-10 procedure code(s) that identify significant procedure(s) performed other than the principal/primary procedure. Up to five ICD-10 procedure codes may be entered. Do not enter the decimal; it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).	a procedure is performed during the date span of the bill
75	Unlabeled field	N/A	Not required
76	Attending physician	Enter the NPI and name of the physician in charge of the patient care. • NPI: Enter the attending physician 10-character NPI ID. • Taxonomy code: Enter valid taxonomy code. • QUAL: Enter one of the following	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		qualifier and ID number: • 0B - State license #. • 1G - Provider UPIN. • G2 - Provider commercial #. • B3 - Taxonomy code. • LAST: Enter the attending physician's last name. • FIRST: Enter the attending physician's first name	
77	Operating physician	REQUIRED when a surgical procedure is performed. Enter the NPI and name of the physician in charge of the patient care. • NPI: Enter the attending physician 10-character NPI ID. • Taxonomy code: Enter valid taxonomy code. • QUAL: Enter one of the following qualifier and ID number:	Conditional REQUIRED when a surgical procedure is performed. Enter the NPI and name of the physician in charge of the patient care

Field number	Field description	Instruction or comments	Required, conditional or not required
		• 0B - State license #. • 1G - Provider UPIN. • G2 - Provider commercial #. • B3 - Taxonomy code. • LAST: Enter the attending physician's last name. • FIRST: Enter the attending physician's first name.	
78 & 79	Other physician	Enter the provider type qualifier, NPI and name of the physician in charge of the patient care. • (Blank Field): Enter one of the following provider type qualifiers: • DN - Referring provider. • ZZ - Other operating MD. • 82 - Rendering provider. • NPI: Enter the other physician 10-character NPI ID. • QUAL: Enter one of the following qualifier and ID	Conditional

Field number	Field description	Instruction or comments	Required, conditional or not required
		number, or 0B - State license number • 1G - Provider UPIN number • G2 - Provider commercial number	
80	Remarks	N/A	Not required
81	CC	A: Taxonomy of billing provider. Use B3 qualifier.	Required
82	Attending Physician	Enter name or seven-digit provider number of ordering physician	Required

Workers' Compensation

Provider Type: Physicians | Participating Physician Groups (PPG) (does not apply to HSP) | Hospitals

If a Health Net member suffers a job-related illness or injury and receives medical services, these services are covered under California workers' compensation. Providers should question the member for possible workers' compensation liability and enter information on the claim.

Health Net may file a lien against the member's workers' compensation benefits. In the interim, Health Net pays the covered charges. When the case is settled, Health Net may recover charges for services from the member's workers' compensation settlement.

Capitated Claims Billing Information

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

Providers who participate in Health Net's Medi-Cal program under a capitated agreement with a participating physician group (PPG) must follow the instructions below.

- Providers must contact their PPG to check for any special billing requirements that the providers' failure to follow could delay the processing of their claims, and to verify the billing address for claims submission.
- Providers have 180 days from the last day of the month of service to submit initial Medi-Cal claims. Exceptions for late filing are:
- New Medi-Cal claims between six-months and one-year-old are permitted without penalty for unknown eligibility status, antepartum obstetric care or a delay in delivery of a custom-made prosthesis
- Claims one-year-old or more are permitted without penalty for retroactive eligibility situations, court orders, state or administrative hearings, county errors in eligibility, Department of Health Care Services (DHCS) orders, reversal of appeal decisions on a Treatment Authorization Request (TAR) form, or if other coverage is primary

Capitated Risk Claims

Capitated-risk claims received by Health Net through paper submissions are forwarded back to the PPG or third-party administrator (TPA) for processing.

Electronically Submitted Claims

Electronically submitted claims that are participating physician group (PPG) capitated-risk claims are forwarded to the PPG or third-party administrator (TPA) for processing. A claim fax summary is printed, batched and forwarded. A batch trailer sheet, indicating the number of claims within a batch, is sent.

EOC 300/308 Report

Denied Claims

Claims received by Health Net or an affiliated health plan for services that are the capitated-risk of a participating physician group (PPG), hospital or other ancillary provider as applicable are forwarded by Health Net or the affiliated health plan to the PPG, hospital or ancillary provider for processing. This may delay payment by several days to several weeks.

The Health Net Medi-Cal Claims Department sends a weekly report to any provider who has submitted claims to Health Net that are denied by Health Net as services capitated to a participating physician group (PPG) or

hospital. The report provides the name and telephone number of the PPG or hospital to which the denied claims have been forwarded for processing.

The EOC 300/308 Report is generated using two explanation of check codes:

- 300 - Service capitated to member's PPG, claim sent to PPG
- 308 - Service capitated to facility, claim sent for processing

Denied claims with these EOC codes are grouped according to the capitated PPG or hospital responsible for the claim.

Field Descriptions

The following information correlates to the numbered fields on the Health Net EOC 300/308 Report (PDF) of denied capitated claims:

Header Information

#	Field	Description
1.	ABS	Health Net's operating system
2.	Program ID	Health Net's assigned number for the report
4.	Claim Type	Facility = UB-04 form Professional = CMS-1500 form
4.	Report Title	The name of the report
5.	Run Date	The day/month/year that the report was generated
6.	Run Time	The time that the report was generated
7.	Page Number	The page number of the report
8.	Remit Num	A 14-digit internal number that gives information about the claim's financial status

#	Field	Description
9.	Check Date	The date of the check issued to a provider for claim payment
10.	Servicing Provider	The TIN and name of the provider who submitted the claim to Health Net for payment
11.	Pay To	The name of the group that the Servicing Provider is linked to. The Servicing Provider and Pay To can be the same

Detail Information

#	Field	Description
12.	Capped PPG/HOSP/PHONE	If a claim was denied on the explanation of check (EOC), then the name of the PPG or hospital where the claim was sent for processing would be listed here with the most current phone number that Health Net has on file
13.	Member ID	Health Net's member identification number
14.	MBR Last Name	The last name of the member
15.	MBR First Name	The first name of the member
16.	Claim Number	Health Net's 11-digit Document Control Number (DCN)
17	Beg DOS	The starting date of facility/ professional services

#	Field	Description
18	End DOS	The ending date of facility/ professional services
19.	PROC	The billed procedure code on the UB-04 or CMS-1500 claim (if services billed are revenue, this field is blank)
20.	DIAG	A three to seven character code based on the ICD-10 coding system, indicating the condition for which services on this claim were rendered
21.	EOC	A three-digit code appears on the provider's EOC explaining the action taken on this claim line. If a claim is coded with EOC 300 or 308, then the claim was denied to responsible capitated PPG or capitated facility for services rendered 300 = Service capitated to member's PPG, claim sent to PPG 308 = Service capitated to facility, claim sent for processing
22.	Billed Amt	The amount billed for a claim line

All provider inquiries about claim status, payment amounts, or denial reasons should be directed to the capitated provider responsible for the services.

Plan-Risk or Shared-Risk Claims

Plan-risk or shared-risk claims must be sent to Health Net for adjudication. Attach a copy of the Plan/Shared-Risk Cover Sheet to each group of claims the provider submits. Additionally, the claims should be separated and batched into plan or shared-risk services and claim types. All claims submitted to Health Net must be on

CMS-1500, LTC form 25-1 or UB-04 claim forms, and must indicate the date of receipt by the participating physician group (PPG). Claims for plan-risk or shared-risk services must be submitted to Health Net.

The following information must be included on every claim:

- Health Net member identification (ID) number or reference number located on the member's ID card
- Provider name and address
- ICD-10 diagnosis code
- Service dates
- Billed charge per service
- Current year CPT procedure or UB-04 revenue code
- Place of service or UB-04 bill type code
- Submitting provider tax identification number or National Provider Identifier (NPI) number
- Member name and date of birth as it appears on the member's ID card
- State license number of the attending provider

If a provider submits a claim directly to Health Net rather than the PPG and the claim includes both plan-risk services and capitated-risk services, Health Net processes the plan-risk services. Services that are the responsibility of the PPG are denied by Health Net and forwarded to the PPG for processing. The Explanation of Check contains the message, "Capitated services, no payment issued-claim sent to IPA, Hospital or Ancillary provider."

Claims for capitated services that are misrouted to Health Net are denied and forwarded to the capitated provider with a copy of the explanation.

In some instances, Health Net is able to split a claim that has both plan-risk and capitated-risk services (for example, chemotherapy provider claims). In these cases, a claim fax is attached to the original claim. The fax contains only those service lines that appear to be capitated-risk. The message "POSSIBLE CAP RISK" appears in the member's address field (box 4 on the fax). These services do not appear on the explanation of check, but appear on the capitated-risk services report.

All other lines on the original claim document are assumed to be plan-risk and are processed by Health Net. It is not necessary to return the claim for those plan-risk services not appearing on the fax.

If, after processing the services on the fax, the capitated provider determines that any of those services are actually plan-risk (for example, out-of-area emergency), return them to Health Net for special handling and processing. Attach the Plan/Shared Risk Services Cover Sheet and return those claims to Health Net.

Anesthesia Procedure Code Modifiers with the Minute Qualifier

Professional anesthesia capitated encounters billed with specific modifiers must use the minute qualifier, MJ. If you use the unit qualifier, UN, an edit will reject the encounter. The edit applies regardless of the date of service.

This change follows the Health Insurance Portability and Accountability Act (HIPAA) 5010 HIPAA 837 Companion Guide.

Use the MJ qualifier with these modifiers:

- AA
- AD
- QK
- QS
- QX
- QY
- QZ

Modifiers, other than the ones listed above, can process with the UN qualifier and not cause an edit.

If a professional encounter claim is sent with the above listed modifiers and the UN qualifier, the edit display will read: ANESTHESIA QUALIFIER IS INCORRECT. Resend a corrected capitated encounter with the MJ qualifier.

Eligibility and Capitation

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

This section includes general information on member eligibility and capitation.

Select any subject below:

- Electronic Capitation Reports

Electronic Capitation Reports

Provider Type: Participating Physician Groups (PPG) | Hospitals

Health Net provides commercial, Medicare Advantage (MA) capitation reports to capitated participating physician groups (PPGs) and hospitals on five electronic media files - Eligibility, Activity Analysis, Remittance Detail, Eligibility Summary by Group, and SB 260 Reconciliation Report.

Eligibility File

The Eligibility file lists all members eligible for benefits for at least one day in the month. It contains member information, including names, addresses, plan codes, and benefit information. Capitation amounts are not included in the file, but may be listed in the Remittance Detail file. The Eligibility file is sorted by the member's last name. All records in this file are 224 bytes long. There are four record types: header, detail, coordination of benefits (COB), and trailer. Data expressed in the X format is left-justified and blank-filled, data expressed in the nine format is right-justified and zero-filled.

Activity Analysis File

The Activity Analysis file provides non-dollar activity, such as additions and cancellations of members, and should be used to update members' files, including retroactive adjudication of affected claims. It also reflects changes to a member's status, such as plan code, address and effective date. Multiple transactions for a member are sorted by prioritization of activity codes and report by prioritization. The Activity Analysis file is sorted by the member's last name. All records in the file are 279 bytes long. There are three record types: header, detail and trailer. Data expressed in the X format is left-justified and blank-filled. Data expressed in the nine format is right-justified and zero-filled.

Remittance Detail File

The Remittance Detail file provides capitation remittance amounts per member. The amount reflected consists of the current month capitation amount plus any adjustments made in the current month for retroactivity. The Remittance Detail file is sorted by the member's last name. All records in this file are 157 bytes long. There are three record types: header, detail and trailer. Data expressed in the X format is left-justified and blank- filled. Data expressed in the nine format is right-justified and zero-filled. All dollar amount fields are signed (-, +) and contain assumed decimals.

Eligibility Summary by Group File

The Eligibility Summary by Group file lists all employer groups with active members enrolled with a specific provider for the month being reported. This file is sorted by the employer group name. All records in this file are 142 bytes long. This file has three record types: header, detail and trailer. Data expressed in the X format is left-justified and blank-filled. Data expressed in the nine format is right-justified and zero-filled.

SB 260 Reconciliation Report

The SB 260 Reconciliation Report provides enrollment and capitation payment summary at the product level for the prior 18 months. All records in this file are 1024 bytes long. This file has three record types: header, detail and trailer. Data expressed in the X format is left-justified and blank-filled. Data expressed in the nine format is right-justified and zero-filled.

Internet Transmission

Health Net also offers providers these five capitation reports through the Internet to help reconcile eligibility and remittance payments. PPGs and hospitals that request their capitation reports online are allowed to test their files for a period of up to two months and still receive hard copy reports. After this two-month testing period, hard copy reports are no longer sent. With the exception of this testing period, only one format of reports is provided. If PPGs or hospitals are interested in receiving capitation files in this format, they should contact their provider relations and contracting specialists for details.

Eligibility Guarantee

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

For more information, select any subject below:

Eligibility Guarantee Under COBRA

Eligibility Guarantee Under COBRA

Provider Type: Participating Physician Groups (PPG) | Hospitals

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) generally allows those who lose eligibility under a group health plan to continue that coverage for a certain period of time at the group rate. Subscribers, and their covered dependents who qualify, are called qualified beneficiaries. Generally, qualified beneficiaries may take up to 60 days from their last day of regular coverage to elect COBRA continuation coverage.

Eligibility guarantee under COBRA does not apply to individual family plans (IFP).

In many cases, COBRA creates problems and delays as the employer sponsor and former plan member carry out various steps before COBRA continuation coverage is effective.

Knowing this, Health Net provides eligibility guarantee protection when the former member certifies that a request for COBRA continuation coverage has been submitted to the employer sponsor of the prior plan. This guarantee is not provided for those who contend that they have not yet requested COBRA continuation coverage, regardless of the time remaining for the former member to elect coverage.

COBRA Eligibility Determination - Not applicable to IFP

Members may be covered by COBRA continuation coverage for up to 18, 29 or 36 months, depending on the event that qualified them for coverage. COBRA continuation can also end at any time.

A member whose name does not appear on the participating physician group's (PPG's) or hospital's current Health Net Eligibility Report or appears with a cancellation notation (a past date in the Provider Cancel Date column of the report) may have become a private-pay member. If the member claims current eligibility because of COBRA, the PPG or hospital should ask the member if COBRA continuation coverage through the employer sponsor of the subscriber's group health plan has been requested.

If the member answers "yes":

- Ask the member to fill out an Eligibility Certification form.

- Provide services with reliance on the eligibility guarantee for the 60-day period following the last day of regular coverage. The PPG or hospital can determine the last day of coverage from an Activity Analysis report from a previous month.
- Call the Health Net Provider Services Center if 60 days pass after the last day of regular coverage and the member does not appear on the PPG's or hospital's current Eligibility Report as NEW CONTRACT with a past date in the Provider Effective Date column.

If the member answers, "No, but I intend to do it within the time period permitted by law," handle the member as a private-pay member, but state that if the member becomes reinstated through COBRA, the member receives a refund of any fees paid.

Eligibility Reports (only applicable to PPGs)

Eligibility records for members who lose eligibility under a group health plan and then obtain COBRA coverage show the following sequence of changes:

1. On member's loss of eligibility, the Eligibility Report states "CANCEL MEMBER" or "CANCEL CONTRACT."
2. When the member is granted COBRA continuation coverage, the Eligibility Report states "ADD CONTRACT."
3. Members who were previously covered as dependents but become subscribers through COBRA are assigned their own subscriber identification numbers.
4. COBRA members are assigned group numbers that differ from their previous group numbers only in that the suffix is a different letter.

Filing a COBRA Eligibility Guarantee Claim

COBRA eligibility guarantee claims are filed in the same manner as non-COBRA claims. All requirements and procedures are the same. Refer to the Eligibility Guarantee topic for more information.

Members Not Entitled to COBRA Continuation

Some employer-sponsored health plans are not subject to COBRA.

Members Requesting COBRA Information

If members, regardless of their relationship with Health Net, have questions about what COBRA requires or permits, refer them to their employer sponsor (current or former).

Fee-For-Service Billing and Submission

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

This section contains general fee-for-service (FFS) claims billing and submission information.

Select any subject below:

Electronic Claims Submission

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

For electronic claim submissions check the current member identification (ID) for the correct payer ID.

The benefits of electronic claim submission include:

- Reduction and elimination of costs associated with printing and mailing paper claims.
- Improvement of data integrity through the use of clearinghouse edits.
- Faster receipt of claims by Health Net, resulting in reduced processing time and quicker payment.
- Confirmation of receipt of claims by the clearinghouse.
- Availability of reports when electronic claims are rejected.
- Ability to track electronic claims, resulting in greater accountability.

Reports

For successful electronic data exchange (EDI) claim submission, participating providers must utilize the electronic reporting made available by their vendor or clearinghouse. There may be several levels of electronic reporting:

- Confirmation/rejection reports from the EDI vendor
- Confirmation/rejection reports from the EDI clearinghouse
- Confirmation/rejection reports from Health Net

Providers are encouraged to contact their vendor/clearinghouse to see how these reports can be accessed/viewed. All electronic claims that have been rejected must be corrected and resubmitted. Rejected claims may be resubmitted electronically.

For questions regarding electronic claims submission, contact the Health Net EDI Department.

Electronic Claims Submission IFP

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

For electronic claims submissions that apply to providers serving individual family plan (IFP) members, check the current member identification (ID) card for the correct payer ID.

The benefits of electronic claim submission include:

- Reduction and elimination of costs associated with printing and mailing paper claims.
- Improvement of data integrity through the use of clearinghouse edits.
- Faster receipt of claims by Health Net, resulting in reduced processing time and quicker payment.
- Confirmation of receipt of claims by the clearinghouse.
- Availability of reports when electronic claims are rejected.
- Ability to track electronic claims, resulting in greater accountability.

For questions about electronic claims or electronic remittance and explanation of payment for IFP member claims, email EDIBA@centene.com or contact the Health Net/Centene EDI Department.

FFS Claims Submission

Provider Type: Physicians

When submitting fee-for-service (FFS) claims, provide all required information accurately. Health Net requires that all FFS professional claims be submitted on the CMS-1500 claim form for Medicare Advantage (MA) HMO, HMO, POS, PPO, EPO, and HSP members within 120 calendar days from the date of service or in accordance with the terms of the Provider Participation Agreement (PPA).

Submit all paper claims and supporting documentation to the appropriate Health Net Claims Department (Medicare Claims, Medi-Cal claims and HMO/HSP/EPO claims).

General Billing Guidelines

Provider Type: Physicians | Hospitals

All claims must be submitted to Health Net within 120 days from the date the services were rendered. Health Net accepts claims submitted on the standard UB-04 (CMS-1450) form and computer-generated claims using these formats.

When using multi-part NCR forms, always submit the original, not second or third copies. Do not write or stamp information on the face of the claim. The physician's signature in box 13 or box 31 is acceptable. Health Net requires the following information on each claim:

- Member name
- Member identification number
- Member date of birth
- Health Net prior authorization number. Primary care physician (PCP) claims do not require prior authorization unless the services performed specifically require prior authorization
- Location where services were rendered
- ICD-10 diagnosis code
- Date of service
- Current year CPT or HCPCS code (physician) or UB-04 revenue code with narrative description (hospital)
- CMS place of service code (professional claims)
- CMS type of service code (professional claims)
- Number of days or units for each service line (professional claims)
- Billed charges
- Physician name, address, federal tax identification number, and National Provider Identifier (NPI)
- State license number of attending provider

Premier Network EPO Claims Submission

Provider Type: Participating Physician Groups (PPG)

Paper claims and supporting documentation should be mailed to the Premier Network EPO claims address.

Professional Claim Editing

Physicians

Health Net has a contractual relationship with Cotiviti to provide a technology solution for professional claim edit policy management. Using Cotiviti's services, Health Net has the ability to apply advanced contextual processing for application of Health Net edit logic. Health Net also uses another editing vendor, Verscend, to perform a secondary review after Cotiviti.

The process is as follows:

- Health Net customizes and controls the selection of all edit policy.
- Claims are transferred through various interfaces to Cotiviti every night.
- Cotiviti reviews each claim in the file and renders coding recommendations based on Health Net's edit policy.
- After Cotiviti review, if there are any unedited lines remaining, they are sent to Verscend for a secondary review.
- Once all reviews are complete edit recommendations from the vendors are then applied to the claims.

Cotiviti and Verscend also provide management support services, including edit policy advisory services. The vendor's Medical Policy teams conduct ongoing research into payment policy sources, including, but not limited to, the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA) and other specialty academies, to provide Health Net with the necessary information to make informed decisions when establishing edit policy.

Refunds

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG)| Ancillary

This section contains general information on refunds, including verpayment procedures and third-party liability recovery.

Select any subject below:

- Overpayment Procedures

Overpayment Procedures

Provider Type: Physicians | Hospitals

If a provider is aware of receiving an overpayment made by Health Net, including, but not limited to, overpayments caused by incorrect or duplicate payments by Health Net, errors on or changes to the provider billing or payment by another payer who is responsible for primary payment, the provider must promptly refund the overpayment amount to the Health Net Overpayment Recovery Department with a copy of the applicable Remittance Advice (RA) and a cover letter indicating why the amount is being returned. If the RA is not available, provide member name, date of service, payment amount, Health Net member identification (ID) number, provider tax ID number, and provider ID number.

When Health Net determines that an overpayment has occurred, Health Net notifies the provider of services in writing within 365 days of the date of payment on the overpaid claim through a separate notice that includes the following information:

- Member name
- Claim ID number
- Clear explanation of why Health Net believes the claim was overpaid
- The amount of overpayment, including interest and penalties

The 365-day time period does not apply to overpayments caused in whole or in part by fraud or misrepresentation on the part of the provider.

The provider of service has 30 business days to submit a written dispute to Health Net if the provider does not believe an overpayment has occurred. In this case, Health Net treats the claim overpayment issue as a provider dispute.

If the provider does not dispute the overpayment, the provider of services must reimburse Health Net within 30 business days from the receipt of Health Net's notice or, as permitted by law, interest begins to accrue at the rate of 10 percent per year beginning with the first day after the 30 business day period.

- Include a copy of the RA that accompanied the overpayment or the refund request letter to expedite Health Net's adjustment of the provider's account. If neither of these documents are available, the following information must be provided: member name, date of service, payment amount, Health Net member ID number, vendor name and number, provider tax ID number, provider number, vendor number and reason for the overpayment refund. If the RA is not available, it may take longer for Health Net to process the overpayment refund.
- Send the overpayment refund and applicable details to the Health Net Overpayment Recovery Department. If a provider is contacted by a third-party overpayment recovery vendor acting on behalf of Health Net, such as AIM, Rawlings, GB Collects, or ORS, the provider should follow the overpayment refund instructions provided by the vendor.

Health Net may recoup uncontested overpayments by offsetting overpayments from payments for a provider's current claims for services if:

- The provider's Provider Participation Agreement (PPA) authorizes it to offset overpayments from payments for current claims for services
- Otherwise permitted under state laws

A written notification is sent to the provider of service if an overpayment is recouped through offsets to claim payments. The notification identifies the specific overpayment and the claim ID number.

Hospital Overpayments

If Health Net has incorrectly paid a hospital as the primary rather than as the secondary carrier, attach a copy of the primary carrier's explanation of benefits (EOB) with a copy of Health Net's RA highlighting the incorrect or duplicate payments and include a check for the overpaid amount. Also include a written explanation indicating the reason for the refund (for example, other coverage, duplicate or other circumstances). Send the overpayment refund and applicable details to the Health Net Overpayment Recovery Department.

Reimbursement

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general provider reimbursement information.

Select any subject below:

- Reimbursement Amount

Reimbursement Amount

Provider Type: Physicians

The Health Net Provider Participation Agreement (PPA) specifies that contracting providers agree to accept the contract amount as payment in full for covered services. Payment is based on the rates in the PPA. Providers must use the correct codes for billing procedures, as stated in the PPA.

When a member receives covered services from a participating provider, the member is not financially responsible. The provider may not charge the member for any expenses except copayments or coinsurance or deductibles, if applicable.

The provider may not charge the member for medical services that Health Net has denied as not medically necessary, unless the member has agreed in writing to be responsible for payment of such charges prior to receiving services.

Salud con Health Net

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG)

Health Net is responsible for processing all claims under Salud con Health Net EPO and PPO plans as follows:

- Medico Hispano/Clinica Medica General providers submit claims to their IPA per established process. The IPA batches the claims and forwards them directly to Health Net for processing
- Lakewood Regional Hospital (Tenet facility) submits claims directly to Health Net for processing
- Sistemas medicos Nacionales S.A. de C.V (SIMNSA) providers send their claims to SIMNSA, which forwards the claims to Health Net
- Salud con Health Net PPO providers in California send their claims directly to Health Net PPO Claims
- Out-of-network providers in Mexico send their claims to SIMNSA, which generates any needed denial letters
- Out-of-network providers in California send their claims to Health Net PPO Claims or Health Net EPO Claims for payment as applicable

For more information, select any subject below:

- Claims Process

Claims Process PPO Plus

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals

Health Net is responsible for processing all claims under the Salud con Health Net PPO Plus plan as follows:

- Health Net PPO providers in California send their claims directly to Health Net PPO claims
- Out-of-network providers in California send their claims to Health Net
- Sistemas medicos Nacionales S.A. de C.V (SIMNSA) providers send their claims to SIMNSA, which forwards the claims to Health Net
- Out-of-network providers in Mexico send their claims to SIMNSA, which generates any needed denial letters and forwards applicable claims to Health Net for payment

Schedule of Benefits and Summary of Benefits

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

Health Net's Schedule of Benefits is a summary of services that may be covered under the plan. Benefits listed on the Schedule of Benefits are subject to change. The Schedule of Benefits and Summary of Benefits is updated weekly with new plan, benefit and copayment changes as applicable and can be access on the Health Net provider portal.

Timely Filing Criteria

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

If a claim is denied for timely filing, but the provider can demonstrate good cause for the delay, Health Net accepts and adjudicates the claim as if it were submitted in a timely manner. The Health Net Provider Appeals Unit considers and makes the determination of whether or not there is a good cause for the delay. Health Net has standardized guidelines for showing good cause for delay and goodwill adjustments.

Good Cause for Delay Guidelines

Good cause for delay applies for providers who received misinformation from members or Health Net that caused timely filing claim denials and can demonstrate good cause for claim submission delays within the guidelines below:

- The delay was not reasonably in the provider's sole ability to control. For example: The provider received misinformation from the member and the provider is submitting one of the following:
    - Patient information form and/or member identification (ID) card presented by the Health Net member.
    - Explanation of benefit (EOB) from incorrect carrier and/or participating physician group (PPG).
    - The provider has followed Health Net instructions.

    - Circumstances existed that the provider could not foresee or prevent.
- The length of the delay was such that it was unreasonably difficult or impossible for the provider, in the normal course of business, to file the claim in a timely manner.
- The delay was not the result of the provider's negligent or willful action or inaction.

Other Adjustments Guidelines

For providers who can show proof of claim timely filing, Health Net gives consideration to other provider claim adjustments. The other adjustment policy guidelines are as follows:

- The provider submits proof in the form of one of the following:
    - Electronic data interchange (EDI) confirmation that Health Net received and accepted the claim.
    - Delivery confirmation evidence (for example, registered receipt or certified mail receipt to a Health Net address).
    - Screen print from accounting software to show the date the claim was submitted.

When Medicare is a Secondary Payer

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG)

Health Net works to coordinate member benefits with identified third-party payers, which may include private and government insurance plans. Medicare is generally the primary payer for a member unless the member's current situation dictates his or her private insurance plan is primary to Medicare, such as when the member is actively employed and covered by an employer group benefit plan. In such cases, and when Medicare has previously paid for services as the primary carrier, Medicare issues a Medicare secondary payer (MSP) recovery demand letter. The demand letter includes the participating provider liability claims and claims details and requests a refund from the employer directly and Health Net indirectly as the employer's designated health plan.

If Health Net determines that the MSP recovery demand contains provider liability claims, Health Net sends the provider's MSP contact a demand letter with detailed instructions for responding to the demand, a spreadsheet listing the claims, and a copy of all claims that require provider intervention. (Centers for Medicare and Medicaid Services (CMS) Medicare Secondary Manuals 100-05 Chapters 1-4)

Providers who have questions, contact the Health Net Provider Services Center or the Medicare Provider Services Center.

Claims Coding Policies

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section describes Health Net's claims coding process and policies.

Select any subject below:

- Code Editing

Code Editing

Provider Type: Physicians

The plan uses Health Insurance Portability and Accountability Act (HIPAA)-compliant clinical claims editing software for physician and outpatient facility coding verification. The software detects, corrects and documents coding errors on provider claim submissions prior to payment. The software contains clinical logic which evaluates medical claims against principles of correct coding utilizing industry standards and government sources. These principles are aligned with a correct coding rule. When the software identifies a claim that does not adhere to a coding rule, a recommendation known as an edit is applied to the claim. When an edit is applied to the claim, a claim adjustment should be made.

While code editing software is a useful tool to ensure provider compliance with correct coding, a fully automated code editing software application will not wholly evaluate all clinical patient scenarios. Consequently, the plan uses clinical validation by a team of experienced nursing and coding experts to further identify claims for potential billing errors. Clinical validation allows for consideration of exceptions to correct coding principles and may identify circumstances where additional reimbursement is warranted. For example, clinicians review all claims billed with modifiers -25 and -59 for clinical scenarios which justify payment above and beyond the basic service performed.

Moreover, the plan may have policies that differ from correct coding principles. Accordingly, exceptions to general correct coding principles may be required to ensure adherence to health plan policies and to facilitate accurate claims reimbursement.

CPT and HCPCS Coding Structure

Current Procedural Terminology (CPT) codes are a component of the Healthcare Common Procedure Coding System (HCPCS). The HCPCS system was designed to standardize coding to ensure accurate claims payment and consists of two levels of standardized coding. CPT codes belong to the Level I subset and consist of the terminology used to describe medical terms and procedures performed by health care professionals. CPT codes are published by the American Medical Association (AMA). CPT codes are updated (added, revised and deleted) on an annual basis.

1. Level I HCPCS Codes (CPT): This code set is comprised of CPT codes that are maintained by the AMA. CPT codes are a 5-digit, uniform coding system used by providers to describe medical procedures and services rendered to a patient. These codes are then used to bill health insurance companies.
2. Level II HCPCS: The Level II subset of HCPCS codes is used to describe supplies, products and services that are not included in the CPT code descriptions (durable medical equipment, orthotics, prosthetics, etc.). Level II codes are an alphabetical coding system and are maintained by Centers for Medicare and Medicaid Services (CMS). Level II HCPCS codes are updated on an annual basis.

3. Miscellaneous/Unlisted Codes: The codes are a subset of the Level II HCPCS coding system and are used by a provider or supplier when there is no existing CPT code to accurately represent the services provided. Claims submitted with unlisted codes are subject to a manual review. To facilitate the manual review, providers are required to submit medical records with the initial claims submission. If the records are not received, the provider will receive a denial indicating that medical records are required. Providers billing unlisted codes must submit medical documentation that clearly defines the procedure performed, including, but not limited to, office notes, operative report, pathology report, and related pricing information. Once received, a registered nurse reviews the medical records to determine if there was a more specific code(s) that should have been billed for the service or procedure rendered. Clinical validation also includes identifying other procedures and services billed on the claim for correct coding that may be related to the unlisted code. For example, if the unlisted code is determined to be the primary procedure, then other procedures and services that are integral to the successful completion of the primary procedure should be included in the reimbursement value of the primary code.
4. Temporary National Codes: These codes are a subset of the Level II HCPCS coding system and are used to code services when no permanent, national code exists. These codes are considered temporary and may only be used until a permanent code is established. These codes consist of G, Q, K, S, H and T code ranges.
5. HCPCS Code Modifiers: Modifiers are used by providers to include additional information about the HCPCS code billed. On occasion; certain procedures require more explanation because of special circumstances. For example, modifier -24 is appended to evaluation and management (E/M) services to indicate that a patient was seen for a new or special circumstance unrelated to a previously billed surgery for which there is a global period.

International Classification of Diseases (ICD-10) Code Set

These codes represent classifications of diseases and related health problems. They are used by healthcare providers to classify diseases and other health problems.

Revenue Codes

These codes indicate the type of procedure performed on patients and where the service was performed. These codes are billed by institutional providers. HCPCS codes may be required on the claim in addition to the revenue code.

Edit Sources

The claims auditing software contains a comprehensive set of rules addressing coding inaccuracies, such as: unbundling, frequency limitations, fragmentation, up-coding, duplication, invalid codes, mutually exclusive procedures, and other coding inconsistencies. Each rule is linked to a generally accepted coding principle. Guidance surrounding the most likely clinical scenario is applied. This information is provided by clinical consultants, health plan medical directors, research, etc.

The software applies edits that are based on the following sources.

- CMS, National Correct Coding Initiative (NCCI) for professional and facility claims. The NCCI edits include Column one/Column two, medically unlikely edits (MUE), exclusive and outpatient code editor (OCE) edits. These edits were developed by CMS to control improper coding leading to inappropriate payment.
- Public domain specialty society guidance (such as, American College of Surgeons, American College of Radiology, and American Academy of Orthopedic Surgeons).
- Medicare Claims Processing Manual.
- NCCI Policy Manual for Medicare Services.
- State Provider Manuals, Fee Schedules, Periodic Provider Updates (bulletins/transmittals).
- CMS coding resources, such as, HCPCS Coding Manual, Medicare Physician Fee Schedule (MPFS), Provider Benefit Manual, MLN Matters and Provider Transmittals.
- AMA resources:
    - CPT Manual
    - AMA Website
    - Principles of CPT Coding
    - Coding with Modifiers
    - CPT Assistant
    - CPT Insider's View
    - CPT Assistant Archives
    - CPT Procedural Code Definitions
    - HCPCS Procedural Code Definitions
- Billing Guidelines Published by Specialty Provider Associations:
    - Global Maternity Package data published by the American Congress of Obstetricians and Gynecologists (ACOG)
    - Global Service Guidelines published by the American Academy of Orthopedic Surgeons (AAOS)
- State-specific policies and procedures for billing professional and facility claims.
- Health plan policies and provider contract considerations.

Code Editing and the Claims Adjudication Cycle

Code editing is the final stage in the claims adjudication process. Once a claim has completed all previous adjudication phases (such as benefits and member/provider eligibility review), the claim is ready for analysis.

As a claim progresses through the code editing cycle, each service line on the claim is processed through the code editing rules engine and evaluated for correct coding. As part of this evaluation, the prospective claim is analyzed against other codes billed on the same claim as well as previously paid claims found in the member/provider history.

Depending upon the code edit applied, the software will make the following recommendations:

- Deny: Code editing recommends the denial of a claim line. The appropriate explanation code is documented on the provider's explanation of payment along with reconsideration/appeal instructions.
- Pend: Code editing recommends that the service line pend for clinical review and validation. This review may result in a pay or deny recommendation. The appropriate decision is documented on the provider's explanation of payment along with reconsideration/appeal instructions.
- Replace and Pay: Code editing recommends the denial of a service line and a new line is added and paid. In this scenario, the original service line is left unchanged on the claim and a new line is added to reflect the software recommendations. For example, an incorrect CPT code is billed for

the member's age. The software will deny the original service line billed by the provider and add a new service line with the correct CPT code, resulting in a paid service line. This action does not alter or change the provider's billing as the original billing remains on the claim.

Code Editing Principles

The below principles do not represent an all-inclusive list of the available code editing principles, but rather an area sampling of edits which are applied to physician and/or outpatient facility claims.

NCCI Procedure-to Procedure (PTP) Practitioner and Hospital Edits

CMS National Correct Coding Initiative (NCCI) - refer to the CMS website at www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html.

CMS developed NCCI to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. CMS has designated certain combinations of codes that should never be billed together, which are known as PTP or Column one/Column two edits. The column one procedure code is the most comprehensive code and reimbursement for the column two code is subsumed into the payment for the comprehensive code. The column two code is considered an integral component of the column one code.

The CMS NCCI edits consist of PTP edits for physicians and hospitals. Practitioner PTP edits are applied to claims submitted by physicians, non-physician practitioners and ambulatory surgical centers (ASC). Hospital PTP edits apply to hospitals, skilled nursing facilities, home health agencies, outpatient physical therapy and speech-language pathology providers, and comprehensive outpatient rehabilitation facilities. While PTP code pairs should not typically be billed together, there are circumstances when an NCCI-associated modifier may be appended to the column two code to identify a significant and separately identifiable or distinct service. When these modifiers are billed, clinical validation will be performed.

NCCI

MUE for Practitioners, DME Providers and Facilities

The purpose of the NCCI MUE program is to prevent improper payment when services are reported with incorrect units of service. MUEs reflect the maximum units of service that a provider would bill under most circumstances for a single member, on a single date of service. These edits are based on CPT/HCPCS code descriptions, anatomic specifications, the nature of the service/procedure, the nature of the analyte, equipment prescribing information, and clinical judgment.

Code Bundling Rules Not Sourced To CMS NCCI Edit Tables

Many specialty medical organizations and health advisory committees have developed rules around how codes should be used in their area of expertise. These rules are published and are available for use by the public domain. Procedure code definitions and relative value units are considered when developing these code sets. Rules are specifically designed for professional and outpatient facility claims editing.

Mutually Exclusive Editing

These are combinations of procedure codes that may differ in technique or approach but result in the same outcome. The procedures may be impossible to perform anatomically. Procedure codes may also be considered mutually exclusive when an initial or subsequent service is billed on the same date of service. The procedure with the highest RVU is considered the reimbursable code.

Incidental Procedures

These are procedure code combinations in which the less comprehensive procedure is considered clinically integral to the successful completion of the primary procedure and should not be billed separately.

Global Surgical Period Editing/Evaluation and Management (E/M) Service Editing

CMS publishes rules surrounding payment of an E/M service during the global surgical period of a procedure. The global surgery data is taken from the CMS Medicare Fee Schedule Database (MFSDB).

Procedures are assigned a 0-, 10- or 90-day global surgical period. Procedures assigned a 90-day global surgery period are designated as major procedures. Procedures assigned a 0- or 10-day global surgical period are designated as minor procedures.

E&M services for a major procedure (90-day global period) that are reported one-day preoperatively, on the same date of service or during the 90-day post-operative period are not recommended for separate reimbursement.

E&M services that are reported with minor surgical procedures on the same date of service or during the 10-day global surgical period are not recommended for separate reimbursement.

E/M services for established patients that are reported with surgical procedures that have a 0-day global surgical period are not recommended for reimbursement on the same day of surgery because there is an inherent evaluation and management service included in all surgical procedures.

Global Maternity Editing Procedures with MMM

Global periods for maternity services are classified as MMM in the Medicare Physician Fee Schedule (MPFS). E&M services billed during the antepartum period (270 days), on the same date of service or during the postpartum period (45 days) are not recommended for separate reimbursement if the procedure code includes antepartum and postpartum care.

Diagnostic Services Bundled to the Inpatient Admission (Three-Day Payment Window)

This rule identifies outpatient diagnostic services that are provided to a member within three days prior to and including the date of an inpatient admission. When these services are billed by the same admitting facility or an entity wholly owned or operated by the admitting facility, they are considered to be bundled into the inpatient admission, and therefore, are not separately reimbursable.

Multiple Code Rebundling

This rule analyzes billing of two or more procedure codes when a single more comprehensive code should have been billed to accurately represent all of the services performed.

Frequency and Lifetime Edits

The CPT and HCPCS manuals define the number of times a single code can be reported. There are also codes that are allowed a limited number of times on a single date of service, over a given period of time or during a member's lifetime. State fee schedules also delineate the number of times a procedure can be billed over a given period of time or during a member's lifetime. A frequency edit will be applied by code auditing software when the procedure code is billed in excess of these guidelines.

Duplicate Edits

Code editing will evaluate prospective claims to determine if there is a previously paid claim for the same member and provider in history that is a duplicate to the prospective claim. The software will also look across different providers to determine if another provider was paid for the same procedure, for the same member on the same date of service. Finally, the software will analyze multiple services within the same range of services performed on the same day. For example a nurse practitioner and physician billing for office visits for the same member on the same date of service.

National Coverage Determination Edits

CMS establishes guidelines that identify whether some medical items, services, treatments, diagnostic services or technologies can be paid under the health plan. These rules evaluate diagnosis to procedure code combinations.

Anesthesia Edits

This rule identifies anesthesia services that have been billed with a surgical procedure code instead of an anesthesia procedure code.

Invalid Revenue to Procedure Code Editing

Identifies revenue codes billed with incorrect CPT codes.

Assistant Surgeon

Evaluates claims billed as an assistant surgeon that normally do not require the attendance of an assistant surgeon per CMS and American College of Surgeons (ACS) guidelines. Modifiers are reviewed as part of the claims analysis.

Co-Surgeon/Team Surgeon Edits

CMS and ACS guidelines define whether or not an assistant, co-surgeon or team surgeon is reimbursable and the percentage of the surgeon's fee that can be paid to the assistant, co-surgeon or team surgeon.

Add-on and Base Code Edits

Identifies claims with an add-on CPT code billed without the primary service CPT code. Additionally, if the primary service code is denied, then the add-on code is also denied. This rule also looks for circumstances in which the primary code was billed in a quantity greater than one when an add-on code should have been used to describe the additional services rendered.

Bilateral Edits

This rule looks for claims where modifier -50 has already been billed, but the same procedure code is submitted on a different service line on the same date of service without the modifier -50. This rule is highly customized as many health plans allow this type of billing.

Replacement Edits

These rules recommend that single service lines or multiple service lines are denied and replaced with a more appropriate code. For example, the provider bills several lab tests separately that are included as part of a more comprehensive code. This rule will deny the individual lab test codes and add a service line with the appropriate comprehensive code. This rule uses a crosswalk to determine the appropriate code to add.

Missing Modifier Edits

This rule analyzes service lines to determine if a modifier should have been reported but was omitted. For example, professional providers would not typically bill the global (technical and professional) component of a service when performed in a facility setting. The technical component is typically performed by the facility and

not the physician. In some instances, the original service line will be denied and a new service line added with the appropriate modifier. This does not change the original billing, as the original service line remains on the claim.

Inpatient Facility Claim Editing

Potentially Preventable Readmissions Edit

This edit identifies readmissions within a specified time interval that may be clinically related to a previous admission. For example, a subsequent admission may be plausibly related to the care rendered during or immediately following a prior hospital admission in the case of readmission for a surgical wound infection or lack of post-admission follow up. Admissions to non-acute care facilities (such as skilled nursing facilities) are not considered readmissions and not considered for reimbursement. CMS determines the readmission time interval as 30 days; however, this rule is highly customizable by state rules and provider contracts.

Administrative and Consistency Rules

These rules are not based on clinical content and serve to validate code sets and other data billed on the claim. These types of rules do not interact with historically paid claims or other service lines on the prospective claim. Examples include, but are not limited to:

- Procedure code invalid rules: Evaluates claims for invalid procedure and revenue or diagnosis codes.
- Deleted Codes: Evaluates claims for procedure codes which have been deleted.
- Modifier to procedure code validation: Identifies invalid modifier to procedure code combinations. This rule analyzes modifiers affecting payment. As an example, modifiers -24, -25, -26, -57, -58 and -59.
- Age Rules: Identifies procedures inconsistent with member's age.
- Gender Procedure: Identifies procedures inconsistent with member's gender.
- Gender Diagnosis: Identifies diagnosis codes inconsistent with member's gender.
- Incomplete/invalid diagnosis codes: Identifies diagnosis codes incomplete or invalid.

Prepayment Clinical Validation

Clinical validation is intended to identify coding scenarios that historically result in a higher incidence of improper payments. An example of clinical validation services is the review of modifiers -25 and -59. Code pairs within the CMS NCCI edit tables with a modifier indicator of "1" allow for a modifier to be used in appropriate circumstances to allow payment for both codes. Furthermore, public domain specialty organization edits may also be considered for override when they are billed with these modifiers. When these modifiers are billed, the provider's billing should support a separately identifiable service (from the primary service billed, modifier -25) or a different session, site or organ system, surgery, incision/excision, lesion or separate injury (modifier -59). MA's clinical validation team uses the information on the prospective claim and claims history to determine whether or not it is likely that a modifier was used correctly based on the unique clinical scenario for a member on a given date of service.

CMS supports this type of prepayment review. The clinical validation team uses nationally published guidelines from CPT and CMS to determine if a modifier was used correctly.

Modifier -59

NCCI states the primary purpose of modifier -59 is to indicate that procedures or non-editing/medical services that are not usually reported together are appropriate under the circumstances. The CPT manual defines modifier -59 as distinct procedural service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other nonservices performed on the same day. Modifier -59 is used to identify procedures/services, other than editing/medical services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.

Some providers are routinely assigning modifier -59 when billing a combination of codes that will result in a denial due to unbundling. We commonly find misuse of modifier -59 related to the portion of the definition that allows its use to describe different procedure or surgery. NCCI guidelines state that providers should not use modifier -59 solely because two different procedures/surgeries are performed or because the CPT codes are different procedures. Modifier -59 should only be used if the two procedures/surgeries are performed at separate anatomic sites, at separate patient encounters or by different practitioners on the same date of service. NCCI defines different anatomic sites to include different organs or different lesions in the same organ. However, it does not include treatment of contiguous structures of the same organ.

The plan uses the following guidelines to determine if modifier -59 was used correctly:

- The diagnosis codes or clinical scenario on the claim indicate multiple conditions or sites were treated or are likely to be treated.
- Claim history for the patient indicates that diagnostic testing was performed on multiple body sites or areas which would result in procedures being performed on multiple body areas and sites.
- Claim history supports that each procedure was performed by a different practitioner or during different encounters or those unusual circumstances are present that support modifier -59 were used appropriately.
- To avoid incorrect denials providers should assign to the claim all applicable diagnosis and procedure codes used, and all applicable anatomical modifiers designating which areas of the body were treated.

Modifier -25

Both CPT and CMS, in the NCCI policy manual, specify that by using a modifier -25 the provider is indicating that a significant, separately identifiable E&M service was provided by the same physician on the same day of the procedure or other service. Additional CPT guidelines state that the E&M service must be significant and separate from other services provided or above and beyond the usual pre-, intra- and postoperative care associated with the procedure that was performed.

The NCCI policy manual states that if a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure (Osteopathic manipulative therapy and chiropractic manipulative therapy have global periods of 000). The decision to perform a minor surgical procedure is included in the value of the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and

separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier -25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI does contain some edits based on these principles, but the Medicare carriers and A/B Medicare administrative contractor (MAC) processing practitioner service claims have separate edits.

The plan uses the following guidelines to determine whether -25 was used appropriately. If any one of the following conditions is met, the clinical nurse reviewer will recommend reimbursement for the E&M service.

- The E&M service is the first time the provider has seen the patient or evaluated a major condition.
- A diagnosis on the claim indicates that a separate medical condition was treated in addition to the procedure that was performed.
- The patient's condition is worsening as evidenced by diagnostic procedures being performed on or around the date of services.
- Other procedures or services performed for a member on or around the same date of the procedure support that an E&M service would have been required to determine the member's need for additional services.
- To avoid incorrect denials, providers should assign all applicable diagnosis codes that support additional E&M services.

Claim Reconsiderations Related To Code Editing

Claims appeals resulting from claim editing are handled per the provider claims appeals process outlined in this manual. When submitting claims appeals, submit medical records, invoices and all related information to assist with the appeals review.

If you disagree with a code edit or edit and request claim reconsideration, you must submit medical documentation (medical records) related to the reconsideration. If medical documentation is not received, the original code edit or edit will be upheld.

Viewing Claims Coding Edits

Code Editing Assistant

The Code Editing Assistant is a Web-based code editing reference tool designed to mirror how the code editing product(s) evaluate code and code combinations during the editing of claims. The tool is available for providers who are registered on our secure provider portal. You can access the tool in the Claims Module by clicking Claim Editing Tool in our secure provider portal.

This tool offers many benefits:

- Prospectively access the appropriate coding and supporting clinical edit clarifications for services BEFORE claims are submitted.
- Proactively determines the appropriate code or code combination representing the service for accurate billing purposes.

The tool will review what was entered, and will determine if the code or code combinations are correct based on the age, sex, location, modifier (if applicable), or other code(s) entered.

The Code Editing Assistant is intended for use as a "what if" or hypothetical reference tool. It is meant to apply coding logic only. The tool does not take into consideration historical claims information which may be used to determine if an edit is appropriate.The Code Editing Assistant can be accessed from the provider web portal.

Disclaimer

This tool is used to apply coding logic ONLY. It will not take into account individual fee schedule reimbursement, authorization requirements or other coverage considerations. Whether a code is reimbursable or covered is separate and outside of the intended use of this tool.

Automated Clinical Payment Policy Edits

Clinical payment policy edits are developed to increase claims processing effectiveness, to decrease the administrative burden of prior authorization, to better ensure payment of only correctly coded and medically necessary claims, and to provide transparency to providers. The purpose of these policies is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. These policies may be documented as a medical policy or pharmacy policy.

Clinical payment policies are implemented through prepayment claims edits applied within our claims adjudication system. Once adopted by the health plan, these policies are posted on the health plan's provider portal.

Clinical medical policies can be identified by an alpha-numeric sequence such as CP.MP.XX in the reference number of the policy. Clinical pharmacy policies can be identified by an alpha-numeric sequence such as CP.PHAR.XX in the reference number of the policy.

The majority of clinical payment policy edits are applied when a procedure code (CPT/HCPCS) is billed with a diagnosis (es) that does not support medical necessity as defined by the policy. When this occurs, the following explanation (ex) code is applied to the service line billed with the disallowed procedure. This ex code can be viewed on the provider's explanation of payment.

- xE: Procedure Code is Disallowed with this Diagnosis Code(s) Per Plan Policy.

Examples

Policy Name	Clinical Policy Number	Description
Diagnosis of Vaginitis	CP.MP.97	To define medical necessity criteria for the diagnostic evaluation of vaginitis in members ages 13 or older.

Policy Name	Clinical Policy Number	Description
Urodynamic Testing	CP.MP.98	To define medical necessity criteria for commonly used urodynamic studies.
Bevacizumab (Avastin)	CP.PHAR.93	To ensure patients follow selection criteria for Avastin use.

Some clinical payment policy edits may also occur as the result of a single code denial for a service that is not supported by medical necessity. When this occurs, the following explanation (ex) code is applied to the service line billed with the disallowed procedure. This ex code can be viewed on the provider's explanation of payment.

- xP: Service is denied according to a payment or coverage policy

Policy Name	Clinical Policy Number	Description
Fractional Exhaled Nitric Oxide	CP.MP.103	To clarify that testing for fractionated exhaled nitric oxide (FeNO) is investigational for diagnosing and guiding the treatment of asthma, as there is insufficient evidence proving it more than or as effective as existing standards of care.

Clinical Payment Policy Appeals

Clinical payment policy denials may be appealed on the basis of medical necessity. Providers who disagree with a claim denial based on a clinical payment policy, and who believe that the service rendered was medically necessary and clinically appropriate, may submit a written reconsideration request for the claim denial using the provider claim reconsideration/appeal/dispute or other appropriate process as defined in the health plan's provider manual. The appeal may include this type of information:

1. Statement of why the service is medically necessary.
2. Medical evidence which supports the proposed treatment.
3. How the proposed treatment will prevent illness or disability.
4. How the proposed treatment will alleviate physical, mental or developmental effects of the patient's illness.
5. How the proposed treatment will assist the patient to maintain functional capacity.

6. A review of previous treatments and results, including, based on your clinical judgment, why a new approach is necessary.
7. How the recommended service has been successful in other patients.

Compliance and Regulations

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section covers general information for providers on compliance and regulation requirements.

Select any subject below:

- Mandatory Data Sharing Agreement
- Provider Offshore Subcontracting Attestation
- Communicable Diseases Reporting
- Federal Lobbying Restrictions
- Health Net Affiliates
- Material Change Notification
- Nondiscrimination

Mandatory Data Sharing Agreement

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

The state of California established the California Health and Human Services (CalHHS) Data Exchange Framework (DxF) to oversee the electronic exchange of health and social services information in California.

Entities listed below must sign a data sharing agreement (DSA). To sign the DSA, go to https://signdxf.powerappsportals.com.

Participating entities that must sign a DSA include:

- General acute care hospitals.
- Physician organizations and medical groups.
- Skilled nursing facilities.
- Clinical laboratories.
- Acute psychiatric hospitals.

The Plan may apply a corrective action plan if the agreement is not signed.

Provider Offshore Subcontracting Attestation

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG)| Ancillary

The plan requires notice of any offshore subcontracting relationship, involving members' protected health information (PHI) to ensure that the appropriate steps have been taken to address the risks involved with the use of subcontractors operating outside the United States.

An example of an offshore subcontracting relationship is a physician, laboratory, medical group, or hospital contracting with an entity to process claims, and that entity uses resources that are not located in the United States to process the provider's claims. The provider is responsible to have processes in place that protect members' PHI.

Participating providers who use offshore subcontractors to process, handle or access member PHI in oral, written or electronic form must submit specific subcontracting information to the plan. Providers may not allow any member data to be transferred or stored offshore. Data may be accessed by an offshore entity through an onshore entity that is located in the United States.

The plan requires that participating providers who have entered into an offshore subcontracting relationship submit the following items to the plan within 20 calendar days of entering into a new offshore agreement or when revising an existing offshore agreement.

- A completed and signed copy of the attestation form (PDF) (CalViva, Community Health Plan of Imperial Valley, Wellcare By Health Net.This attests that the participating provider has taken appropriate steps to address the risks associated with the use of subcontractors operating outside the United States. Each attestation form includes the contact information for providers to return the completed form and materials.
- Providers contracting with the plan for the Medicare line of business must provide a copy of the agreement between the provider and offshore subcontractor with proprietary information removed. The plan is required to validate that the necessary contractual provisions are included in the agreement.
- A policy and procedure for ensuring and maintaining the security of members' PHI.
- A policy and procedure that documents the process used for immediate termination of the offshore subcontractor upon discovery of a significant security breach.
- A policy and procedure that documents the process used for conducting annual audits, regular monitoring and tracking results, and resolving any identified deficiencies.

Providers must submit this information for each offshore subcontractor they have engaged to perform work, regardless of whether the information was already completed for a different health plan.

Communicable Diseases Reporting

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

To protect the public from the spread of infectious, contagious and communicable diseases, every health care provider knowing of or in attendance on a case or suspected case of any of the communicable diseases and conditions specified in Title 17, California Code of Regulations (CCR), Section 2500, are required by law to notify the local health department (LHD). A health care provider having knowledge of a case of an unusual disease not listed must also promptly report the facts to the local health officer.

The term health care provider includes physicians and surgeons, veterinarians, podiatrists, nurse practitioners, physician assistants, registered nurses, nurse midwives, school nurses, infection control practitioners, medical examiners, coroners, and dentists.

Notification

Providers must report cases of communicable diseases using the Confidential Morbidity Report (PDF) . They must send a completed copy of the report to the Communicable Disease Control division of the County Health Department. The time frame for reporting suspected cases of communicable diseases varies according to disease and ranges from immediate reporting by telephone or fax to seven days by mail.

The notification must include the following, if known:

- Name of the disease or condition being reported
- Date of onset
- Date of diagnosis
- Name, address, telephone number, occupation, race or ethnic group, Social Security number (SSN), age, sex, and date of birth for the case or suspected case
- Date of death, if death has occurred
- Name, address and telephone number of the person making the report

HIV Reporting Requirements for Laboratories

The following document applies only to Ancillary providers.

HIV is a reportable disease under California state law. Laboratories are required by law to submit specified information using the complete name of the patient for each confirmed HIV test to the local health officer for the local jurisdiction where the health care provider is located and the requesting provider within seven calendar days.

Laboratories must report confirmed HIV cases by either one of the following:

- Courier service, U.S. Postal Service Express, registered mail or other traceable mail
- Person-to-person transfer with the local health officer or their designee

Laboratories may not submit reports containing personal information by electronic fax, electronic mail or non-traceable mail. Laboratories should contact the local county health department for information and reporting forms.

A confirmed HIV test is a test used to monitor HIV, including HIV nucleic acid detection (such as viral load), or any test verifying one of the following:

- The presence of HIV
- A component of HIV

- Antibodies to, or antigens of, HIV, including:
  - HIV antibody (HIV-Ab) test
  - HIV p-24 antigen test
  - Western blot (Wb) test
  - Immunofluorescence antibody test

Testing laboratories generate a report that consists of the following information:

- Complete name of patient
- Patient date-of-birth (2-digit month, 2-digit day, 4-digit year)
- Patient gender (male, female, transgender male-to-female, or transgender female-to-male)
- Name, address and telephone number of the health care provider and the facility that submitted the biological specimen to the laboratory, if different
- Name, address the telephone number of the laboratory
- Laboratory report number as assigned by the laboratory
- Laboratory results of the test performed
- Date biological specimen was tested in the laboratory
- Laboratory Clinical Laboratory Improvement Amendment (CLIA) number

Laboratories may not submit reports to the local health department for confirmed HIV tests for patients of an alternative testing site, other anonymous HIV testing programs, blood banks, plasma centers, or for participants of a blinded or unlinked seroprevalence study.

HIV Reporting Requirement for Providers

HIV is a reportable disease under California state law. Health care providers are required by law to submit specified information using the complete name of the patient for each confirmed HIV test to the local health officer within, 7 calendar days.

Providers must complete an HIV case report for each confirmed HIV test not previously reported and send it to the local health officer for the jurisdiction where the health care provider facility is located.

Providers must report confirmed HIV cases by either one of the following:

- Courier service, U.S. Postal Service Express, or registered mail or other traceable mail
- Person-to-person transfer with the local health officer or their designee

Providers may not submit reports containing personal information by electronic fax, electronic mail or non-traceable mail.

A confirmed HIV test is a test used to monitor HIV, including HIV nucleic acid detection (such as viral load), or any test verifying one of the following:

- The presence of HIV
- A component of HIV
- Antibodies to, or antigens of, HIV, including:
  - HIV antibody (HIV-Ab) test
  - HIV p-24 antigen test
  - Western (Wb) blot test
  - Immunofluorescence antibody test

A health care provider that orders a laboratory test used to identify HIV, a component of HIV, or antibodies to or antigens of HIV must submit to the laboratory a pre-printed laboratory requisition form that includes all documentation specified in 42 CFR 493.1105 (57 FR 7162, Feb. 28, 1992, as amended at 58 FR 5229, Jan. 19, 1993) and adopted in Business and Professions Code, Section 1220.

The person authorized to order the laboratory test must include the following when submitting information to the laboratory:

- Complete name of patient
- Patient date-of-birth (2-digit month, 2-digit day, 4-digit year)
- Patient gender (male, female, transgender male-to-female, or transgender female-to-male)
- Date biological specimen was collected
- Name, address and phone number of the health care provider and the facility where services were rendered, if different

Most laboratories are also required to report confirmed tests to the local health office; however, this does not relieve the provider's reporting responsibility. Laboratories may not submit reports to the local health department for confirmed HIV tests for patients of an alternative testing sites other anonymous HIV testing programs, blood banks, plasma centers, or for participants of a blinded or unlinked seroprevalence study.

Reporting Requirements for Hepatitis and Sexually Transmitted Infections

When a provider reports a case of hepatitis or a sexually transmitted infection (STI), the report must include the following information, if known:

- Hepatitis information including the type of hepatitis, type-specific laboratory findings, and sources of exposure
- STI information on the specific causative agent, syphilis-specific laboratory findings, and any complications of gonorrhea or Chlamydia infections

Tuberculosis Reporting and Care Management

Tuberculosis (TB) reporting is done immediately by phone or fax to expedite the process. The Confidential Morbidity Report form (PDF) should be used to notify the local health department's Communicable Disease Reporting Divisions. When reporting a case of TB, the health care provider must provide information on the diagnostic status of the case or suspected case; bacteriological, radiological and tuberculin skin test findings; information regarding the risk of transmission of the disease to other persons; and a list of the anti-tuberculosis medications administered to the member. In addition, a report must be made any time a person ceases treatment for TB, including when the member fails to keep an appointment, relocates without transferring care, or discontinues care. Further, the local health officer may require additional reports from the health care provider.

The health care provider who treats a member with active TB must maintain written documentation of the member's adherence to their individual treatment plan. Reports to the local health officer must include the individual treatment plan, which indicates the name of the medical provider who specifically agreed to provide

medical care, the address of the member, and any other pertinent clinical or laboratory information that the local health officer may require.

In addition, each health care provider who treats a member for active TB must examine or arrange for examination of all persons in the same household who have had contact with the member. The health care provider must refer those contacts to the local health officer for examination and must promptly notify the local health officer of the referral. The local health officer may impose further requirements for examinations or reporting.

Prior to discharge from an inpatient hospital, health care providers must report any cases of known or suspected TB to the local health officer and receive approval for discharge. The local health officer must review and approve the individual treatment plan prior to discharge.

Tuberculosis Care Management

When requested by the primary care physician (PCP) or local county health TB control officer, the Care Management Department provides assistance with coordination of the member's care. All cases referred to the Care Management Department are managed by gathering demographic and medical information. The care managers analyze the data, assess the member's needs, identify potential interventions, and follow the interventions with the member, family and health care team, within the limits of confidentiality. Following the evaluation, the care manager notifies the provider about the member's eligibility for the Care Management Program.

Primary Care Physician Responsibilities

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Primary care physicians (PCPs) are responsible for preventive care counseling and education for their assigned members. Counseling and education is documented in the medical record of each member. Health Net distributes brochures on communicable disease topics to PCP offices.

Federal Lobbying Restrictions

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

United States Code Title 31, Section 1352, prohibits the use of federal funds for lobbying purposes in connection with any federal contract, grant, loan, cooperative agreement, or extension, or continuation of any of them. Participating providers are required to develop and comply with filing procedures as follows:

- File a declaration with the plan Net certifying that no inappropriate use of federal funds has occurred or will occur (use Certification for Contracts, Grants, Loans, and Cooperative Agreements Form (PDF)). This extends to any subcontract a participating provider may have that exceeds $100,000 in value. In these cases, the participating provider is required to collect and retain these declarations

- File a specific disclosure form if non-federal funds have been used for lobbying purposes in connection with any line of business (use Disclosure of Lobbying Activities Form and Disclosure Form Instructions (PDF))
- File quarterly updates, such as a disclosure form at the end of any calendar quarter in which disclosure is required or in which an event occurs that materially affects the previously filed disclosure form

While the statute and related regulations do not specify that the $100,000 limit mentioned in the first bullet is to be calculated annually, the plan believes it reasonable to apply the $100,000 threshold to the term of the Provider Participation Agreement (PPA). If the PPA term is for one year, renewable automatically if not terminated, the threshold would renew at the beginning of each new one-year term. If it is a multiyear term, the calculation of the threshold would be based on the payments received throughout the multiyear term.

Participating providers who complete the Certification for Contracts, Grants, Loans, and Cooperative Agreements Form should send it directly to their assigned provider relations and contracting specialist.

Participating providers are required to comply with applicable state laws and regulations and plan policies and procedures. The contents of the operations manuals are supplemental to the PPA and its addendums. When the contents of the operations manuals conflict with the PPA, the PPA takes precedence.

Health Net Affiliates

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Below is a listing of certain Health Net affiliates. Health Net affiliates and subsidiaries, including those listed below, as well as any other subsidiary or affiliate of Health Net not listed, may opt to periodically access the *Provider Participation Agreement* (*PPA*) for covered services delivered by providers under those benefit programs in which providers participate.

- Arizona Complete Plan
- California Health and Wellness Plan
- Health Net Community Solutions, Inc.
- Health Net Federal Services, LLC.
- Health Net Health Plan of Oregon, Inc.
- Health Net Insurance Services, Inc.
- Health Net Life Insurance Company
- Health Net of California, Inc.
- Managed Health Network, Inc.
- MHN Government Services, Inc.
- Network Providers LLC.
- Wellcare of California, Inc.

Material Change Notification

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

In accordance with AB 2907 (ch. 925, 2002) and AB 2252 (ch. 447, 2012), Section 1375.7 (c)(3) of the Health and Safety Code and Section 10133.65 (d)(3) of the Insurance Code, the health care provider's Bill of Rights, the plan is required to give notice at least 45 business days in advance to participating providers, including dental providers in reference to coverage of medical services only, when the plan intends to amend a material term of a manual, policy or procedure document referenced in the Provider Participation Agreement (PPA). The term material is defined as a provision in a contract to which a reasonable person would attach importance in determining the action to be taken with respect to the provision. If the change is required by federal or state law or an accreditation entity, a shorter notice period may apply.

The plan informs participating providers of material changes through provider updates and letters and announcements on the provider website. Once finalized, such changes are incorporated into the provider operations manuals. Information sent to providers through provider updates and letters is also added to the text of the appropriate operations manuals. The provider has the right to negotiate and agree to material changes. If an agreement cannot be reached, the provider has the right to terminate the PPA prior to implementation of the material change.

Nondiscrimination

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

The following nondiscrimination requirements apply.

Employment

The plan and its participating providers must comply with the provisions of the Fair Employment and Housing Act (FEHA) (California Government Code, Section 12900 and following) and the regulations set forth in the California Code of Regulations, Title 2, Chapter 2, commencing with Section 7286.0 and following. The plan and its participating providers may not unlawfully discriminate against any employee or applicant for employment because of race, religion, color, national origin, ancestry, physical handicap, medical condition, marital status, age, or sex. In addition, the plan and its participating providers ensure the following:

- Evaluation and treatment of employees and applicants for employment is free of such discrimination
- Written notice of obligations under this clause is given to labor organizations with which the plan or its participating providers have a collective bargaining or other agreement

Health Programs and Activities

The following requirements apply[1, 2]:

- Participating providers must add plan-specific nondiscrimination notices and taglines in significant publications and communications issued to members. To obtain additional information refer to Industry Collaboration Effort (ICE) website. If you are not able to locate specific notices or taglines, contact the Delegation Oversight Department.
- If necessary, participating providers must assess and enhance existing policies and procedures to ensure effective communication with members.
- Participating providers must ensure programs or activities provided through electronic or information technology, such as websites or online versions of materials, are accessible to individuals with disabilities. If necessary, participating providers must assess and enhance website compliance with Title II of the ADA.
- Participating providers must notify the plan immediately of a discrimination grievance submitted by a member and continue to follow the plan's existing issue write-up procedures for detection and remediation of non-compliance. Additionally, participating providers must comply with the plan, regulatory or private litigation research, investigations, and remediation requirements.
- Participating providers must assess and enhance, if necessary, existing language assistance services to ensure they are compliant.
- Participating providers must implement, enhance and reinforce prohibitions on exclusions, denials or discrimination such as in design, operation or behavior of benefits or services on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation. Additionally, they must implement, where applicable:
    - Medical necessity reviews for all gender transition services and surgery.
    - Program or activity changes to avoid discrimination where necessary.
    - Plan design changes where necessary, such as removing categorical gender or age exclusions.
    - Additionally, providers must remove prohibited categorical exclusions and denial reasons, and update nondiscrimination policies and procedures to include prohibitions against discrimination on the basis of sex, including gender identity and sex stereotyping.
- Participating providers can consider implementing the following:
    - Ability to capture gender identity.
    - Mandatory provider and staff civil rights and/or cultural sensitivity training.

[1] For Medicare Advantage and Commercial products: In addition to the State of California nondiscrimination requirements and in accordance with Section 1557, 45 CFR Part 92 of the Affordable Care Act of 2010 (ACA).

[2] For Medi-Cal and Dual Special Need Plans: In addition to the State of California nondiscrimination requirements, and in accordance with all applicable federal requirements in Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities, as amended); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973 including sections 504 and 508, as amended; Titles I, II and III of the Americans with Disabilities Act of 1990, as amended; Section 1557 of the Patient Protection and Affordable Care Act of 2010; and federal implementing regulations issued under the above-listed statutes.

Coordination of Benefits

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information for providers on coordination of benefits.

Select any subject below:

Overview

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

Coordination of benefits (COB) allows group health plans to eliminate the opportunity for a person to profit from an illness or injury as the result of duplicate group health plan coverage. Generally, one plan is determined to be primary, and that plan pays without regard to the other. The secondary plan then makes only a supplemental payment that results in a total payment of not more than the eligible expenses for the medical service provided.

If one plan is an individual plan, not a group plan, both plans pay as primary. The payments do not coordinate.

Participating providers are required to administer COB when such provisions are a requirement of the benefit plans. The participating provider should ask the member for possible coverage through any other group or individual insurance or HMO plan and enter the other health insurance information on the claim.

Contact the Provider Services Department with any information identifying COB coverage for a member.

The Plan's Right to Pay Others

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

A payment made by another health plan may include an amount that should have been paid by the plan. If this happens, the plan may pay the amount to the organization that made the payment. The amount is then treated as though paid under the member's coverage. The plan does not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case payment made means the reasonable cash value of the benefits provided in the form of services.

When the Plan is the Primary Carrier

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

When the plan is the primary carrier, the participating provider is entitled to bill the other carrier as secondary after the provider has received the plan's adjudication decision.

A member is not entitled to an itemized statement reflecting the cash value of the services provided by the participating provider and covered by the plan (compliance with a request for itemization could enable a member to obtain unjust payment from an insurer or to document an itemized tax deduction far in excess of the actual cost).

A member is entitled to a statement documenting copayments made to the participating provider and charges for services not covered by the plan.

When Wellcare By Health Net is the primary payer and the member is enrolled in our exclusively aligned Dual Special Needs Plan (D-SNP), the secondary claim will be automatically forwarded to Health Net for payment on the Medi-Cal covered portion.

Refer to Claims Reimbursement and Balance Billing sections for more information.

Balance Billing

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

Balance billing is strictly prohibited by state and federal law and Health Net's Provider Participation Agreement (PPA).

Balance billing occurs when a participating provider bills a member for fees and surcharges above and beyond a member's copayment and coinsurance responsibilities for services covered under a member's benefit program, or for claims for such services denied by Health Net or the affiliated participating physician group (PPG). Participating providers are also prohibited from initiating or threatening to initiate a collection action against a member for non-payment of a claim for covered services. Participating providers agree to accept Health Net's fee for these services as payment in full, except for applicable copayments, coinsurance, or deductibles.

Dual Special Needs Plan (D-SNP) members are not subject to copayments, so providers must not charge D-SNP members coinsurance, copayments, deductibles, financial penalties, or any other amount due to their Medi-Cal eligibility. Any amounts non-covered by the Medicare payment/reimbursement must be sent for secondary payment to the member’s Medi-cal managed care plan (MCP) or directly to the Department of Health Care Services (DHCS) if not assigned to a Medi-cal MCP for that date of service.

Providers can verify the member’s Medi-cal MCP by checking the Medi-Cal Automated Eligibility Verification (PDF) .

Providers can refer to the Verifying and Clearing Share-of-Cost section for information regarding D-SNP members' share of cost (SOC) responsibility for certain services.

Participating providers may bill a member for non-covered services when the member is notified in advance that the services to be provided are not covered and the member, nonetheless, requests in writing that the services be rendered. A participating provider who exhibits a pattern and practice of billing members will be contacted by Health Net and is subject to disciplinary action.

When the Plan is the Secondary Carrier

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

When the plan is the secondary carrier, the participating provider is entitled to receive payment from the primary carrier for services provided directly to the member.

The participating provider should obtain the signature of the member who is the policyholder with the other carrier on a standard Assignment of Benefits form.

The participating provider should also obtain from the member any claim form the other carrier might require.

Upon receiving an adjudication decision from the primary carrier, the participating provider submits a secondary claim to the plan with an attachment of the primary carrier's Explanation of Benefits (EOB). When the participating provider expects to receive reimbursement from the plan amounting to more than any required copayment, do not collect a copayment.

If, after both carriers have reimbursed the participating provider, the provider has not received reimbursement equal to or greater than the amount that is due under the provider's Provider Participation Agreement (PPA), the member can be billed for the required copayment provided the total reimbursement from all sources is no greater than what is due under the provider's PPA.

When the primary carrier is another HMO and the member is enrolled with two different participating providers (one with the primary carrier and one with the plan), the member may receive services through either participating provider. The participating provider cannot deny services based on the plan's status as the secondary carrier.

Copayments

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section includes general information on the collection and verification of copayments.

Select any subject below:

- Calculation of Coinsurance
- Out-of-Pocket Maximum
- Verify Copayments

Calculation of Coinsurance

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals

Health Net's method of calculating member coinsurance for institutional charges is described below. This applies to plans that require a percentage coinsurance for inpatient or outpatient hospital services.

The coinsurance is based on the lesser of the allowable charges (billed charges minus disallowed charges) or the contract amount. For example, if a hospital submits a bill to Health Net for $5,000 and Health Net has a contract with the hospital for $4,000, the member (who has a 20 percent coinsurance) would then be responsible for 20 percent of the contract amount ($4,000), which would be $800 ($4,000 x 20% = $800).

Out-of-Pocket Maximum

Provider Type: Physicians | Ancillary | Hospitals

When the member's total copayments, coinsurance and applicable deductible payments during any calendar or plan year, equal the out-of-pocket maximum (OOPM) listed in the Schedule of Benefits , no further deductibles (if applicable), copayments or coinsurance are required from the member for the remainder of that calendar or plan year.

Eligible copayments or coinsurance amounts paid by the member for services provided through the PPO plan apply towards the OOPM for out-of-network providers. In addition, the coinsurance paid for services provided through out-of-network providers applies towards the OOPM for PPO. Refer to the Schedule of Benefits for plan exceptions.

Verify Copayments

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Refer to the Schedule of Covered Services and Copayments in the subscriber's Evidence of Coverage (EOC) or Certificate of Insurance or the plan chart in the Schedule of Benefits to determine whether a copayment should be collected. For example, most plans have a copayment for emergency room or urgent care center treatment (when the copayment for emergency room or urgent care center treatment is less than the billed amount, the member is only responsible for the lesser amount).

Some plans have a copayment for hospitalization or for home health visits beginning with the 31st day of home health services. The copayments for emergency room, urgent care or hospitalization, inpatient or outpatient, must be collected by the institution providing the services. The copayments for home health services must be collected by the home health agency providing the services. These copayments contribute to the out-of-pocket maximum (OOPM).

For professional services, capitation or fee-for-service payments are supplemented by the Health Net member's copayments. Some of these payments accrue to the participating physician group (PPG) or provider and increase the total compensation received by the PPG or provider.

For benefit application purposes, Health Net's definition of a newborn is an infant from birth through its first 30 days. This is relevant only to a few plans that require office visit copayments for newborns.

Credentialing

Provider Type: Physicians(does not apply to Cal MediConnect) | Participating Physician Groups (PPG)(does not apply to HSP) | Hospitals | Ancillary

This section describes Health Net's provider credentialing process.

Select any subject below:

- Application Process

Application Process

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Practitioners or organizational providers subject to credentialing or recredentialing and contracting directly with the plan must submit a completed plan-approved application. By submitting a completed application, the practitioner or provider:

- Affirms the completeness and truthfulness of representations made in the application, including lack of present illegal drug use.
- Indicates a willingness to provide additional information required for the credentialing process.
- Authorizes the plan to obtain information regarding the applicant's qualifications, competence, or other information relevant to the credentialing review.
- Releases the plan and its independent contractors, agents and employees from any liability connected with the credentialing review.

Approval, Denial or Termination of Credentialing Status

The Credentialing Committee or physician designee reviews rosters of delegated and non-delegated practitioners and organizational providers meeting all plan criteria and approves their admittance or continued participation in the network.

A peer review process is used for practitioners with a history of adverse actions, member complaints, negative quality improvement (QI) activities, impaired health, substance abuse, health care fraud and abuse, criminal history, or similar conditions to determine whether a practitioner should be admitted or retained as a participant in the network.

Practitioners are notified within 60 calendar days of all decisions regarding approval, denial, limitation, suspension, or termination of credentialing status consistent with the health plan, state and federal regulatory requirements and accrediting entity standards. This notice includes information regarding the reason for denial determination. If the denial or termination is based on health status, quality of care or disciplinary action, the practitioner is afforded applicable appeal rights. Practitioners who have been administratively denied are eligible to reapply for network participation as soon as the administrative matter is resolved.

Failure to respond to recredentialing requests may result in the practitioner's administrative termination from the network.

Appeals

Practitioners, whose participation in the plan's network has been denied, reduced, suspended, or terminated for quality of care/medical disciplinary causes or reasons, are provided notice and an opportunity to appeal. This policy does not apply to practitioners who are administratively denied admittance to, or administratively terminated from, the network.

The notice of altered participation status will be provided in writing to the affected practitioner and include:

- The action proposed against the practitioner by the Credentialing or Peer Review committee.
- The reason for the action.
- The plan policies or guidelines that led to the committee's adverse determination.
- Detailed instructions on how to file an appeal (informal reconsideration or formal hearing).

A practitioner may choose to engage in an informal appeal and provide additional information for the Credentialing Committee's consideration or move directly to a formal fair hearing. Affected practitioners who are not successful in overturning the original committee decision during an informal reconsideration are automatically afforded a fair hearing, upon request in writing within 30 days from the date of notice of the denial.

A practitioner must request a reconsideration or fair hearing in writing. The plan's response to the request will include:

- Dates, times and location of the reconsideration or hearing.
- Rules that govern the applicable proceedings.
- A list of practitioners and specialties of the committee or fair hearing panel.

The composition of the fair hearing panel must include a majority of individuals who are peers of the affected practitioner. A peer is an appropriately trained and licensed physician in a practice similar to that of the affected practitioner.

Affected practitioners whose original determinations are overturned are granted admittance or continued participation in the plan's network. The decision is forwarded to the affected practitioner in writing within 14 calendar days of the fair hearing panel's decision.

Affected practitioners whose original determinations have been upheld are given formal notice of this decision within 14 days of the fair hearing panel's ruling. The actions are reported to the applicable state licensing board and to the National Practitioner Data Bank (NPDB) within 14 days of the hearing panel's final decision.

Practitioners who have been denied or terminated for quality-of-care concerns must wait a minimum of five years from the date the adverse decision is final in order to reapply for network participation. At the time of the reapplication, the practitioner must:

- Meet all applicable plan requirements and standards for network participation.
- Submit, at the request of the committee or Credentialing Department, additional information that may be required to confirm the earlier adverse action no longer exists.
- Fulfill, according to applicable current credentialing policies and procedures, all administrative credentialing requirements of the plan's credentialing program.

Credentialing Responsibility, Oversight and Delegation

The plan may delegate to individual practitioners, participating physician groups (PPGs) or other entities responsibility for credentialing and recredentialing activities. Credentialing procedures used by these entities may vary from plan procedures, but must be consistent with the health plan, state and federal regulatory requirements and accrediting entity standards.

Prior to entering into a delegation agreement, and throughout the duration of any delegation agreement, the oversight of delegated activities must meet or exceed plan standards. The plan oversees delegated responsibilities on an ongoing basis through an annual audit and semiannual, or more frequent, review of delegated PPG-specific data.

The plan can revoke the delegation of any or all credentialing activities if the delegated PPG or entity is deemed noncompliant with established credentialing standards. The plan retains the right, based on quality issues, to terminate or restrict the practice of individual practitioners, providers and sites, regardless of the credentialing delegation status of the PPG.

Each delegated practitioner or provider losing delegated credentialing status must complete the plan's initial credentialing process within six months.

Hiring Non-Participating Providers

The following document applies only to Physicians and Participating Physician Groups (PPG).

In an effort to comply with applicable federal and state laws and regulations, all participating providers in the plan's network must comply with the following standards when hiring a non-participating provider to provide services to plan members. Participating providers must be able to demonstrate that each non-participating provider has supporting documentation that includes:

- Current, unencumbered state medical license.
- Valid, unencumbered Drug Enforcement Agency (DEA) certificate, as applicable or Chemical Dependency Services (CDS) certificate, as applicable.
- Evidence of adequate education and training for the services the practitioner is contracting to provide.

- Malpractice insurance coverage that meet these standards: Individual providers one million/three million and for organizational providers three million/ten million.
- Absent of any sanctions that would not allow them to see a Medicare member.

Additionally, the practitioner must be absent from:

- The Medicare Opt Out report if treating Medicare members.
- The Office of the Inspector General's (OIG) sanctions list of individuals and entities (LEIE) if treating Medicaid and Medicare members.
- The System for Award Management's Exclusions Extract Data Package (EEDP) if treating Medicare members.
- The Federal Employee Health Benefits Program Debarment Report if treating federal members.

The plan's participating providers are responsible for ongoing monitoring of sanctions and validating licensing. All participating providers are required to comply with applicable federal, state and local laws and regulations as well as the policies and procedures as outlined in the Provider Participation Agreement (PPA).

Investigations

The plan investigates adverse activities indicated in a practitioner or provider's initial credentialing or recredentialing application materials or identified between credentialing cycles. The plan may also be made aware of such activities through primary source verification utilized during the credentialing process or by state and federal regulatory agencies. Health Net may require a practitioner or provider to supply additional information regarding any such adverse activities. Examples of such activities include, but are not limited to:

- State or local disciplinary action by a regulatory agency or licensing board.
- Current or past chemical dependency or substance abuse.
- Health care fraud or abuse.
- Member complaints.
- Substantiated quality of care concerns activities.
- Impaired health.
- Criminal history.
- Office of Inspector General (OIG) Medicare/Medicaid sanctions.
- Federal Employees Health Benefits Program (FEHBP) debarment.
- System Award Management (SAM), inclusive of Excluded Parties List System (EPLS), EEDP.
- The Medi-Cal Suspended and Ineligible Provider listing.
- Substantiated media events.
- Trended data.

At the plan's request, a practitioner or provider must assist the plan in investigating any professional liability claims, lawsuits, arbitrations, settlements, or judgments that have occurred within the prescribed time frames.

Organizational Providers Certification or Recertification

An organizational provider (OP) is an institutional provider of health care that is licensed by the state or otherwise authorized to operate as a health care facility. Examples of OPs include, but are not limited to, hospitals, home health agencies, skilled nursing facilities (SNFs), and ambulatory surgical centers (ASCs).

Organizational providers that require assessments by the plan or its delegated entities include:

- Hospitals

- Home health agencies
- Hospices
- Clinical laboratories *(accreditation is mandatory)*
- Skilled nursing facilities
- Comprehensive outpatient rehabilitation facilities
- Outpatient physical therapy, occupational therapy and speech pathology providers
- Ambulatory psychiatric and addiction disorder facilities and clinics
- Psychiatric and addiction disorder residential treatment facilities
- Twenty-four-hour behavioral healthcare units in general hospitals
- Substance abuse treatment facilities
- Other freestanding psychiatric hospitals and treatment facilities
- Ambulatory surgery centers
- Providers of end stage renal disease services
- Providers of outpatient diabetes self-management training
- Portable x-ray suppliers
- Rural health centers (RHCs), federally qualified health centers (FQHCs) and Indian Health Centers (IHCs)*
- Sleep study centers (as applicable)
- Radiology/imaging centers (as applicable)
- Urgent care facilities (as applicable)
- Community Based Adult Services (CBAS)
- Free Standing and Alternative Birthing Centers
- Telehealth/Telemedicine Services Provider*
- Intermediate Care Facility

CalAIM - Community Supports Provider/In Lieu of Services Provider.**

Non-Traditional providers are not certified or credentialed. They require vetting to ensure acceptance into our network. Of note; if a traditional Provider, Hospital, Ancillary, PPG or Practitioner oversee the non-traditional providers, the Provider is responsible to ensure they meet the needs to join our network.

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-Term Post Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Community Transition Services/Nursing
- Facility Transition to a Home
- Personal Care and Homemaker Services
- Sobering Centers
- Environmental Accessibility Adaptions (Home Modifications)
- Meals/Medically Tailored Meals or Medically Supportive Foods
- Asthma Remediation
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for the Elderly (RCFE) and Adult Residential Facilities (ARF)

CalAIM – Enhanced Care Management Provider**

Community Health Worker - Provider**

*The facility is exempt from the certification process if the individual practitioners within this clinic are individually contracted/credentialed.

** Non-Traditional Care Facilities are required to submit a vetting attestation only.

Is licensed to operate in the state and is following any other applicable federal or state requirements.

Providers contracting directly with the plan must submit a completed, signed plan-approved hospital or ancillary facility credentialing application and any supporting documentation to the plan for processing. The documentation, at a minimum, includes:

- Evidence of a site survey that has been conducted by an accepted agency, if the provider is required to have such an on-site survey prior to being issued a state license. Accepted agency surveys include those performed by the state Department of Health and Human Services (DHHS), Department of Public Health (DPH) or Centers for Medicare & Medicaid Services (CMS).
- Evidence of a current, unencumbered state facility license. If not licensed by the state, the facility must possess a current city license, fictitious name permit, certificate of need, or business registration.
- Copy of a current accreditation certificate appropriate for the facility. If not accredited, then a copy of the most recent DHHS/DPH site survey as described above is required. A favorable site review consists of compliance with quality-of-care standards established by CMS or the applicable state health department. The plan obtains a copy of each surgery center's site survey report and ensures each provider has received a favorable rating. This may include a completed corrective action plan (CAP) and DHHS CAP acceptance letter.
- Professional and general liability insurance coverage that meets plan requirements.
- Overview of the facility's quality assurance/quality improvement program upon request.

Organizational providers are recredentialed at least every 36 months to ensure each entity has continued to maintain prescribed eligibility requirements.

Practitioner's Rights

Right of Review Request for Current Network Status

A practitioner has the right to review information obtained by the plan for the purpose of evaluating that practitioner's credentialing or recredentialing application. This includes non-privileged information obtained from any outside source (for example, malpractice insurance carriers, state licensing boards or the National Practitioner Data Bank), but does not extend to review of information, references or recommendations protected by law from disclosure.

A practitioner may request to review such information at any time by sending a written request via letter or fax to the credentialing manager or supervisor. The credentialing manager or supervisor notifies the practitioner within 72 hours of the date and time when such information is available for review at the Credentialing Department. Upon written request, the Credentialing Department provides details of the practitioner's current status in the initial credentialing or recredentialing process.

Notification of Discrepancy

Practitioners are notified in writing, via letter or fax, when information obtained by primary sources varies substantially from information provided on the practitioner's application. Examples include reports of a practitioner's malpractice claim history, actions taken against a practitioner's license or certificate, suspension or termination of hospital privileges, or board-certification expiration when one or more of these examples have not been self-reported by the practitioner on their application. Practitioners are notified of the discrepancy at the time of primary source verification. Sources are not revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

Correction of Erroneous Information

A practitioner who believes that erroneous information has been supplied to the plan by primary sources may correct such information by submitting written notification to the Credentialing Department. Practitioners must submit a written notice via letter or fax, along with a detailed explanation, to the Credentialing Department manager or supervisor. Notification to the plan must occur within 48 hours of the plan's notification to the practitioner of a discrepancy or within 24 hours of a practitioner's review of their credentials file. Upon receipt of notification from the practitioner, the plan re-verifies the primary source information in dispute. If the primary source information has changed, a correction is made immediately to the practitioner's credentials file. The practitioner is notified in writing, via letter or fax, that the correction has been made. If, upon re-review, primary source information remains inconsistent with the practitioner's notification, the Credentialing Department notifies the practitioner via letter or fax.

The practitioner may then provide proof of correction by the primary source body to the Credentialing Department via letter or fax within 10 business days. The Credentialing Department re-verifies primary source information if such documentation is provided. If after 10 business days the primary source information remains in dispute, the practitioner is subject to administrative denial or termination.

Primary Source Verification for Credentialing and Recredentialing

The Credentialing Department obtains and reviews information on a credentialing or re-credentialing application and verifies the information in accordance with the primary source verification practices. The plan requires participating physician groups (PPGs) to which credentialing has been delegated to obtain primary source information (outlined below)* in accordance with the standards of participation, state and federal regulatory requirements, and accrediting entity standards.

*Primary Source Verification

- Medical doctors (MD)
- Nurse Practitioners (NP)
- Oral surgeons (DDS/DMD)
- Chiropractors (DC)
- Osteopaths (DO)
- Podiatrists (DPM)
- Mid-level practitioners (non-physicians)
- Acupuncturist

Recredentialing for Practitioners

The plan's credentialing program establishes criteria for evaluating continuing participating practitioners. This evaluation, which includes applicable primary source verifications, is conducted in accordance with the health plan, state and federal regulatory requirements and accrediting entity standards. Practitioners are subject to recredentialing within 36 months. Only licensed, qualified practitioners meeting and maintaining the standards for participation requirements are retained in the network.

Practitioners due for recredentialing must complete all items on an approved plan application and supply supporting documentation, if required. Documentation includes, but is not limited to:

- Current state medical license.
- Attestation to the ability to provide care to members without restriction.
- Valid, unencumbered Drug Enforcement Agency (DEA) certificate or Chemical Dependency Services (CDS) certificate, if applicable. A practitioner who maintains professional practices in more than one state must obtain a DEA certificate for each state.
- Evidence of active admitting privileges in good standing, with no reduction, limitation or restriction on privileges, with at least one participating hospital or surgery center, or a documented coverage arrangement with a credentialed or participating practitioner of a like specialty.
- Malpractice insurance coverage that meets these standards: Individual providers one million/three million and for organizational providers three million/ten million.
- Trended assessment of practitioner's member complaints, quality of care, and performance indicators.

Standards of Participation

All practitioners participating in the plan's network must comply with the following standards for participation in order to receive or maintain credentialing.

Applicants seeking credentialing and practitioners due for recredentialing must complete all items on an approved credentialing application and supply supporting documentation, if required. The verification time limit for a plan approved application is 180 days. Applications are available at the Council of Affordable Quality Healthcare (CAQH) website at www.caqh.org for the Universal Credentialing DataSource link. Supporting documentation includes:

- Current, unencumbered state medical license.
- Valid, unencumbered Drug Enforcement Agency (DEA) certificate, as applicable or Chemical Dependency Services (CDS) certificate, as applicable. The DEA and/or CDS registration must be issued in the state(s) in which the practitioner is contracting to provide care to the members.
- Continuous work history for the previous five years with a written explanation of any gaps of a prescribed time frame (initial credentialing only).
- Evidence of adequate education and training for the services the practitioner is contracting to provide.
- Evidence of active admitting privileges in good standing, with no reduction, limitation, or restriction on privileges, with at least one participating hospital or surgery center, contracted hospitalist group or a documented coverage arrangement with a credentialed, participating practitioner of a like specialty.
- Malpractice insurance coverage that meets these standards: Individual providers one million/three million and for organizational providers three million/ten million.
- The practitioner will answer all confidential questions and provide explanations in writing for any questions answered adversely.

Additionally, the practitioner must be absent from:

- The Medicare Opt-Out Report if treating members under the Medicare lines of business.
- The Medicare/Medicaid Cumulative Sanction Report if treating members under the Medicare lines of business.
- The Federal Employee Health Benefits Program Debarment Report if treating federal members.
- The Excluded Parties List System (EPLS) EEDP through the System for Award Management (SAM) Report.
- The Medi-Cal Suspended and Ineligible Provider listing.

Terminated Contracts and Reassignment of Members

The plan notifies members as required by state law if a practitioner's contract participation status is terminated. The plan oversees reassignment of these members to another participating provider where appropriate.

Denial Notification

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

This section contains general information for claims and service denials.

Select any subject below:

- Service Denial Templates
- Member Denial Letter Templates
- Required Elements for Provider Notification Letters
- Requirements for Notification of Utilization Management Decisions

Service Denial Templates

Provider Type: Participating Physician Groups (PPG) | Hospitals

Delegated participating physician groups (PPGs) and hospitals are required to notify a member in writing when a service is denied.

Service denial letters must specify:

- Letter date
- Member name
- Provider name
- Specific service

- Date of service for concurrent review, if applicable
- Reason for the denial - Service denials for members must include a denial message; refer to the Industry Collaboration Effort (ICE) website at www.iceforhealth.org/home.asp to download the Commercial Pre-Service Denial Reasons Matrix Guidelines and other templates
- Appeals process and information
- Health Net department name, address, and telephone number for appeals
- The Department of Managed Health Care (DMHC) Required Statement for language and telephone number

Health Net encourages PPGs and hospitals to use the standardized ICE-approved HMO service denial letter templates. Refer to the ICE to view the following templates located under Approved ICE Documents:

- Commercial Service Denial Notice
- Commercial Delay Needed - Additional Information
- Notice of Non-Coverage - Termination of Services
- Acknowledgment of Receipt - Refusal to Sign
- Refusal to Transfer
- SNF Exhaustion of Benefits
- SNF Reinstatement Letter
- Carve-Out Situations

Letters to Members

Communications regarding decisions to approve prior authorization requests must state the specific health care service approved.

Member notification letters indicating a denial, delay or modification of service must include:

- A clear and concise explanation of the reasons for the decision specific to medical necessity, benefit coverage or eligibility
- A description of the criteria or guidelines used
- The clinical reasons for any decisions regarding medical necessity
- Information on filing a grievance (or appeal)

PPG medical directors are encouraged to cite the language from the Evidence of Coverage (EOC) text models, including the specific service provision and the definition of medical necessity, in the denial of service notification to the member. Denials based on any determinant of medical necessity require further substantiation by medical literature, utilization management (UM) criteria set (such as Milliman and Robertson or Interqual), or other reputable evidenced-based criteria.

Providers are encouraged to use the approved ICE Commercial Service Denial Notice template when sending service denial notices to their members; refer to the ICE website to view the template located under Approved ICE Documents.

Refer to the DMHC Required Statement for additional requirements.

DMHC-Required Statement on Written Correspondence

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The Department of Managed Health Care (DMHC) maintains a program to assist consumers with resolution of complaints involving HMOs. The DMHC requires that all written correspondence that could result in a member appeal or grievance, including claim denial letters, contain the following statement with the department's phone numbers, the department's TDD line, the department's Internet address, and the plan's phone number in 12-point boldface type in the following regular type statement:

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(insert health plan's telephone number)** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

The applicable Member Services Department telephone number for each line of business should also be included.

Member Denial Letter Templates

Provider Type: Participating Physician Groups (PPG)

For utilization management (UM) and claims-delegated participating physician groups (PPGs), Health Net-specific Language Assistance Program (LAP) notices and member denial letter templates are available on the Industry and Collaborative Effort (ICE) website at www.iceforhealth.org/library.asp located under Approved ICE Documents.

Required Elements for Provider Notification Letters

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG)

Communications regarding decisions to approve requests must state the specific health care service approved.

Provider notification letters indicating a denial, delay or modification of service must include:

- A clear and concise explanation of the reasons for the decision
- A description of the criteria or guidelines used
- The clinical reasons for the decisions regarding medical necessity
- Information on filing a grievance (or appeal)
- The name and direct telephone number (or extension) of the physician or otherwise qualified and licensed health care professional (such as a PharmD) responsible for the decision

In the case of a denial, the referring provider must be given an opportunity to discuss the denial with the physician who made the denial decision. Refer to the Industry Collaboration Effort (ICE) website at www.iceforhealth.org/home.asp to view the Denial File Fax Back template located under Approved ICE Documents. An expedient method for this purpose is to complete a Denial File Fax-Back Sample, including the name and telephone number of the physician who denied the service when faxing back the denial information.

Requirements for Notification of Utilization Management Decisions

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG)

Health Net and its participating physician groups (PPGs) to which utilization management (UM) functions have been delegated are required to comply with timeliness standards for UM decisions and notifications. Health Net has adopted the timeliness standards approved by the Industry Collaboration Effort (ICE) and the National Committee for Quality Assurance (NCQA).

For current standards, refer to the ICE website at www.iceforhealth.org/home.asp to locate the Approved ICE Documents for the commercial and Medi-Cal ICE UM Timeliness Standards.

Eligibility

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains information on eligibility requirements and how to determine eligibility for members.

Select any subject below:

Extension of Benefits

Provider Type: Participating Physician Groups (PPG) | Hospitals

When a totally disabled member loses coverage because the group agreement between Health Net and the employer group has terminated, California laws require group health plans (HMOs) and group policy underwriters (PPOs) to extend coverage, but only for services directly related to the disabling condition. Application for the extension of benefits must be submitted by the member and certification of the disabling condition completed within 90 days following the date the group agreement terminated. The request for extension of benefits must include written certification by the member's participating physician group (PPG) that the member is totally disabled.

If benefits are extended because of total disability, the member must provide Health Net with proof of total disability at least once every 90 days during the extension, before the end of the 90-day period.

The extension of benefits ends on the earliest of any of the following dates:

- On the date the member is no longer totally disabled
- On the date the member becomes covered by a replacement health policy or plan obtained by the group and this coverage has no limitation for the disabling condition
- On the date that available benefits are exhausted
- On the last day of the 12-month period following the date the extension began

Refer to the member's Evidence of Coverage (EOC) or Certificate of Insurance (COI) for additional information, or contact the Health Net Provider Services Center.

Provider Responsibility for Verifying Eligibility for On-Exchange IFP Members in Delinquent Premium Grace Period

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

It is imperative that providers verify benefits, eligibility and cost shares each time a member is scheduled to receive services. Presentation of a member identification (ID) card is not a guarantee of eligibility. Providers must always verify eligibility on the same day services are required.

To verify eligibility providers can utilize the Health Net provider portal.

PREMIUM GRACE PERIOD FOR MEMBERS RECEIVING FEDERAL ADVANCE PREMIUM TAX CREDITS AND/OR CALIFORNIA PREMIUM SUBSIDIES

Provisions of the Affordable Care Act and California law require that Health Net allow members receiving federal Advance Premium Tax Credits (APTCs) and/or California premium subsidies a three-month grace period to pay premiums before coverage is terminated.

- Members receiving federal APTCs and/or California premium subsidies will have a federally mandated grace period of three months in which to make payment for their portion of the premium.
    - Premiums are billed and paid at the subscriber level; therefore, the grace period is applied at the subscriber level.
    - All members associated with the subscriber will inherit the enrollment status of the subscriber.
    - When providers are verifying eligibility through the secure provider portal during the first month of nonpayment of premium, the provider will receive a message that the member is active but delinquent due to nonpayment of premium. However, claims may be submitted and Health Net will pay for covered services rendered during the first month of the grace period.
    - During months two and three of the grace period, the member's eligibility status is suspended, and claims will be pended. The EX code on the explanation of payment will state: "LZ - Pend: Non-Payment of Premium."
    - Coverage will remain in force during the grace period.
    - If payment of all premiums due is not received from the member by the end of the three-month grace period, the member's policy will automatically terminate to the last day of the first month of the grace period.
    - The member will be financially responsible for the cost of covered services received during the second and third months of the grace period, as well as any unpaid premium.
    - In no event shall coverage extend beyond the date the member policy terminates.

BILLING FOR COVERED SERVICES TO MEMBERS IN SUSPENDED STATUS DURING MONTHS TWO AND THREE

For members whose eligibility is in a suspended status and seeking services from providers:

1. Providers may advise the member that providers are not obligated under their Health Net contract to provide services while the member's eligibility is in suspended status. (Status must be verified through the Health Net secure provider portal or by calling Provider Services. Providers should follow their internal policies and procedures regarding this situation.)
2. Should a provider make the decision to render services, the provider may require payment from the member. Providers may submit a claim to Health Net as well, but the claim will be contested and only paid if the member's eligibility status is returned to active status after all overdue premiums are paid in full.
3. If the member subsequently pays his or her premium and is removed from a suspended status, claims will be adjudicated by Health Net. The provider is then responsible for reconciling any payment received from the member and the payment received from Health Net. The provider may then bill the member for an underpayment or return any overpayment to the member.

4. If the member does not pay his or her premiums in full by the end of the three-month grace period and Health Net plan coverage is terminated, providers may bill the member for the full billed charges.

Verifying Eligibility for IFP Members

Providers are responsible for verifying benefits, eligibility and cost shares each time a member is scheduled to receive services. Presentation of a member identification (ID) card is not a guarantee of eligibility. Providers must always verify eligibility on the same day services are required. Member eligibility can be verified on the provider portal. For more information download Save Time Navigating the Provider Portal booklet.

When viewing eligibility of IFP members on the secure portal, providers will see a status message (PDF).

If the member's information is not found online, contact the applicable Health Net Provider Services Center.

Steps to Determine Eligibility

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains information on verifying and determining member eligibility.

Select any subject below:

- Eligibility Verification Methods

Eligibility Verification Methods

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

When an individual seeks medical attention from a participating physician group (PPG), hospital or other provider, the provider must attempt to determine eligibility with Health Net before providing care.

Member eligibility is verified at the time that the identification (ID) card is issued; however, possession of the card does not guarantee eligibility. In cases where a member has lost an ID card or where eligibility may be in question, eligibility can be verified as follows:

Eligibility Reports (applies to capitated PPGs and hospitals). Refer to Use Eligibility Report to Verify Member Information in the Monthly Eligibility Reports section for more information.

- Online: Download the Save Time Navigating the Provider Portal (PDF) booklet for step-by-step instructions.
- The interactive voice response (IVR) system for employer group EPO, HMO, HSP and PPO members to obtain information on member eligibility, copayment and claims status.

- Refer to the IVRs available for Covered California and Individual Family Plan (IFP) members to obtain information on member eligibility, copayments and claims status.
- Eligibility verification via the provider's clearinghouse. Health Net is a Phase I- and Phase II-certified entity with the Council for Affordable and Quality Healthcare (CAQH) Committee on Operating Rules (CORE) for eligibility responses. Providers must contact their vendor/ clearinghouse to submit transactions via this method using an EDI transaction or clearinghouse product.

Grace Period - Suspended Eligibility Status

A member's eligibility status may indicate that eligibility is suspended. Members who qualify for advanced premium tax credits (APTC) to subsidize his or her purchase of a health benefit plan through the Covered California marketplace are allowed an extended premium payment grace period of three months before the member's coverage is terminated. Refer to Premium Payment Grace Period for Beneficiaries Qualifying for APTC for additional information on member, provider and Health Net's rights when the member's eligibility is in suspended status during the first, second, or third month of the grace period.

Monthly Eligibility Reports

Provider Type: Participating Physician Groups (PPG) | Hospitals

Activity Analysis Report

Each month, capitated participating physician groups (PPGs) and hospitals receive an Activity Analysis Report along with the Eligibility Report. This report identifies and summarizes membership activity. It lists additions, deletions, transfers in and out of PPGs and hospitals, reinstatements, contract type changes, and plan type changes. PPGs and hospitals use this report to note new members and monitor retroactive cancellations. If a member is deleted retroactively from the Activity Analysis Report, the PPG and hospital pull the member's chart to verify whether he or she received any services. If services were provided during the time the member was determined ineligible, the PPG and hospital follow procedures for eligibility guarantee.

Use Eligibility Report to Verify Member Information

Health Net provides each capitated participating physician group (PPG) and capitated hospital with a monthly Eligibility Report listing eligible members enrolled with the PPG and capitated to the hospital per applicable PPG affiliation for the calendar month. The Eligibility Report is organized alphabetically and is sorted by member last name. The following information appears in the report:

- Member code
- Subscriber identification (ID) number
- Group number
- Contract type

- Copayment information for office visits, emergency room service and durable medical equipment (DME)
- Plan code
- Birth date
- Provider effective date
- Provider cancel date
- Physician ID number
- Coordination of benefits (COB) information

When a member requests medical services, the Eligibility Report or Health Net's eligibility verification methods are consulted by the provider to check eligibility before providing services. Because Eligibility Report lists canceled members on active contracts and canceled contracts for one month following cancellation, it is vital that the provider cancel date is reviewed on the report prior to assuming Health Net eligibility.

Premium Payment Grace Period for Beneficiary Qualifying for APTC

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Beneficiaries who qualify for the advanced premium tax credit (APTC) subsidy used to purchase a health benefit plan through the Covered California marketplace are allowed a premium payment grace period for delinquent premiums for three months before Health Net can disenroll the beneficiary. This grace period does not apply to marketplace beneficiaries who do not receive the APTC.

Overview

During the first month of premium delinquency, Health Net reimburses providers for covered services delivered to APTC beneficiaries, in accordance with standard benefit guidelines.

Starting with the first day of the second month of delinquency, the beneficiary's eligibility reflects a suspended coverage status when a provider verifies eligibility prior to rendering services.

The suspended coverage status remains throughout the second and third month of the grace period unless the beneficiary pays his or her outstanding premium in full. If the premium remains unpaid at the end of the grace period, the beneficiary is disenrolled from the Health Net plan effective the last day of the first month of the grace period.

Claims Submission and Processing

If a provider delivers covered services during the first month of the grace period, Health Net processes the claim for payment in accordance with standard benefit guidelines. Prior to delivering care to a beneficiary, providers must verify the beneficiary's active eligibility status with Health Net. Starting with the second month of the grace period, if a provider delivers covered services to a beneficiary in suspended coverage status, Health Net contests the claims, as the beneficiary is not considered eligible. If the beneficiary pays delinquent

premiums in full before the end of the grace period, Health Net processes these claims for payment. If the beneficiary does not pay delinquent premiums in full by the end of the grace period, Health Net denies these claims due to the beneficiary's ineligibility.

Provider Notification

Health Net participating providers who have submitted claims in the two months prior to a beneficiary entering the second month of the grace period receive notification from Health Net of the beneficiary's transition to suspended coverage status. Additionally, for beneficiaries enrolled in a Ambette HMO, the beneficiary's primary care physician (PCP) and affiliated participating physician group (PPG), if any, receive a notification of suspended coverage status. Health Net mails providers a notice of contested claims upon initial contesting, as well as 30 days after, if the beneficiary is still in the grace period. Upon the beneficiary's payment of all outstanding premiums that results in his or her reinstatement of eligibility, or upon expiration of the grace period that results in the beneficiary's termination as of the last day of the first month of the grace period, Health Net processes these claims accordingly.

Providers are under no contractual obligation to provide services during the suspended coverage period and may require patients to pay for care directly or agree to a payment guarantee in the event they eventually disenroll at the end of the grace period.

Emergency Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information on emergency care services.

Select any subject below:

- Overview
- Additional Monitoring Responsibilities
- Instructions to Members Regarding Authorization
- Out-of-Area Emergency or Urgently Needed Care

Overview

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals

Emergency care is covered for acute illness, new injuries or an unforeseen deterioration or complication of an existing illness, injury or condition already known to the person or that a reasonable person with an average knowledge of health and medicine would seek if he or she was having serious symptoms (including symptoms of severe mental illness and serious emotional disturbances of a child), and believes that without immediate treatment, any of the following would occur:

- His or her health would be put in serious danger (and in the case of a pregnant woman, would put the health of her unborn child in serious danger)
- His or her bodily functions, organs or parts would become seriously impaired
- His or her bodily organs or parts would seriously dysfunction

Emergency care also includes:

- Treatment of severe pain or active labor. Active labor means labor at the time that either of the following would occur:
  - There is inadequate time to effectively transfer safely to another hospital prior to delivery
  - A transfer poses a threat to the health and safety of the covered person or unborn child
- Ambulance and ambulance transport services provided through the 911 emergency response system, if the request was made for emergency care
- Additional screening, examination and evaluation by a physician (or other health care provider acting within the scope of his or her license) to determine if a psychiatric emergency medical condition exists, and the care and treatment are necessary to relieve or eliminate such condition, within the capability of the facility
- Treatment of shortness of breath and/or bleeding

Health Net makes final determinations about emergency care.

Additional Monitoring Responsibilities

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG)

When a participating primary care physician (PCP) is contacted by an out-of-area provider to determine benefit coverage for a Health Net member, the participating PCP must:

- Verify that the member has Health Net coverage.
- Verify that the member receives health care services from the PCP.
- Inform the out-of-area provider that Health Net only covers out-of-area emergency admissions (less any applicable copayments or deductibles).
- Provide any follow-up care or obtain out-of-area authorization from Health Net.

The out-of-area provider or PCP is responsible for notifying the Hospital Notification Unit of all out-of-area emergency hospitalizations. The Medical Management Department monitors the out-of-area emergency hospital care, conducts concurrent review and determines whether the member can be transferred safely into the service area.

Claims are retrospectively reviewed to determine medical necessity and eligibility for payment of out-of-area services.

Instructions to Members Regarding Authorization

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals

According to the Evidence of Coverage (EOC) or Certificate of Insurance (COI), members are required to adhere to the following instructions regarding emergency services and urgently needed care:

- Emergency services do not require prior authorization; however, the member is required to notify their participating physician group (PPG), primary care physician (PCP) or Health Net as soon as possible so that follow-up care can be coordinated.
- Hospitals are responsible for notifying Health Net of the admission of a Health Net member.
- PPGs and PCPs are available 24 hours a day, seven days a week, to respond to member telephone calls regarding medical care that the member believes is needed immediately. The member's PPG or PCP should evaluate the member's situation and recommend where the member should obtain emergency or urgent care.

Out-of-Area Emergency or Urgently Needed Care

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

For information on out-of-area emergency or urgently needed care, refer to the Emergency Services, Coverage Explanation section.

Encounters

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

This section contains general information about encounter data submission.

Select any subject below:

- Overview
- Lien Recoveries

Overview

Provider Type: Participating Physician Groups (PPG) | Ancillary | Hospitals

To comply with the requirements of the Department of Health and Human Services (DHHS), the Centers for Medicare & Medicaid Services (CMS), the California Department of Health Care Services (DHCS), the California Disproportionate Share Hospital (DSH) Program, the Managed Risk Medical Insurance Board (MRMIB), and the National Committee for Quality Assurance (NCQA), Health Net requires information from its providers on members' use of health services.

Capitated participating physician groups (PPGs), hospitals and ancillary providers are required to provide complete encounter data about professional services rendered to Health Net members. These services include office visits; X-rays; laboratory tests; surgical procedures; anesthesia; physician visits to the hospital; inpatient, outpatient, emergency room, out-of-area, or skilled nursing facility (SNF) services; and all professional referral services. Capitated participating facilities (and physician groups with dual-risk contracts) are required to provide encounter data no less than monthly about institutionally-based services rendered to Health Net members.

Encounter data submissions must include all member-paid cost-share amounts, such as copayments, coinsurance and deductibles, applicable to the member's benefit. In addition, any rejected encounter data must be corrected and resubmitted in order for complete information and correct member-paid cost-share amounts to be captured and accumulated. Encounter data submission is also an integral part of the Health Net Quality of Care Improvement Program (QCIP) (applicable only for HMO and Point of Service (POS) products) and Healthcare Effectiveness Data and Information Set (HEDIS®). Refer to the Quality Improvement (QI) topic for more information about QCIP.

Lien Recoveries

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Some hospitals assume the responsibility for collecting third-party recoveries through their contract with Health Net. The hospital may have its own lien right independent of the contractual lien described in Health Net's Evidence of Coverage (EOC) or Certificate of Insurance (COI), in which case the hospital asserts its own lien. It is the participating provider's staff responsibility to coordinate assertion of liens with the hospital and Health Net to avoid duplication or confusion. In the assertion of any lien, the hospital and the participating providers staffs must be clear about the nature and basis of the third-party recovery right they are asserting and any limitations on the lien under the law.

Member Cooperation

If the member refuses to honor the obligation to sign and return the lien form and declines to reimburse Health Net and the participating provider after settling with the third party, the participating provider should not delay or deny providing services or reimbursing the member's claims.

Enrollment

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information and procedures regarding member enrollment.

Select any subject below:

Subscriber and Member Identification Numbers

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The plan develops unique identification (ID) numbers for all subscribers. The group subscriber ID number is formatted as an alphanumeric code, beginning with the letter "R" followed by eight digits. The individual Medicare subscriber ID number is formatted as an alphanumeric code, beginning with the letter "C" followed by eight digits.

With the exception of Medicare members, individual members of a subscriber's household are assigned the same subscriber ID number as the subscriber and a unique member code identifying the relationship of the member to the subscriber. Medicare members have one enrollee per subscriber ID number.

In compliance with California law (SB 168 (ch. 720, 2001)), the subscriber ID number replaces the member's Social Security number (SSN) on most member-oriented materials and communications, including member ID cards.

Provider-oriented materials, including eligibility reports and other health plan correspondence, include both the subscriber's ID number and SSN for identification purposes. The plan also continues to use SSNs for internal verification and administration purposes as allowed by law.

Use of Social Security Numbers

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The plan has implemented the use of alternate identification (ID) numbers for all members to replace the member's Social Security number (SSN) as the subscriber or member ID number on most member-oriented materials and communications, including member ID cards.

The purpose of this change is to comply with SB 168 (ch. 720, 2001), which prohibits any person or agency (excluding state or local agencies) from any of the following:

- Publicly posting or displaying an individual's SSN.
- Printing a member's SSN on any card needed to access products or services, such as a member ID card.
- Requiring members to transmit their SSNs over the Internet unless the connection is secure or the SSN is encrypted.
- Requiring members to use their SSNs to access a website, unless a password or unique ID number is also required to access the website.
- Printing a member's SSN on any materials that are mailed to the member, unless required by state or federal law.

Exceptions established by SB 1730 (ch 786, 2002) include applications, forms and other documents sent by mail for the following:

- As part of an application or enrollment process.
- To establish, amend or terminate an account, contract or policy.
- To confirm the accuracy of the SSN.

These exceptions are subject to restrictions established by AB 763 (ch. 532, 2003), which prohibits the printing of the SSN, in whole or in part, on a postcard or any other type of mailer that does not require an envelope and allows the SSN to be visible without opening the mailer.

Provider-oriented materials, including eligibility reports and other health plan correspondence, includes both the member's alternate ID number and SSN for identification purposes. The plan also continues to use SSNs for internal verification and administration purposes as allowed by law.

Participating providers are subject to the same regulations.

Refer to the discussion of subscriber/member ID numbers under the Enrollment topic for more information on ID number format.

ID Cards

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information about member identification (ID) cards for Health Net plans, as well as sample ID cards.

Select any subject below:

- Member ID Card

Member ID Card

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

A new identification (ID) card is automatically sent when:

- A new member enrolls
- A member changes his or her name, physician or medical group
- A dependent is added or deleted from the policy
- The medical plan is changed

Refer to the following samples to view a picture and descriptions of the informational fields on Health Net member ID card:

- Identification card (Primary EPO) (PDF)

These are sample ID cards only. The information included in them is subject to change. Providers should refer to a member's ID card when they present for services for current benefit and health plan information.

Medical Records

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Participating providers are required to maintain member medical records in a manner that is current, detailed, complete, and organized. In addition, medical records must reflect all aspects of member care, be readily available to health care providers and provide data for statistical and quality-of-care analysis. Health Net and its participating providers must maintain active books, records, documents, and other evidence of accounting procedures and practices for 10 years. An active book, record or document is one related to current, ongoing or in-process activities and referred to on a regular basis to respond to day-to-day operational requirements.

The following retention events must also be considered in reference to the required timeframes in which medical records must be maintained by providers. These retention requirements are based on Health Net's current Corporate Records Retention Schedule:

- Pediatric medical records must be maintained for seven years after age 21
- Hospitals, acute psychiatric hospitals, skilled nursing facilities (SNFs), primary care clinics, and psychology and psychiatric clinics must maintain medical records and exposed X-rays for a minimum of seven years following patient discharge, except for minors
- Records of minors must be maintained for at least one year after a minor has reached age 18, but in no event for less than seven years

Health Net must ensure maintenance of all records and documentation (including medical records) necessary to verify information and reports required by statute, regulation or contractual obligation for five years from the end of the fiscal year in which Health Net's contract expires or is terminated with a member.

Standards for the administration of medical records by participating providers are established by the Health Net Quality Improvement Committee (HNQIC). The standards form the basis for the evaluation of medical records by Health Net. Medical records for primary care physicians (PCPs) may be selected for evaluation as part of the annual delegation oversight assessment.

Health Net requires participating providers to have a written policy in place that provides for the protection of confidential protected health information (PHI) in accordance with the Health Insurance Portability and Accountability Act (HIPAA). The policy must be kept in hard copy or electronic format and must include a functioning mechanism designed to safeguard medical records and information against loss, destruction, tampering, unauthorized access or use, and verbal discussions about member information to maintain confidentiality.

Provision of Medical Records

Participating physician groups (PPGs), physicians, hospitals and ancillary providers are required to provide Health Net with copies of medical records and accounting and administrative books and records, as they pertain to the Provider Participation Agreement (PPA).

The provider has financial responsibility to provide copies of medical records so that Health Net can make claims and benefit determinations for Health Net utilization management, quality improvement, Healthcare Effectiveness Data and Information Set (HEDIS®), and appeals and grievance programs.

Medical records may be required for regulatory reviews by the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), National Committee for Quality Assurance (NCQA), Independent Quality Review and Improvement Organization (QIO), and other regulatory bodies.

Right to Audit and Access Records, including Electronic Medical Records (EMR)

Access to Records and Audits by Health Plan

Subject only to applicable state and federal confidentiality or privacy laws, the provider must share records when Health Net or its designated representative requests access to them in order to audit, inspect, review, perform chart reviews, and duplicate such records.

For on-Exchange plans and Medicare line of business, if performed onsite, access to records for the purpose of an audit must be scheduled at mutually agreed upon times, upon at least 30 business days prior written notice by the health plan or its designated representative, but not more than 60 days following such written notice.

For Medi-Cal and Cal MediConnect, if performed onsite, access to records for the purpose of an audit must be scheduled at mutually agreed upon times, upon at least 30 business days prior written notice by Health Net or its designated representative, but not more than 60 days following such written notice. However, access to records and audits that are part of a facility site review audit, grievance visit or potential quality issue (PQI) visit can be unannounced.

EMR Access

When Health Net requests access to electronic medical records (EMR), the provider will grant the health plan access to the provider's EMR in order to effectively case manage members and capture medical record data for risk adjustment and quality reporting. There will be no other fees charged to the health plan for this access.

Written Protocols

Participating providers are required to have systems and procedures in place that provide consistent, confidential and comprehensive record-keeping practices. Written procedures must be available upon Health Net's request for:

- Confidentiality of patient information - Policy and procedure must address the protection of confidential protected health information (PHI) of the patient in accordance with the Health Information Portability and Accountability Act (HIPAA). The policy must include a written or electronic functioning mechanism designed to safeguard records and information against loss, destruction, tampering, unauthorized access or use, and additional safeguards to maintain confidentiality during verbal discussions about patient information. Information about written, electronic and verbal privacy, periodic staff training regarding confidentiality of PHI, and securely stored records that are inaccessible to unauthorized individuals must also be included
- Release of medical records and information, including faxes
- Medical record organization standards - Policy and procedure must include information about individual medical records; securely fastened medical records; medical records with member identification on each individual page; and a consistent area in the medical record designated for the member's history, allergies, problem list, medication list, preventive care, immunizations, progress notes, therapeutic, diagnostic operative, and specialty physician reports, discharge summaries, and home health information
- Filing system for records (electronic or hardcopy)
- Formal system for the availability and retrieval of medical records - Policy and procedure must allow for the ease of accessibility to medical records for scheduled member encounters within the facility or in an approved health record storage facility off the facility premises
- Filing of partial medical records - Policy and procedure must outline the process for filing partial medical records offsite, including a process that alerts authorized staff regarding the offsite filing of the partial record
- Retention of medical records in accordance with state laws and regulations (for providers who see commercial health plan patients)
- Retention of medical records in accordance with federal laws and regulations (for providers who accept Medicare patients)
- Preventive care guidelines for pediatric and adult members
- Referrals to specialists
- Accessibility of consultations, diagnostic tests, therapeutic service and operative reports, and discharge summaries to health care providers in a timely manner
- Inactive medical records - Policy and procedure must include guidelines that describe how and when a medical record becomes inactive. Member medical records may be converted to microfilm or computer disks for long-term storage. Every provider of health care services who creates, maintains, preserves, stores, abandons, or destroys medical records shall do so in a manner that preserves the confidentiality of member information

Provision of Medical Records (CalViva Health)

Participating physician groups (PPGs), physicians, hospitals, and ancillary providers are required to provide Health Net and CalViva Health with copies of medical records and accounting and administrative books and records, as they pertain to the Provider Participation Agreement (PPA).

The provider has financial responsibility to provide copies of medical records so that Health Net and CalViva Health can make claims and benefit determinations for utilization management, quality improvement, Healthcare Effectiveness Data and Information Set (HEDIS®), and appeals and grievance programs.

Medical records may be required for regulatory reviews by the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), National Committee for Quality Assurance (NCQA), Independent Quality Review and Improvement Organization (QIO), and other regulatory bodies.

Right to Audit and Access Records, including Electronic Medical Records (EMR)

Access to Records and Audits by Health Plan

Subject only to applicable state and federal confidentiality or privacy laws, the provider must share records when the health plan or its designated representative requests access to them, in order to audit, inspect, review, perform chart reviews, and duplicate such records.

If performed onsite, access to records for the purpose of an audit must be scheduled at mutually agreed upon times, upon at least 30 business days prior written notice by the health plan or its designated representative, but not more than 60 days following such written notice. However, access to records and audits that are part of a facility site review audit, grievance visit or potential quality issue (PQI) visit can be unannounced.

EMR Access

When the health plan requests access to electronic medical records (EMR), the provider will grant the health plan access to the provider's EMR in order to effectively case manage members and capture medical record data for risk adjustment and quality reporting. There will be no other fees charged to the health plan for this access.

For more information, select any subject below:

- Confidentiality of Medical Records
- Medical Record Documentation
- Medical Record Forms and Aids

Confidentiality of Medical Records

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Members are entitled to confidential treatment of member communications and records. Case discussion, consultation, examination, claims and treatment are confidential and must be conducted discreetly. A provider shall permit a patient to request, and shall accommodate requests for, confidential communication in the form and format requested by the patient, if it is readily producible in the requested form and format, or at alternative

locations. The confidential communication request shall apply to all communications that disclose medical information or provider name and address related to receipt of medical services by the individual requesting the confidential communication. Written authorization from the member or authorized legal representative must be obtained before medical records are released to anyone not directly concerned with the member's care, except as permitted or as necessary for administration by the health plan.

Health Net requires participating providers to have a written policy in place that provides for the protection of confidential protected health information (PHI) in accordance with the Health Insurance Portability and Accountability Act (HIPAA). The policy must be kept in hard copy or electronic format and must include a functioning mechanism designed to safeguard records and information against loss, destruction, tampering, unauthorized access or use, and verbal discussions about member information to maintain confidentiality.

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

PHI is considered confidential and encompasses any individual health information, including demographic information collected from a member, which is created or received by Health Net and relates to the past, present or future physical, mental health or condition of a member; the provision of health care to a member; or the past, present or future payment for the provision of health care to a member; and that identifies the member or there is a reasonable basis to believe the information may be used to identify the member. Particular care must be taken, as confidential PHI may be disclosed intentionally or unintentionally through many means, such as conversation, computer screen data, faxes, or forms. Disclosure of PHI must have prior, written member authorization.

Confidentiality of Medical Information

Sensitive services are defined as all health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, and includes services described in Sections 6924-6930 of the Family Code, and Sections 121020 and 124260 of the California Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the services.

Assembly Bill 1184 (2021), amends the Confidentiality of Medical Information Act to require health care plans to take additional steps to protect the confidentiality of a subscriber’s or enrollee’s medical information regardless of whether there is a situation involving sensitive services or a situation in which disclosure would endanger the individual.

These steps include:

- A protected individual (member) is not required to obtain the primary subscriber or other enrollee’s authorization to receive sensitive services or to submit a claim for sensitive services if the member has the right to consent to care.
- Not disclose a member’s medical information related to sensitive health care services to the primary subscriber or other enrollees, unless the member’s authorization is present.
- Notify the subscriber and enrollees that they may request confidential communications and how to make the request. This information must be provided to “enrollees” at initial enrollment and annually.
- Respond to confidential communications requests within:
    - 7 calendar days of receipt via electronic or phone request or
    - 14 calendar days of receipt by first-class mail

- Communications (written, verbal or electronic) regarding a member's receipt of sensitive services should be directed to the member's designated mailing address, email address, or phone number. For protected individuals who may not have designated an alternative mailing address, the provider and/or Plan is required to send the communications to the address or phone number on file in the name of the protected individual.
- Confidential communication includes:
  - Bills and attempts to collect payment.
  - A notice of adverse benefits determinations.
  - An explanation of benefits notice.
  - A plan's request for additional information regarding a claim.
  - A notice of a contested claim.
  - The name and address of a provider, description of services provided, and other information related to a visit.
  - Any written, oral, or electronic communication from a plan that contains protected health information.

Agencies Must be Authorized to Receive Medical Records

The relationship and communication between a participating provider and member is privileged and the medical records containing information about the relationship is confidential. The participating provider's code of ethics, as well as California and federal law, protect against the disclosure of the contents of medical records and protected health information (PHI), whether written, oral or electronic, to individuals or agencies that are not properly authorized to receive such information.

REQUIREMENTS FOR A VALID AUTHORIZATION FOR RELEASE OF INFORMATION

Providers must obtain signed authorization from the member to use or disclose the member's medical information. You also need to give instructions to members on how to access additional copies or digital versions of the signed authorization. The signed authorization must:

- Be written in plain language and no smaller than 14-point font.
- Be dated and signed with an electronic or handwritten signature by the member or person authorized to act on behalf of member.
- Specify the type of individuals authorized to disclose information about the member.
- Specify the nature of the information authorized to be disclosed.
- State the name or functions of the persons or entities authorized to receive the information.
- Specify the purposes for which the information is collected.
- Specify the length of time the authorization shall remain valid.
- State an expiration date or event. The expiration date for a valid signature is up to one year unless the person signing the authorization requests a specific date beyond a year, or the authorization is related to an approved clinical trial[1] after which the provider, health care service plan, pharmaceutical company, or contractor is no longer authorized to disclose the medical information.

Basic Principles

Protected health information (PHI) may be shared with participating providers in the same facility only, on a need-to-know basis, and may be disclosed outside the facility only to the extent necessary such release is authorized.

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), PHI, whether it is written, oral or electronic, is protected at all times and in all settings. Disclosure of PHI must have prior written member authorization. Health Net participating providers only release PHI without authorization when:

- Needed for payment
- Necessary for treatment or coordination of care
- Used for health care operations (including, but not limited to, Healthcare Effectiveness Data and Information Set (HEDIS®) reporting, appeals and grievances, utilization management, quality improvement, and disease or care management programs)
- Where permitted or required by law

Health Net and participating providers may transmit PHI to individuals or organizations, such as pharmacy or disease management vendors, who contract to provide covered services to members. PHI cannot be intentionally shared, sold or otherwise used by Health Net, its subsidiaries, participating providers, or affiliates for any purpose other than for payment, treatment or health care operations or where permitted or required by law without an authorization from the member.

AB 715 (ch. 562, 2003) supports compliance with HIPAA and applicable state laws relating to use of PHI for marketing. Marketing is defined as a communication about a product or service that encourages recipients to purchase or use the product or service. Health plans, providers, pharmaceutical benefit managers, and disease management entities are prohibited from using PHI to market a product or service unless the communication meets one of the exceptions described below:

- Written or oral communication whereby the communicator receives no compensation from a third party
- Communications made to a current member solely for the purpose of describing a provider's participation in an existing health care provider network or health plan network to which the member subscribes
- Communications made to a current member solely for the purpose of describing products, services, payment, or benefits for the health plan to which the member subscribes
- Communication to describe a plan benefit or an enhancement or replacement to a benefit
- Communications describing the availability of more cost-effective pharmaceuticals
- Compensation communications tailored to a specific individual that educate or advise them about disease management or life-threatening, chronic or seriously debilitating conditions if:
    - The member receiving the communication is notified in writing that the provider, contractor or health plan has been compensated, and identifies the source of the compensation
    - The communication must include information on how the member can opt out of receiving further communications by calling a toll-free number and must be written in 14 point font or larger. No communication can be made to a member who has opted out after 30 days from the date of the request
- Special authorization is required for uses and disclosures involving sensitive conditions, such as psychotherapy notes, AIDS or substance abuse. To release PHI regarding sensitive conditions, Health Net and participating providers must obtain written authorization from the member (or

authorized representative) stating that information specific to the sensitive condition may be disclosed.

In the event the member is unable to give authorization, Health Net or the participating provider accepts the authorization of the person holding power of attorney or any other authorized representative in order to release information or have access to information about the member. Refer to the Procedure discussion for more information regarding authorized representatives.

Members may obtain their own medical records upon request. Adult members have the right to provide a written addendum to the medical record if the member believes that the record is incomplete or inaccurate. Members may request that their PHI be limited or restricted from disclosure to outside parties or may request the confidential communication of their PHI to an alternate address. Members may file a grievance with respect to any concerns they have regarding confidentiality of data.

Procedure

Participating providers, policies and procedures governing the confidentiality of medical records and the release of protected health information (PHI) must address levels of security of medical records, including the:

- Assurance that the files are secure and not accessible to unauthorized users
- Indication of who has access to the medical records
- Identification of who may execute different database functions for computerized medical records
- Assurance that staff is trained with respect to the Health Insurance Portability and Accountability Act (HIPAA), privacy requirements and related policies
- Signed confidentiality agreements on file from staff who have access to medical records
- Assurance that photocopies or printouts of the medical records are subject to the same control as the original record
- Designation of a person to destroy the medical record when required

Release of medical information guidelines must address:

- Requests for PHI via the telephone
- Demands made by subpoena duces tecum
- Timely transfer of medical records to ensure continuity of care when a Health Net member chooses a new primary care physician (PCP)
- Availability and accessibility of member medical records to Health Net and to state and federal authorities or their delegates involved in assessing quality of care or investigating enrollee grievances or other complaints
- Availability and accessibility of member medical records to the member in a timely manner in accordance with industry standards and best practices
- Requirements for medical record information between providers of care:
    - A physician or licensed behavioral health care provider making a member referral must transmit necessary medical record information to the provider receiving the member referral
    - A physician or licensed behavioral health care provider furnishing a referral service provides appropriate information back to the referring provider
    - A physician or licensed behavioral health care provider requesting information from another treating provider as necessary to provide care. Treating physicians or licensed behavioral health care providers may include those from any organization with which the member may subsequently enroll

An authorization form must be in plain language and contain the following to be HIPAA-compliant:

- A specific and meaningful description of the information to be used or disclosed
- The name of the person or entity authorized to make the requested use or disclosure
- The name of a person or entity to which the use or disclosure may be made
- A description of each purpose or use for the information. If the individual requests the authorization for their own purposes, the description here may read simply "at the request of the individual"
- An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure
- The signature of the individual and the date
- If the personal representative signs for the individual, a description of such representative's authority to act for the individual must be provided
- A statement about the individual's right to revoke the authorization at any time if the revocation is in writing, the exceptions to the revocation right, and a description of how the individual may revoke the authorization. Alternatively, the revocation statement may state the individual's right to revoke and instruct the individual to refer to the covered entity's Notice of Privacy Practices for instructions and limitations on revocation
- A statement that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining the authorization, unless a valid exception applies (such as, pre-enrollment underwriting or information needed for payment of a specific claim for benefits), but the authorization cannot require release of psychotherapy notes for either exception
- The consequences to the individual of a refusal to sign when the plan can condition enrollment in the health plan, eligibility for benefits or payment on failure to obtain such authorization
- A statement that the information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by the privacy rule

Medical Record Documentation

Provider Type: Physicians | Participating Physician Groups (PPG) (does not apply to HSP) | Hospitals | Ancillary

The Health Net Quality Improvement Committee (HNQIC) develops standards for the administration and evaluation of medical records. Participating providers are required to comply with all medical record documentation standards.

Health Net requires participating providers to maintain medical records in a manner that is accurate, current, detailed, complete, organized, in accordance with industry standards and best practices, and permits effective and confidential member care and quality review. Medical records must reflect all aspects of member care, be readily available to health care providers and provide data for statistical and quality-of-care analysis. Medical records may be selected for evaluation as part of the annual delegation oversight assessment.

For more information, select any subject below:

- Advance Directives
- Medical Record Documentation Standards
- Medical Record Performance Measurements

Advance Directives

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

An “Advance Health Directive” is a legal form that allows the member to designation a representative; a person they want make decisions on their behalf or if loose the capacity to make decisions. Additionally, the member can also name people that they do not want to make decisions on their behalf, if they lose the capability to speak or loose the capacity make decision for themselves. The member can ask a family member or a primary care physician or someone they trust to help fill out the form. Members have certain rights regarding a “Advance Health Directive”: The right to learn about changes to the law regarding Advance Health Directives; The right to have their Advance Health Directive be placed in their medical record; and The right to change or cancel their Advance Health Directive at any time.

Medical Record Documentation Standards

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Participating providers are required to meet Health Net medical record documentation standards. The following documentation guidelines must be followed and all of the elements must be included in the medical records of members.

- Format - The primary language and linguistic service needs of non- or limited-English proficient (LEP) or hearing impaired persons, individual personal biographical information, emergency contact, and identification of the member's assigned primary care physician (PCP)
- Documentation - Medical record entries and corrections must be documented in accordance with acceptable legal medical documentation standards; allergies, chronic problems, and ongoing and continuous medications must be documented in a consistent and prominent location; all signed consent forms and the ofference of advance health care directive information and education to members ages 18 and older must be included
- Routine record keeping - Department of Managed Health Care (DMHC) regulations require that the refusal of interpreter services for a Health Net member must be documented in the medical record. Department of Insurance (CDI) regulations also require that, when a minor, or friend or family member interprets at a member's request, even when a qualified interpreter is offered and available at no charge, the offer and the refusal at each visit it occurs shall be documented in the member's medical record
- Coordination of care - Notation of missed appointments, follow-up care and outreach efforts, practitioner review of diagnostic tests and consultations, history of present illness, progress and resolution of unresolved problems at subsequent visits, and consistent diagnosis and treatment plans
- Preventive care
    - Adult preventive care - Notation of periodic health evaluations according to the United States Preventive Services Task Force (USPSTF); assessment of immunization status and the year of the immunization(s); tuberculosis screenings and testing; blood pressure and cholesterol

screenings; Chlamydia screenings for sexually active females to age 25 or at risk; and mammograms and Pap tests for females
- Pediatric preventive care - Notation of age-appropriate physical exams according to the American Academy of Pediatrics (AAP); immunizations specified and within AAP and Healthcare Effectiveness Data and Information Set (HEDIS®) requirements; anticipatory guidance for age-appropriate levels; vision, hearing, lead, and tuberculosis screenings and testing; and nutrition and dental assessments
- Perinatal preventive care - Notation of prenatal care visits according to the most recent American Congress of Obstetrics and Gynecology (ACOG) standards, including a timely prenatal visit within the first trimester; postpartum visit three to eight weeks after delivery - this interval may be modified according to the needs of teh patient, such as HEDIS timlines of 21-56 days after delivery; domestic violence and abuse screenings; HIV, alpha fetoprotein (AFP) and genetic screenings; and assessments of infant feeding status

Medical Record Performance Measurements

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net monitors medical record documentation through a variety of measures, which includes, but is not limited to, various quality initiatives, data collection by way of primary care physician (PCP) medical record audits, and records collected through the Healthcare Effectiveness Data and Information Set (HEDIS®) process. Data is aggregated and analyzed at least annually. Opportunities for improvement are identified and appropriate interventions are implemented based on compliance levels established for each individual activity. Interventions may include sending providers updates, educational or reference materials, creating template medical record forms, and provider and staff education and training. Participating providers are required to obtain a performance level of at least 80% on the medical record performance measures for a conditional pass.

Medical Record Forms and Aids

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains references and links to a variety of forms and aids for use and reference to help providers meet medical record documentation standards and requirements.

Select any subject below:

- Medical Record Forms and Aids

Medical Record Forms and Aids

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | Ancillary

Health Net has various medical record documentation forms and aids for participating providers.

- Advance Directive Labels (PDF)
- Adult Health Maintenance Checklist with Standards (PDF)
- Annual Care for Older Adults (COA)/Advance Care Planning (ACP) Form (PDF)
- Audiometric Screening form (PDF)
- Chronic Problem List (PDF)
- History Form - English (PDF)
- History Form -Spanish (PDF)
- Initial Health Appointment (IHA) Tickler Log (PDF)
- Language Labels (PDF)
- Medication and Chronic Problem Summary (PDF)
- Message Log (PDF)
- Preventive Care Forms (PDF)
- Referral Log (PDF)
- Signature Page (PDF)

Member Rights and Responsibilities

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information on member rights and responsibilities.

Select any subject below:

- Advance Directives
- Member Rights and Responsibilities

Advance Directives

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Providers should consider discussing advance directives during routine office visits with Health Net members, instead of waiting until a member is acutely ill.

Health Net and its participating providers are required to comply with the PSDA for all new and renewing members. Health Net's policy is that any adult member has the right to make an advance directive concerning health issues. Additionally, in accordance with Title 22 of the California Code of Regulations and 422.128(b)(1)(ii)(E) of the Code of Federal Regulations, providers must document in a prominent place in the member's medical records (adult members only), whether the member has been informed of, or has executed, an advance directive.

An advance directive is a written document signed by a member, such as a durable power of attorney for health care (DPAHC), a declaration pursuant to the Natural Death Act, or a living will that explains the member's wish concerning a given course of medical care should a situation arise where they is unable to make these wishes known. The member may specify guidelines for care or delegate the decision-making authority to a family member, close friend, or other representative.

According to AB 2805 (ch.579, 2006), a written advance health care directive is legally sufficient if all the following requirements are satisfied:

- The advance directive contains the date of its execution
- The advance directive is signed either by the member or in the member's name by another adult in the member's presence and at the member's direction
- The advance directive is either acknowledged before a notary public or signed by at least two witnesses who satisfy the requirements of Sections 4674 and 4675 of the California Probate Code
- If the advance directive is acknowledged before a notary public, and a digital signature is used, the digital signature must meet all of the following requirements:
    - It either meets the requirements of Section 16.5 of the Government Code and Chapter 10 (commencing with Section 22000) of Division 7 of Title 2 of the California Code of Regulations, or the digital signature uses an algorithm approved by the National Institute of Standards and Technology
    - It is unique to the person using it
    - It is capable of verification
    - It is under the sole control of the person using it
    - It is linked to data in such a manner that if the data are changed, the digital signature is invalidated
    - It persists with the document and not by association in separate files
    - It is bound to a digital certificate

For more information, select any subject below:

- Provider Responsibilities and Procedures

Provider Responsibilities and Procedures

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Participating providers must establish procedures ensuring that any advance directive is brought to the attending provider's immediate attention if, in the opinion of that provider, the member is unable to make health care decisions. If any adult Health Net member has such a directive in force, the following must occur:

- Each health care provider must honor advance directives to the fullest extent permitted under California and federal law

- Primary care physicians (PCPs) must be open to any discussion with a member and provide medical advice if the member desires guidance or assistance regarding this matter. Direct inquiries to the regional office or the Health Net Provider Services Center
- In no event may the participating provider refuse to treat a member or otherwise discriminate against a member because the member has completed an advance directive

For additional information on Advance Directive, refer to the member's Evidence of Coverage (EOC).

Member Rights and Responsibilities

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Members have the right to expect a certain level of service from their health care providers. Members are also responsible for cooperating with providers in obtaining health care services. Health Net developed member rights and responsibilities statements in accordance with the National Committee for Quality Assurance (NCQA) and the Centers for Medicare and Medicaid Services (CMS). These member rights and responsibilities apply to member's relationships with Health Net, and all participating providers responsible for member care. In addition to member rights and responsibilities, medical services must be provided in a culturally competent manner without regard to race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, health status, physical or mental handicap, or disability.

Health Net members are notified annually of their rights and responsibilities via the member's Evidence of Coverage (EOC) or Certificate of Insurance (COI) and are listed below for reference. The actual statements of member rights and responsibilities may vary slightly from what is included in the EOC or COI. Health Net members with questions regarding their rights and responsibilities should be directed to their specific member materials.

Members have the right to:

- Receive information about Health Net, its services, its providers and member rights and responsibilities.
- Be treated with respect and recognition of their dignity and right to privacy;
- Participate with providers in making decisions about their health care;
- A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage;
- Use interpreters who are not your family members or friends;
- File a grievance in your preferred language by using the interpreter service or by completing the translated grievance form that is available on www.healthnet.com;
- File a complaint if your language needs are not met;
- Voice complaints or appeals about the organization or the care it provides; and
- Make recommendations regarding the organization's member rights and responsibilities policies.

Members have the responsibility to:

- Supply information (to the extent possible) that the organization and its providers need in order to provide care;
- Follow plans and instructions for care that they have agreed on with their providers;
- Be aware of their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible; and

- Refrain from submitting false, fraudulent, or misleading claims or information to Health Net or your providers.

Prescription Drug Program

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information on the prescription drug program.

Select any subject below:

- Compounded Medications
- Diabetic Supplies
- Exclusions and Limitations
- Generic Medications
- Off-Label Medication Use
- Participating Pharmacy
- Physician Self-Treatment
- Prescription Mail-Order Program
- Prior Authorization Process
- Quantity of Medication to Be Prescribed
- Recommended Drug List and Cal MediConnect Formulary

Exclusions and Limitations

Provider Type: Physicians | Participating Physician Groups (PPG) | Ancillary

The following list of exclusions and limitations (benefits vary by plan) applies to the Health Net prescription drug program:

- Medications prescribed by a non-participating physician are not covered except when the physician's services have been authorized because of a medical emergency, illness or injury, or the physician is the authorized referring physician.
- Allergy serum.
- Appetite suppressants or medications for body weight reduction, unless medically necessary for morbid obesity, require prior authorization.
- Blood.
- Compounded medications - Prescription orders that are combined or manufactured by the pharmacist and placed in an ointment, capsule, tablet, solution, suppository, cream or other form using Food and Drug Administration (FDA)-approved medications, are covered at the Level III copayment. Coverage for compounded medications is subject to prior authorization by the plan and medical necessity. Compounded medications are not covered if there is a similar proprietary product available.
- Devices other than diaphragms.

- Dietary or nutritional supplements - Medications used as dietary or nutritional supplements, including vitamins and herbal remedies, are limited to medications that are listed in the Recommended Drug List (RDL). Phenylketonuria (PKU) is covered under the medical benefit.
- Medications prescribed for cosmetic purposes - Medications that are prescribed for the following non-medical conditions are not covered: hair loss, sexual performance, athletic performance, anti-aging, and mental performance. Examples of medications that are excluded when prescribed for such conditions include, but are not limited to Penlac®, Renova™ , Retin-A®, Vaniqua®, Propecia®, and Lustra.™
- Supply amounts (for any number of days), which exceed the Food and Drug Administration's (FDA's) or Health Net's usage recommendations.
- Hypodermic syringes and needles - Hypodermic syringes and needles are limited to disposable insulin needles and syringes and reusable pen devices.
- Medications prescribed for non-FDA-approved use.
- Medications prescribed for non-covered services.
- Lost, stolen or damaged medications.
- Prescriptions from non-participating pharmacies.
- Non-prescription (over-the-counter) medications, equipment and supplies (except insulin, diabetic supplies and as required under preventive care coverage).
- Oxygen.

Compounded Medications

Provider Type: Physicians | Participating Physician Groups (PPG) | Ancillary

Most Health Net pharmacy benefit plans cover medically necessary and appropriate compounded prescriptions that meet all of the following conditions:

- Includes at least one federal legend medication listed on the Health Net Recommended Drug List (RDL) as one of its main compounded ingredients.
- There is scientific evidence and peer-reviewed literature demonstrating safety and effectiveness for the specific medical condition.
- There is no acceptable proprietary alternative medication.

Diabetic Supplies

Provider Type: Physicians | Participating Physician Groups (PPG) | Ancillary

Health Net covers specific brands of blood glucose meters at no charge and test strips at Tier II of the Recommended Drug List (RDL). The selected brands meet the needs of the majority of members and physicians. The following blood glucose meters and test strips are available with a primary care physician (PCP) prescription at participating pharmacies:

- OneTouch® Verio® IQ meter and test strips

- OneTouch® Ultra® Mini meter
- OneTouch® Ultra® 2 meter
- One Touch® Ultra® Blue test strips
- FreeStyle® test strips
- Freestyle Lite® meter and test strips
- Freestyle InsuLinx ® meter and test strips
- Precision Xtra® meter and test strips

No other meters or test strips are covered at Tier II on the Health Net RDL.

Test strips are available in packages of 50 and 100 and may be prescribed to allow for up to a 30-day supply. Prior authorization is required if more than 200 test strips per month are prescribed.

Most members have coverage for diabetic supplies under their pharmacy benefit. Insulin-dependent and noninsulin-dependent diabetics are eligible for blood glucose monitoring supplies.

Insulin needles and syringes are covered under the Health Net Prescription Drug Program.

Generic Medications

Provider Type: Physicians | Participating Physician Groups (PPG) | Ancillary

A generic-equivalent medication is the pharmaceutical equivalent of a brand-name medication for which the brand-name medication's patent has expired. The Food and Drug Administration (FDA) must approve the generic medication as meeting the same standards of safety, purity, strength, and effectiveness as the brand-name medication.

Generic Substitution Program

If a generic product cannot be used due to medical necessity, a prescriber may:

1. Clearly indicate on the prescription "do not substitute" (DNS) or "dispense as written" (DAW). The pharmacist must make the indication on the prescription claim, and the member may be charged the higher copayment, or
2. Request prior authorization for the brand-name medication documenting failure or clinically significant adverse effects to the generic equivalent.

Off-Label Medication Use

Provider Type: Physicians | Participating Physician Groups (PPG) | Ancillary

A medication prescribed for a use that is not stated in the indications and usage information published by the manufacturer is covered only if the medication is:

- Approved by the Food and Drug Administration (FDA).
- On the Recommended Drug List (RDL) and prescribed or administered by a participating licensed health care professional for the treatment of:
  - A life-threatening condition
  - A chronic and seriously debilitating condition for which the medication is determined to be medically necessary to treat such condition
- Recognized for treatment of the life-threatening or chronic and seriously debilitating condition by one of the following:
  - The American Hospital Formulary Service (AHFS) Drug Information.
  - One of the following compendia, if recognized by the federal Centers for Medicare & Medicaid Services (CMS) as part of an anticancer therapeutic regimen:
    - Elsevier Gold Standard's Clinical Pharmacology..
    - National Comprehensive Cancer Network Drug and Biologics Compendium.
    - Thomson Micromedex DrugDex.
- Two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.

The following definitions apply to the terms mentioned in this provision only.

Life-threatening means either or both of the following:

- Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.
- Diseases or conditions with potentially fatal outcomes, where the end-point of clinical intervention is survival.

Chronic and seriously debilitating refers to:

- Diseases or conditions that require ongoing treatment to maintain remission or prevent deterioration and cause significant long-term morbidity

Participating Pharmacy

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Members are required to obtain medications from Health Net participating pharmacies, with a few exceptions. Health Net contracts with many major pharmacy chains, supermarket-based pharmacies and independently owned neighborhood pharmacies.

For a complete and up-to-date list of participating pharmacies, contact the Health Net Provider Services Center (Commercial, or Medicare), or go to ProviderSearch.

Physician Self-Treatment

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net does not cover physician self-treatment rendered in a non-emergency. This includes treatment of immediate family members. Physician self-treatment occurs when physicians provide their own medical services, including prescribing their own medication, ordering their own laboratory tests and self-referring for their own services. Claims for emergency self-treatment are subject to review by Health Net.

Prescription Mail-Order Program

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

A prescription mail-order program is available to Health Net members. Members are required to pay their mail-order copayments for up to a 90-day supply of medication depending on their plan. The member copayment applies to a 90-consecutive-calendar-day supply of maintenance medications (prescription medications used to manage chronic or long-term conditions when members respond positively to medication treatment and dosage adjustments are either no longer required or made infrequently) and each refill allowed by that order when prescribed by a Health Net participating physician or an authorized specialist. The 90-day-supply maximum is subject to the physician's judgment, the Food and Drug Administration (FDA) and Health Net's recommendations for use. In cases where a 90-day supply is not recommended by the FDA, the prescriber or Health Net, the mail order pharmacy dispenses the correct quantity. Prescriptions filled through the mail-order program should be written for a 90-day supply whenever possible.

- **For members with Commercial HMO and PPO products:** New prescription medication requests may be mailed by the member to the mail order pharmacy CVS Caremark Pharmacy, or faxed or e-prescribed to the mail order pharmacy by the prescribing physician. The member's Health Net identification (ID) number, date of birth, phone number including area code, and Health Net should appear on the prescription request to ensure it is processed correctly. If available, a generic equivalent medication is automatically substituted unless the prescriber indicates DAW (dispense as written) or DNS (do not substitute). Members are charged a higher copayment. Specialty drugs are not available through mail order.
- **For members with Ambetter HMO or Ambetter PPO:** New prescription medication requests may be mailed by the member to Express Scripts® Pharmacy, faxed to Express Scripts Pharmacy by the prescribing physician at 800-837-0959, or e-prescribed by the prescribing physician to Express Scripts Pharmacy. Members can request mail order service for prescription medications and refills from Express Scripts Pharmacy by phone, mail or online at express-scripts.com/rx. The member's Health Net ID number, date of birth, phone number including area code, and Health Net should appear on the prescription request to ensure it is processed correctly. If available, a generic equivalent medication is automatically substituted unless the prescriber indicates DAW or DNS. Members are charged a higher copayment. Specialty drugs are not available through mail order.

Prior Authorization Process

Provider Type: Physicians | Participating Physician Groups (PPG) | Ancillary

Prior authorization is needed for prescription medications when:

- A medication is listed on the Health Net Drug List (Formulary) as needing prior authorization.
- A medication is not listed on the Formulary.
- A step therapy exception is requested.

There are three options for submitting a prior authorization form:

1. Submit the prior authorization electronically through CoverMyMeds.
2. Complete the Prescription Drug Prior Authorization or Step Therapy Exception Request Form (PDF) and submit to Pharmacy Services.
3. Contact Pharmacy Services directly via telephone.

When using the Prescription Drug Prior Authorization or Step Therapy Exception Request Form (PDF) it must be electronically submitted, faxed to Pharmacy Services or submitted by any reasonable means of transmission. Faxes are accepted 24 hours a day, and each request is tracked to ensure efficient handling of inquiries from physicians and members. Requests for prior authorization may also be called into Pharmacy Services. Requests are processed within 24 hours for urgent requests and 72 hours for standard requests. If a health care service plan, contracted physician group or utilization review organization fails to notify a prescribing provider of its coverage determination within 72 hours for nonurgent requests, or within 24 hours if exigent circumstances exist, upon receipt of a completed prior authorization or step therapy exception request, the prior authorization or step therapy exception request shall be deemed approved for the duration of the prescription, including refills.

Pharmacy Services will respond via fax to advise providers the status of the request.

The Prescription Drug Prior Authorization or Step Therapy Exception Request Form (PDF) and medication-use guidelines are also available through Pharmacy Services fax-back system: select option 2, for commercial claim form.

Exigent Requests

Exigent circumstances take place when a member is suffering from a serious health condition that may jeopardize their life, health or ability to regain maximum functions, or is undergoing a current course of treatment using a non-formulary medication.

Providers may request an expedited medication review based on exigent circumstances by contacting Pharmacy Services. The request must include an oral or written statement, which includes the following:

- An exigency exists and the basis for the exigency.
- A justification supporting the need for the non-formulary medication to treat the member's condition, including a statement that covered formulary medications on any tier would not be as effective as the non-formulary medication, or would have adverse effects.

Health Net makes a coverage determination and notifies the member and prescribing physician or other prescriber, as appropriate, of the determination no later than 24 hours after receiving the request or any additional information requested by Health Net that is reasonably necessary to make the determination. If approved, Health Net continues to provide the requested medication throughout the duration of the member's health condition.

Participating physician group (PPG) step therapy and exception process

For PPGs delegated as financially responsible through capitation or other financial arrangement, or for which medical management (medical necessity review) is done by other than the health plan, the utilization review organization must comply with state law[1] relating to self-injectable medications and self-injectable step therapy exception determinations and procedures.

[1]Health and Safety Code Sections 1367.206 and 1367.241.

- The provider may appeal a denial of an exception request for coverage of a nonformulary drug, prior authorization request or step therapy exception request consistent with the plan's current utilization management processes. The law requires the provider to submit justification and supporting clinical documentation supporting the provider's determination that the required prescription drug is inconsistent with good professional practice for provision of medically necessary covered services.
- PPGs that do their own utilization review on behalf of the plan, or between the plan and another contracted entity, are required to comply with the specified provisions of state law relating to step therapy determinations and procedures. Denial of step therapy exception requests require a notification to the prescribing provider and member on the external appeal process through the plan (independent medical review) or request additional or clinical documentation to make a coverage determination. In addition, notification of an incomplete or missing clinical documentation step therapy exception request requires notification to the prescribing provider.

PPGs must ensure that they have this process in place.

As a result, a financially responsible PPG **cannot deny, as standard practice:**

- PA for a nonformulary drug only because the member has not tried and failed with a formulary drug, and
- PA for a step therapy exception only because the member has not tried and failed with a preferred drug in the step therapy process.
- **Denial or approval must be based on the medically necessary documentation provided with the PA.**

Quantity of Medication to Be Prescribed

Provider Type: Physicians | Participating Physician Groups (PPG) | Ancillary

Maintenance medication should be prescribed for a 30-day supply unless the member wants to use the Health Net mail-order program; then a 90-day supply of maintenance medication should be prescribed.

Up to a 30-day supply is covered for medications that come in specific quantities, such as inhalers or insulin vials. In some cases, this may be less than a 30-day supply.

For acute treatment, a standard course of therapy should be prescribed. Medications that are used as needed or come packed in small quantities, such as Imitrex®, should be prescribed for the smallest package size. The Health Net Recommended Drug List (RDL) indicates quantity limits on specific medications. Quantities larger than a 30-day supply or dosing greater than that approved by the Food and Drug Administration (FDA) or Health Net's medication usage guidelines require prior authorization.

Copayments are charged per 30-day supply for maintenance medications and per course of therapy or individual package for acute medications. Some medications have a specific quantity per copayment. Refer to the RDL for specific quantity limitations.

Recommended Drug List

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The Health Net Recommended Drug List (RDL) is the approved list of covered medications. In addition, they identify whether a generic version of a brand-name medication exists and whether prior authorization is required.

Medications that are listed in the RDL are covered if the member has a prescription benefit plan; however, the prescription medication must be dispensed for a condition, illness or injury that is covered by Health Net. Some medications may require prior authorization from Health Net in order to be covered.

The Health Net RDL is available for review or download from the provider portal.

Prior Authorizations

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information on prior authorizations requirements.

Select any subject below:

- How to Secure Prior Authorization on Health Net Provider Portal
- NIA - Prior Authorization
- Prior Authorization Process for Direct Network Practitioners
- TurningPoint

How to Secure Prior Authorization on the Provider Portal

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

To obtain step-by-step guidance on how to determine whether services require prior authorization and how to secure prior authorization on Health Net's provider portal, download the Save Time Navigating the Provider Portal (PDF), Save Time Navigating the Provider Portal – Community Health Plan of Imperial Valley (PDF), Save Time Navigating the Provider Portal – CalViva (PDF) or Save Time Navigating the Provider Portal – WellCare by Health Net booklet.

NIA - Prior Authorization

Provider Type: Physicians

Health Net partners with Evolent Specialty Services, Inc. to provide utilization management (UM) services, including prior authorization determinations for certain advanced and cardiac imaging for fee-for-service (FFS) members.

Go to the Health Net provider website for more information.

Prior Authorization Process for Direct Network Providers

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Selected specialty and outpatient services that cannot be provided in a primary care physician's (PCP's) or specialist's office require prior authorization as outlined in the Commercial Prior Authorization Requirements or the Medicare Prior Authorization Requirements.

PCPs and specialists must fax requests for prior authorization to the Health Net Medical Management Department using the appropriate form listed below:

- Inpatient California Health Net Commercial Prior Authorization (PDF)
- Outpatient California Health Net Commercial Prior Authorization (PDF)
- Inpatient California Health Net Medicare Authorization (PDF)
- Outpatient California Health Net Medicare Authorization (PDF)

The Health Net Medical Management Department accepts prior authorization requests for elective and urgent services by fax only.

To initiate the prior authorization process, PCPs and specialists must:

- Verify member eligibility and benefit coverage by accessing the Health Net provider portal or by contacting the Health Net Provider Services Center.
- Complete the prior authorization form, including CPT codes and sufficient clinical information to support the medical necessity of the request. Incomplete forms or forms with insufficient information at the time of submission delay processing (some surgical requests, such as requests for reconstructive surgery or repair require submission of non-returnable color photos, models or X-rays).

Contact the Health Net Medical Management Department or visit the Health Net provider website to obtain the status of an authorization.

Allow 14 calendar days for routine organization determinations and 72 hours for expedited organization determinations.

Emergency services do not require prior authorization.

TurningPoint

Health Net is partnered with TurningPoint Healthcare Solutions, LLC to provide utilization management (UM) services, including prior authorization determinations for certain inpatient and outpatient musculoskeletal procedures for fee-for-service (FFS) members.

Submit requests for prior authorization to TurningPoint for the following procedures.

Orthopedic surgical procedures (including partial, total and revision surgeries)

- Acromioplasty and rotator cuff repair
- Ankle arthroplasty
- Ankle fusion
- Anterior cruciate ligament repair
- Elbow arthroplasty
- Femoroacetabular arthroscopy
- Hip arthroplasty
- Hip arthroscopy
- Hip resurfacing
- Knee arthroplasty
- Knee arthroscopy
- Knee replacement for unicompartmental or bicompartmental
- Osteochondral defect repair
- Meniscal repair
- Shoulder arthroplasty
- Shoulder fusion
- Wrist arthroplasty
- Wrist fusion

Spinal surgical procedures (including partial, total and revision surgeries)

- Disc replacement
- Implantable pain pumps
- Kyphoplasty or vertebroplasty
- Laminectomy/discectomy
- Spinal cord neurostimulator
- Spinal decompression
- Spinal fusion surgeries

Other operations remain unchanged:

- In accordance with the Provider Participation Agreement (PPA), lack of prior authorization approval may result in nonpayment of claims.
- Emergency-related procedures do not require authorization.

Product Descriptions

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information about Health Net health plans.

Select any subject below:

- Primary EPO Plan Overview

Primary EPO Plan Overview

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net's Primary Exclusive Provider Organization (EPO) plan is modeled after Health Net's HMO plans. Primary EPO members are required to select a primary care physician (PCP) upon enrollment. All services must be obtained or coordinated through the member's PCP. The member's PCP coordinates referrals to a network of participating EPO specialists and hospitals. Services received from a provider that is affiliated with Health Net's EPO network are covered.

Provider Oversight

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information on provider oversight requirements and monitoring.

Select any subject below:

Fraud, Waste and Abuse

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Fraud is intentional misrepresentation or deception for the purpose of obtaining payment or other benefits not otherwise due. Abuse includes those practices that are inconsistent with accepted sound fiscal, business or medical practices. The following are examples of fraud and abuse:

- Intentional misrepresentation of services rendered.
- Deliberate application for duplicate reimbursement.
- Intentional improper billing practices.
- Failure to maintain adequate records to substantiate services.
- Failure to provide services that meet professionally recognized standards of health care.
- Provision of unnecessary services .

Health Net is responsible for reporting to the state its findings of suspected fraud and abuse by participating providers or vendors under its Medi-Cal plans. Suspected fraud and abuse is identified through various sources that include aggregate data analysis, review of high-cost providers, review of CPT-4 codes with potential for over-use, members, the state, law enforcement agencies, other providers, and associates.

Providers and their office staff are legally required to report suspected cases of fraud and abuse to Health Net. Reports of suspected fraud may be made anonymously to the Health Net Fraud Hotline.

Monitoring Provider Exclusions

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The Centers for Medicare & Medicaid Services (CMS) requires contractors and their first-tier, downstream and related entities (FDRs) to monitor federal and state exclusion lists. The parties or entities on these lists are excluded from various activities, including rendering services to Medicare enrollees (unless in the case of an emergency, as stated in 42 CFR §1001.1901), and employing or contracting with excluded parties to provide services to Medicare enrollees. Health Net requires that its participating physician groups (PPGs), hospitals, ancillary providers, and practitioners continuously monitor federal and state exclusion lists.

Monitoring for Excluded Parties

The names of parties that have been excluded from participation in federal health programs are published in the Office of the Inspector General U.S. Department of Health and Human Services (OIG-HHS) List of Excluded Individuals and Entities (LEIE), CMS Preclusion List, Medi-Cal Suspended and Ineligible Provider List (SIPL), Office of Personnel Management (OPM) under the Federal Employee Health Benefit Plan (FEHBP) and on the General Services Administration's (GSA) Exclusions Extract Data Package (EEDP) (or Excluded Parties List System (EPLS), which was replaced by the EEDP), as referenced through the System for Award Management (SAM) website.

Medicare Advantage organizations (MAOs) and their FDRs must abide by the regulations documented in the Social Security Act 1862(e)(1)(B),), 5 CFR §890.1043(a)(b)(c), 42 CFR §422.503(b)(4)(vi)(F), 422.752(a)(8), 423.504(b)(4)(vi)(F), 423.752(a)(6), 422.222, 422.224 and 1001.1901. These federal exclusion requirements are further interpreted and communicated as guidance by CMS in Medicare Manual, Volume 100-16, Chapters 9 and 21 §50.6.8.

Additional regulations that require sponsors to include CMS requirements in their contracts, as well as monitor their FDRs, are available in 42 CFR §422.504(i)(4)(B)(v) and 423.505(i)(3)(v).

Health Net and Provider Responsibilities

Health Net is required to monitor federal and state exclusion lists to ensure that Health Net is not hiring, contracting or paying excluded parties or entities for services rendered to enrollees in Health Net's Medicare (MA and MA-PD) plans. Health Net's FDRs must check the LEIE, CMS Preclusion List, SIPL, FEHBP and EEDP federal exclusion lists prior to hiring or contracting with any new employee, temporary employee, volunteer, consultant, governing body member, or FDR for Part C- and Part D-related activities. MAOs and their FDRs must continuously monitor these lists at least monthly to ensure parties or entities that were previously screened have not become excluded later.

LEIE

The OIG-HHS imposes exclusions under the authority of sections 1128 and 1156 of the Social Security Act. A list of all exclusions and their statutory authority is available on the Exclusion Authority website.

The current LEIE is available on the OIG-HHS website. Refer to Frequently asked questions (FAQs) for additional information about the LEIE.

Providers on the OIG list will be terminated from all products, federal and non-federal.

FEHBP

The OPM, under the OIG-HHS, imposes suspension and debarment actions for entities contracted with the FEHBP. The current FEHBP suspended and debarred report is available by contacting your plan representative.

Providers on the FEHBP list will be terminated from all products, federal and non-federal. Additionally, a 12-month claims look-back review must occur for all identified participating and non-participating providers. Federal Employee Health Benefit Plan members identified through the claims review must receive notification that the provider is no longer available to receive services from.

Resctricted Provider Database (RPD)

The RPD is published by DHCS to identify providers placed under a payment suspension while under investigation based upon a credible allegation of fraud (Title 42, Code of Federal Regulations (CFR) section 455.23 and Welfare and Institution Code (WIC) section 14107.11. Search Part 455 of the CFR. Search the WIC. The sanction action is specific to the individual rendering provider's National Provider Identifier and/or Tax Identification Number as listed on the database file. Subcontractors and delegated entities may continue contractual relationships with providers on the RPD that are listed under a "payment suspension only"; however, reimbursements for Medi-Cal covered services must be withheld. Contracts must be terminated with providers on the RPD that are not listed under a "payment suspension only." Subcontractors and delegated entities choosing to terminate a provider's contract must notify Health Net per the language in the Provider Participation Agreement (PPA) and within the required advance notification turnaround times included in the Medi-Cal provider operations manual under Provider Oversight > Facility and Physician Additions, Changes and Deletions > Closure and Termination available in the Provider Library online. Providers under a payment suspension will be indicated as such under the "comment" column of the database file. If you would like a copy of the latest RPD data file, subcontractors and delegated entities should submit a request to Health Net at ProvServicesOps@healthnet.com.

EEDP

The GSA's EEDP is a government-wide compilation of various federal agency exclusions, and replaces the Excluded Parties List System (EPLS). Exclusions contained in the EEDP are governed by each agency's regulatory or legal authority. The EEDP also includes parties and entities from other federal exclusion databases. All parties or entities listed on the EEDP are subject to exclusion from Medicare participation. The current EEDP is available on the SAM website.

Providers on the EEDP list will be terminated from all products, federal and non-federal.

SIPL

The SIPL is published by DHCS to identify suspended and otherwise ineligible providers. It is updated monthly and available on the DHCS Medi-Cal website > References > Suspended & Ineligible Provider List. Additional information about the list is located in the Medi-Cal Suspended and Ineligible Provider List introduction.

Providers on the SIPL will be terminated from all products, federal and non-federal.

CMS Preclusion List

The CMS Preclusion List is published by CMS to identify precluded providers. It is updated monthly and available on the Healthnet.com site, after logging on, under the regulatory section.

Providers on the CMS Preclusion List will be terminated from all products, federal and non-federal.

CLAIMS PAYMENT FOR EXCLUDED PARTIES

Health Net, its PPGs, hospitals, and ancillary providers cannot pay participating and nonparticipating parties or entities included on these lists for any services using federal funds, except as documented in the CMS Internet Only Manual, publication 100-16, Chapter 6 - Relationships with Providers, which states, "The OIG has a limited exception that permits payment for emergency services provided by excluded providers under certain circumstances. See 42 CFR §1001.1901." FDRs contracting with Health Net must have a documented process in place to ensure compliance with these guidelines, and notify enrollees who obtain services from excluded parties and make claims payments as allowed under these exceptions. This documentation

Contractual Financial and Administrative Requirements

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information on contractual financial and administrative requirements.

Select any subject below:

- Contracts with Ancillary Providers
- Discrimination against Health Care Professional Prohibited
- Use of Performance Data

Contracts with Ancillary Providers

Provider Type: Hospitals | Ancillary

The plan may review copies of the hospitals' contracts with its ancillary providers to ensure the contracts meet regulatory requirements. Contracts must include language stating that:

- Members are not liable to the provider for any sums owed by the plan (hold-harmless language).
- Providers may not apply surcharges or any other charges, other than copayments, for covered services.
- Providers must maintain the confidentiality of member information and records.
- Providers must maintain timely, accurate and complete medical records.
- Providers must maintain records for a minimum of ten years.
- Providers must submit encounter data as required.
- Providers must comply with the medical policy, quality improvement (QI) and medical management policies of the plan.
- Providers must allow open provider-member communication regarding appropriate treatment alternatives.
- Providers must comply with applicable state, federal, and Medicare laws, regulations and reporting requirements.
- Contracts may not contain any incentive plan that includes payment as an inducement to deny, reduce, limit, or delay specific, medically necessary and appropriate services.

- Contracts must include accountability provisions.
- Contracts must allow access to medical records, to the extent permitted by law.

Discrimination against Health Care Professional Prohibited

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

In accordance with standards established by the Centers for Medicare & Medicaid Services (CMS), health plans may not discriminate against the following:

- Any health care professional who is acting within the scope of their license, in terms of participation, reimbursement or indemnification.
- Professionals who serve high-risk populations or who specialize in the treatment of costly conditions.

Health plans are also required to issue written notice to providers regarding the reason the plan is declining to accept the provider or participating physician group (PPG). For additional information regarding provider credentialing, refer to the Credentialing topic.

Use of Performance Data

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net is subject to various statutory, regulatory and accreditation requirements, and must ensure that all agreements comply with any such mandates. Accreditation from the National Committee for Quality Assurance (NCQA) is critical to both the health plan and network providers, and ensures that Health Net meets the highest possible standards of excellence and care.

One of the requirements of NCQA is that Health Net may use practitioner performance data for quality improvement activities. Therefore, Health Net's contract templates have been updated with the following language:

Provider agrees to cooperate with quality management and improvement (QI) activities; maintain the confidentiality of member information and records pursuant to this agreement; and allow Health Net to use provider's performance data.

Facility and Physician Additions, Changes and Deletions

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section includes information on requirements for adding or removing a participating provider.

Select any subject below:

Facility and Satellites

Provider Type: Participating Physician Groups (PPG) | Hospitals

If a facility expands its capacity by adding new or satellite facilities, or new member physicians or other subcontracting providers, the facility must notify the plan in writing at least 90 days before the addition. The plan has the right, in its sole discretion, to determine whether the new or satellite facilities or the new member physicians are acceptable to the plan.

Facilities and Satellite Contracts

According to the terms of the Provider Participation Agreement (PPA), participating physician groups (PPGs) agree not to add new or satellite facilities until the plan has approved them. The plan is free to deny participation under the PPA to any new or satellite facilities, and is not obligated to state a cause or explain the denial of the addition or provide the PPG with any right to appeal or any other due process. The plan's decisions regarding additions to the network are considered final and binding.

Facility Terminations

Facilities are required to notify the regional Provider Network Management Department in writing at least 90 days in advance of the date that a subcontracting provider terminates its relationship with the facility.

PPG and Hospital Termination

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Participating physician groups (PPGs) and hospitals must notify the Health Net regional Provider Network Management Department in writing as stated in their Provider Participation Agreement (PPA)).

Health Net offers transition of care assistance to members who request to complete a course of treatment of covered services by a terminated provider. Refer to the Continuation of Care Assistance discussion under the Utilization Management topic.

Provider Online Demographic Data Verification

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

On a monthly basis, providers should validate that their demographic information is reflected correctly on the provider website under ProviderSearch. According to the terms of the Provider Participation Agreement (PPA), participating providers are required to provide a minimum of 30 days advance notice of any changes to their demographic information. If the change pertains to the status of accepting new patients or no longer accepting new patients, you must notify Health Net or the applicable PPG within five business days.

Providers directly contracting with Health Net must notify Health Net of changes to by completing the online form or by reaching out to your provider relations and contracting specialist (formally provider network administrator). The online form is available on the provider website. Providers must have privileges to update and submit changes online.

Providers contracting through a PPG must notify the PPG directly of changes, and the PPG notifies Health Net. PPGs must have policies in place that establish and implement processes to collect, maintain and submit their provider demographic changes to Health Net on a real-time basis. Real-time is within 30 days, as recently defined by the Centers for Medicare & Medicaid Services (CMS).

If a provider sees patients at multiple locations, the provider should review address, phone number, fax number, and office hours for all locations to ensure data accuracy.

Demographic Information

Providers' demographic data information should include the following:

- Name
- Alternate name
- Address
- Telephone number

- Fax number
- License number
- National Provider Identifier
- Office hours

- Patient age ranges (lowest to highest) seen by provider
- Specialty
- Email address - used for members and is Health Insurance Portability and Accountability Act (HIPAA) compliant

- Practice website
- Hospital affiliation
- Languages other than English spoken by the physician
- Languages other than English spoken by the office staff

- Panel status - Accepting new patients, accepting existing patients, available by referral only, available only through a hospital or facility, not accepting new patients
- Handicap accessibility status for parking (P), exterior building (EB), interior building (IB), restroom (R), exam room (ER), and exam table/scale (T) - if accessibility is not yes to all, then indicate no

Provider Outreach Requirements

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net is required to contact directly contracting practitioners biannually, including physicians and other health professionals such as physical therapists (PTs), occupational therapists (OTs) and podiatrists; and annually contact PPGs, hospitals and ancillary providers to validate the accuracy of the information for each provider listed in Health Net's provider directories. The notification includes:

- The information Health Net has in its directories for the provider, including a list of networks and products in which the provider participates.
- A statement that the failure to respond to the notification may result in a delay of payment or reimbursement of a claim.
- Instructions on how the provider can update information including the option to use an online interface to submit verification or changes electronically which generates an acknowledgment from Health Net.
- A statement requiring an affirmative response from the provider acknowledging that the notification was received, and requiring the provider to confirm that the information in the directories is current and accurate or to provide an update to the information required to be in the directories, including whether the provider is accepting new patients for each applicable Health Net network or product. Note: this requirement does not apply to general acute care hospitals. If Health Net does not receive an affirmative response and confirmation from the provider that the information is current and accurate, or as an alternative, receive updated information from the provider within 30 business days, the following will occur:
    - Health Net takes no more than an additional 15 business days to verify whether the provider's information is correct or requires updates. Health Net documents the receipt and outcome of each attempt to verify the information.

- If Health Net is unable to verify whether the provider's information is correct or requires updates, Health Net notifies the provider 10 business days prior to removal that the provider will be removed from provider directories. The provider is removed from the provider directories at the next required update of the provider directories after the 10 business-day notice period. A provider is not removed from the provider directories if they respond before the end of the 10 business-day notice period. This requirement does not apply to general acute care hospitals.

Health Net will sometimes work with an outside vendor (i.e., Symphony Provider Directory) to reach out to providers to validate practitioner participation and demographic data. Providers are required to respond to requests from Health Net, and/or may update changes as needed directly with Symphony.

Provider Status Change Notification Requirements

Providers are required to inform Health Net or the applicable PPG within five business days when either of the following occurs:

- The provider is not currently accepting new patients, when they had previously accepted new patients.
- The provider is currently accepting new patients, when they had previously not accepted new patients.

Additionally, if a provider who is not accepting new patients is contacted by a member or potential enrollee seeking to become a new patient, the provider is required to direct the member or potential enrollee to both Health Net for additional assistance in finding a provider and to the appropriate regulator listed below to report any inaccuracy with the provider directories.

Regulator	Contact Information	Line of Business
Department of Managed Health Care (DMHC)	1-888-466-2219 1-877-688-9891 (TDD) www.hmohelp.ca.gov	HMO, POS, HSP, Medi-Cal
California Department of Insurance (CDI)	1-800-927-4357 www.insurance.ca.gov	EPO, PPO

PPGs must have policies in place that establish and implement processes to collect, maintain and submit provider demographic changes to Health Net within the required turnaround times.

Report of Inaccurate Information in Directories

When Health Net receives a report indicating that information listed in its provider directories is inaccurate by a potential enrollee, member, regulator or provider, Health Net promptly investigates the reported inaccuracy and,

no later than 30 business days following receipt of the report, either verifies the accuracy of the information or updates the information in its provider directories, as applicable.

At a minimum, Health Net does the following:

1. Contacts the affected provider no later than five business days following receipt of the report.
2. Documents the receipt and outcome of each report, including the provider's name, location, and a description of Health Net's investigation, the outcome of the investigation, and any changes or updates made to the provider directories.
3. If changes to Health Net's directories are required as a result of the plan's investigation, the changes to the online provider directories must be made within the weekly turnaround time. For printed provider directories, changes must be made no later than the next required update or sooner if required by federal law or regulations.

Pursuant to Uniform Provider Directory Standards cited by Health and Safety Code (HSC) 1367.27(k) and Insurance Code 10133.15(k), Health Net will omit a provider, provider group or category of providers similarly situated from the directory if one of the below conditions is met.

- The provider is currently enrolled in the Safe at Home program.
- The provider fears for his or her safety or the safety of his or her family due to his or her affiliation with a health care service facility or due to his or her provision of health care services.
- A facility or any of its providers, employees, volunteers, or patients is or was the target of threats or acts of violence within one year of the date of this statement.
- Good cause or extraordinary circumstances (must provide detailed information on the cause or circumstances).

Providers must complete and sign the Directory Removal for At-Risk Providers form – Health Net (PDF), Directory Removal for At-Risk Providers form – Community Health Plan of Imperial Valley (PDF) or Directory Removal for At-Risk Providers form – CalViva Health (PDF) to be omitted from the directory.

Service and Quality Requirements

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section includes information on requirements for adding or removing a participating provider.

Select any subject below:

- Access to Care and Availability Standards
- Threshold Languages and Language Assistance Codes
- Authorization and Referral Timelines
- Credentialing and Recredentialing
- Obtaining Interpreter Services

Access to Care and Availability Standards

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net's access and availability policies, procedures and guidelines for practitioners, providers and health care facilities providing primary care, specialty care, behavioral health care, and ancillary services are in accordance with applicable federal and state regulations, contractual requirements and accreditation standards. These access standards are regulated by the California Department of Insurance (CDI) and comply with the National Committee for Quality Assurance (NCQA).

Note: Behavioral health and chemical dependency services are administered by Health Net.

Health Net and its participating providers are required to demonstrate that, throughout the geographic regions for Health Net's service area, a comprehensive range of primary, specialty, institutional, and ancillary care services are readily available and accessible at reasonable times to all Health Net members. Additionally, Health Net and its participating providers are required to demonstrate that members have access to non-discriminatory and appropriate covered health care services within a reasonable period of time appropriate for the nature of the member's condition and consistent with good professional practice. This includes, but is not limited to, provider availability, waiting time and appointment access with established time-elapsed standards.

The following information delineates the medical appointment access standards, triage and/or screening access requirements, and telephonic access to health care services and the monitoring activities to ensure compliance:

Member Notification

Members are notified annually, via member newsletters or the Evidences of Coverage (EOC), of time-elapsed appointment access standards, the availability of triage or screening services and how to obtain these services.

Primary Care Physician and Specialist Office Hours

As required by applicable federal and state statutes and regulations, primary care physician (PCP) and specialty care practitioner (SCP) office hours must be reasonable, convenient and sufficient to ensure that they do not discriminate against members and members are able to access care within established time-elapsed access standards. PCP and SCP office hours must be posted in the provider's office. Health Net requires a PCP practice to be open at least 20 hours per week and a SCP practice to be open at least 16 hours per week for members to schedule appointments within established appointment access standards. During evenings, weekends and holidays, or whenever the office is closed, an answering service or answering machine should be utilized to provide members with clear and simple instruction on after-hours access to medical care.

After-Hours Access Guidelines

As required by applicable statutes, Health Net's participating providers must ensure that, when medically necessary, they have medical services available and accessible to members 24 hours a day, seven days a

week, and PCPs are required to have an appropriately licensed professional back up for absences. Participating physician groups (PPGs) and PCPs who do not have services available 24 hours a day may use an answering service or answering machine to provide members with clear and simple instruction on after-hours access to medical care (urgent/emergency medical care).

PCPs (or on-call physicians) must return telephone calls and pages within 30 minutes and be available 24 hours a day, seven days a week. The PCP or on-call physician designee must provide urgent and emergency care. The member must be transferred to an urgent care center or hospital emergency room, as medically necessary.

Additionally, Health Net provides triage and screening services 24 hours a day, seven days a week through medical/nurse advice lines. Refer to the Triage and Screening Services/Advice Lines section below for further information.

Note: Although Health Net does not delegate triage and screening services, PCPs are still required to comply with these after-hours requirements since medically necessary services are required to be available and accessible 24 hours a day, seven days a week.

After-Hours Sample Scripts

In times of high stress, when members may have an urgent or emergent situation, it is important to provide clear messaging with call-back time frames and directions on how to access urgent and emergency care to prevent potential quality of care issues. Directing members to the appropriate level of care using simple and comprehensive instructions can improve the coordination and continuity of the member's care, health outcomes and satisfaction. Health Net has designed an after-hours script template that PPGs or physicians who have a centralized triage service or other answering service can utilize as a guide for staff answering the telephone. For PPGs or physicians who use an automated answering system, this template can be used as a script to advise members on how to access care. Health Net'safter-hours scripts provide easy to use messaging examples on how to direct members to emergency care services and who to talk to when they need urgent medical advice.

Health Net makes the script in the following threshold languages:

- English (PDF)
- Spanish (PDF)
- Chinese/Cantonese (PDF)

After-hours scripts are available in additional languages upon request. Contact the Provider Network Management, Access & Availability Team for more information.

Answering Services

Providers are responsible for the answering service they use. If a member calls after hours or on a weekend for a possible medical emergency, the practitioner is held liable for authorization of, or referral to, emergency care given by the answering service. There must be a message immediately stating, "If this is an emergency, hang up and call 911 or go to the nearest emergency room."

Answering service staff handling member calls cannot provide telephone medical advice if they are not a licensed, certified or registered health care professional. Staff members may ask questions on behalf of a licensed professional in order to help ascertain the condition of the member so that the member can be

referred to licensed staff; however, they are not permitted, under any circumstance, to use the answers to questions in an attempt to assess, evaluate, advise, or make any decision regarding the condition of the member, or to determine when a member needs to be seen by a licensed medical professional. Unlicensed telephone staff should have clear instructions on the parameters relating to the use of answers in assisting a licensed provider.

Additionally, non-licensed, non-certified or non-registered health care staff cannot use a title or designation when speaking to a member that may cause a reasonable person to believe that the staff member is a licensed, certified or registered health care professional.

Health Net encourages answering services follow these steps when receiving a call:

- Inform the member that if they are experiencing a medical emergency, they should hang up and call 911 or proceed to the nearest emergency medical facility.
- If language assistance is needed, offer the member interpreter services, and question the member according to the PCP's or PPG's established instructions (who, what, when, and where) to assess the nature and extent of the problem.
- Contact the on-call physician with the facts as stated by the member.
- After office hours, physicians are required to return telephone calls and pages within 30 minutes. If an on-call physician cannot be reached, direct the member to a medical facility where emergency or urgent care treatment can be given. This is considered authorization, which is binding and cannot be retracted.

In the event of a hospitalization, the PPG or hospital must contact Hospital Notification Unit within 24 hours or the next business day of the admission.

The answering service should document all calls. Answering services frequently have a high staff turnover, so providers should monitor the answering service to ensure emergency procedures are followed.

Triage and/or Screening Services/Nurse Advice Lines

As defined in 28 CCR 1300.67.2.2(b)(5), Health Net provides 24-hour-a-day, seven-day-a-week triage or screening services by telephone. This program is a service offered in conjunction with the PCP and does not replace the PCP's instruction, assessment and advice. According to community access-to-care standards, all PCPs must provide 24-hour telephone service for urgent/emergent instructions, medical condition assessment and advice. The Health Net Member Services Department coordinates member access to the service, if necessary.

The program allows registered nurses (RNs) and other applicable licensed health care professionals to assess a member's medical condition and, through conversation with the caller, take further action, and provide instruction on home and care techniques and general health information.

Health Net ensures that telephone triage or screening services are provided in a timely manner appropriate for the member's condition, and the triage or screening wait time does not exceed 30 minutes. Health Net provides triage or screening services through a contracted medical/nurse advice line. Health Net members can access these services by contacting the Nurse Advice Line telephone number on the back of their ID cards.

Facility Access for the Disabled

Health Net and its participating providers do not discriminate against members who have physical disabilities. Participating providers are required to provide reasonable access for disabled members in accordance with the Americans with Disabilities Act of 1990 (ADA). Access generally includes ramps, elevators, restroom equipment, designated parking spaces, and drinking fountain design.

Providers are to reasonably accommodate members and ensure that programs and services are as accessible (including physical and geographic access) to members with disabilities as they are to members without disabilities. Providers must have written policies and procedures to ensure appropriate access, including ensuring physical, communication and programmatic barriers do not inhibit members with disabilities from obtaining all covered services.

Appointment and Referrals

PPO and EPO members may seek care through participating providers or out-of-network providers according to their benefit plans.

Missed Appointments

According to Health Net's Medical Records Documentation Standards policies and procedures (KK47-121230), missed appointment follow-up and outreach efforts to reschedule must be documented in the member's record.

Appointment Rescheduling

According to new timely access regulations (28 CCR 1300.67.2.2) and to Health Net's Medical Records Documentation Standards policy and procedure (KK47-121230), when it is necessary for a provider or a member to reschedule an appointment, the appointment must be rescheduled promptly; in a manner that is appropriate for the member's health care needs. Efforts to reschedule the appointment must ensure continuity of care and be consistent with good professional practice and with the objectives of Health Net's access and availability policies and procedures.

Shortening or Extending Appointment Waiting Time

The applicable waiting time for a particular appointment may be shortened or extended by the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of their practice and consistent with professionally recognized standards of practice. If the applicable licensed health care provider has determined to extend the appointment wait time, the provider must document in the member's record that a longer waiting time will not have a detrimental impact on the member's health, as well as the date and time of the appointment offered.

Emergency and Urgent Care Services

Emergency and urgent care services are available and accessible to members within Health Net's service area 24 hours a day, seven days a week.

Providing Emergency and Urgent Care Services in the PCP's Office

The physician, registered nurse (RN) or physician assistant (PA) on duty is responsible for evaluating emergency and urgent care members in the office and making the decision to further evaluate and treat, summon an ambulance for transport to the nearest emergency room, directly admit to the hospital, or refer to a same-day visit at another provider or urgent care facility.Provider Telephone Assessment

Telephone assessment of a member's condition, and subsequent follow-up, may only be performed by licensed staff (physicians, RNs, and nurse practitioners (NPs)) and only in accordance with established standards of practice.

Telehealth

Telehealth services are subject to the requirements and conditions of the enrollee benefit plan and the contract entered into between Health Net and its participating providers. Prior to the delivery of health care via telehealth, the participating provider at the original site must verbally inform the member that telehealth services may be used and obtain verbal consent from the member. The verbal consent must be documented in the member's medical record. To the extent that telehealth services are provided as described herein and as defined in Section 2290.5(a) of the Business & Professions Code, Section 1374.13 of the Health and Safety Code, and Sections 14132.72 and 14132.725 of the Welfare and Institutions Code, these telehealth services comply with the established appointment access standards.

Interpreter Services

In order to comply with applicable federal and state laws and regulations, Health Net requires providers to coordinate interpreter services with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment. If an appointment is rescheduled, it is very important to reschedule the interpreter for the time of the new appointment to ensure the member is provided with these services.

Cultural Considerations

Health Net and its participating providers must ensure that services are provided in a culturally competent manner to all members, including those who are limited-English proficient (LEP) or have limited reading skills, and those from diverse cultural and ethnic backgrounds. Refer to Language Assistance and Cultural Competency (Hospitals)for more information.

Minor Consent Services

As defined in 42 CFR 2.14 (a) the term "minor" means a person who has not attained the age of majority specified in the applicable state law, or if no age of majority is specified in the applicable state law, age 18 years.

Under California state law, minor consent services are those covered services of a sensitive nature that minors do not need parental consent to access or obtain. The health care practitioner is not permitted to inform a parent or legal guardian without the minor's consent. Minors under age 18 may consent to medical care related to:

- Prevention or treatment of pregnancy (except sterilization) - California Family Code (CFC) §6925.
- Family planning services, including the right to receive birth control - CFC§6925.
- Abortion services (without parental consent or court permission) - American Academy of Pediatrics (AAP) v. Lungren, 16 Cal. 4th 307 (1997)..
- Sexual assault, including rape diagnosis, treatment and collection of medical evidence; however, the treating provider must attempt to contact the minor's parent/legal guardian and note in the minor's treatment record the date and time of the attempted contact and whether or not it was successful. This provision does not apply if the treating provider reasonably believes that the minor's parent or guardian committed the sexual assault on the minor or if the minor is over age 12 and treated for rape - CFC §6927 and CFC §6928.
- HIV testing and counseling (for children ages 12 and older) - CFC§6926..
- Infectious, contagious, communicable, and sexually transmitted diseases diagnosis and treatment (for children ages 12 and older) - CFC§6926.
- Drug or alcohol abuse (for children ages 12 and older) treatment and counseling except for replacement narcotic abuse treatment - CFC§6926(b).
- Outpatient behavioral health treatment or counseling services (for children ages 12 and older) if in the opinion of the attending provider the minor is mature enough to participate intelligently in the outpatient or residential shelter services and the minor would present a danger of serious physical or mental harm to self or to others without the mental health treatment or counseling or residential shelter services, or is the alleged victim of incest or child abuse - CFC§6924.
- Skeletal X-ray - a health care provider may take skeletal X-rays of a child without the consent of the child's parent/legal guardian, but only for the purposes of diagnosing the case as one of possible child abuse or neglect and determining the extent of it - Cal. Penal Code CFC §11171.
- General medical, psychiatric or dental care if all of the following conditions are satisfied: (1) The minor is age 15 or older, (2) The minor is living separate and apart from their parents or guardian, whether with or without the consent of a parent or guardian and regardless of the duration of the separate residence, (3) The minor is managing their own financial affairs, regardless of the source of the minor's income. If the minor is an emancipated minor they may consent to medical, dental and psychiatric care - CFC § 6922(a) and§ 7050(e).

Routine Authorization (Pre-Service) – Deferral Needed

An initial decision may be deferred for 14 calendar days from the date of receipt of the original request if the referring provider, treating provider, or triaging health professional has determined and noted in the relevant record that a longer waiting time will not have detrimental impact on the health of the enrollee," in accordance with Section 1367.03(a)(5)(H), and:

- Additional clinical information is required.
- Consultation by an expert reviewer is required.

- Additional examination or tests are to be performed.
- The Plan can provide justification upon request by the State of the need for additional information and how it is in the member's interest. (42 CFR 438.210(d) 438.404).

The decision may be deferred for an additional 14 calendar days (not to exceed a total of 28 calendar days from the date of receipt of the original request) only if: The member or the member's provider requests an extension, or the Plan can provide justification upon request by the State of the need for additional information and how it is in the member's interest.

Written Notification, Notice of Action – Deferral is sent to the enrollee and requesting provider within the initial five working days from receipt of the original request, or as soon as the Plan becomes aware that it will not meet the timeframe, whichever occurs first, and:

- Specify the additional information requested but did not receive; requesting only that information that is reasonably necessary to make a decision.
- Provide the anticipated date of decision.
- Advise the requesting provider that:
  "In accordance with Section 1367.03(a)(5)(H):
  - If this delay to obtain additional information and resulting delay will have a detrimental impact on the health of the member, you must contact the Plan.
  - If this delay will not have a detrimental impact on the health of the member, you must document this in the member record."
- Advise the member that they have a right to file a grievance to dispute the delay.

Determination Timeline for a Decision following a Deferral

- When additional information is received: If requested information is received, a decision must be made within five working days from the receipt of information, not to exceed 28 calendar days from the date of receipt of the original request.
- Decision when additional information received is incomplete or not received:
  If the provider has not complied with the request for additional information, the Plan reviews the request with the information available and makes a determination within five working days of the expiration of the deferral notice, not to exceed 28 calendar days from receipt of the original request (Health & Safety Code 1367.01).

Expedited Authorization (Pre-Service) - Deferral Needed

An initial decision may be deferred for 14 calendar days from the date of receipt of the original request if the referring provider, treating provider, or triaging health professional has determined and noted in the relevant record that a longer waiting time will not have detrimental impact on the health of the enrollee," in accordance with Section 1367.03(a)(5)(H), and:

- Additional clinical information is required.
- Requires consultation by an expert reviewer.
- Additional examination or tests are to be performed.

Written Notification, Notice of Action – Deferral: Written notification is sent to the member and requesting provider within the initial 72 hours from receipt of the original request, or as soon as the Plan becomes aware that it will not meet the timeframe, whichever occurs first, and:

- Specify the additional information requested; requesting only that information that is reasonably necessary to make a decision.

- Provide the anticipated date of decision.
- Advise the requesting provider that:

"In accordance with Section 1367.03(a)(5)(H):

- If this delay to obtain additional information will have a detrimental impact on the health of the member, you must contact the Plan.
- If this delay will not have a detrimental impact on the health of the member, you must document this in the member record."

Determination Timeline for a Decision following a Deferral

- When additional information is received: If requested information is received, a decision must be made within five working days from the receipt of information, not to exceed 28 calendar days from the date of receipt of the original request.
- Decision when additional information received is incomplete or not received:

If the provider has not complied with the request for additional information, the Plan reviews the request with the information available and makes a determination within five working days of the expiration of the deferral notice, not to exceed 28 calendar days from receipt of the original request (Health & Safety Code 1367.01).

Quality Assurance

Health Net has a documented system for monitoring and evaluating practitioner/provider availability and accessibility of care. At least annually, Health Net monitors appointment access to care and provider availability standards through member and provider surveys. At least quarterly, Health Net reviews and evaluates the information available to Health Net regarding accessibility, availability, and continuity of care, through information obtained from appeals and grievances, triage or screening services, and customer service telephone access to measure performance, confirm compliance, and ensure the provider network is sufficient to provide appropriate accessibility, availability and continuity of care to Health Net members.

At least on a quarterly basis, the Plan will review reports from the Quality Improvement Department regarding Incidents of non-compliance resulting in substantial harm to an enrollee that are related to access. The Plan will address areas related to network non-compliance with the regional Provider Network Management teams. Corrective actions will be implemented as applicable.

PPGs are responsible to monitor data provided by Health Net regarding their provider adherence to the following standards, as corrective actions may be required of providers that do not comply. Refer to the Corrective Action section below for further information.

Health Net's performance goals for access-related, time-elapsed provider criteria are available for providers' reference.

Monitoring and Reporting

Health Net collects and analyzes all data to identify opportunities for improvement, which is communicated to the appropriate quality committee or department to review for recommendations. Health Net implements plan-wide corrective actions based on its assessment as indicated. Plan-level results and applicable actions for

improvement are communicated to practitioners, providers and PPGs through the Quality Improvement Committee.

At least annually, Health Net surveys providers to measure and evaluate member access. Listed below are Health Net's performance goals for access-related, time-elapsed provider criteria:

Health Net EPO and PPO Plans Medical Appointment Access Standards

ACCESS MEASURE	STANDARD	PERFORMANCE GOAL
Non-urgent appointments for primary care - regular and routine care (PCP)	Appointment within 10 business days of request	70%
Urgent care (PCP) services that do not require prior authorization	Appointment within 48 hours of request	70%
Non-urgent appointments with specialist (SCP)	Appointment within 15 business days of request	70%
Urgent care services (SCP and other) that require prior authorization	Appointment within 96 hours of request	70%
After-hours care (PCP)	Ability to contact on-call physician after hours within 30 minutes for urgent issues. Appropriate after hours emergency instructions	90%
Non-urgent ancillary services for MRI/mammogram/physical therapy	Appointment within 15 business days of request	70%
In-office wait time for scheduled appointments (PCP and SCP)	Not to exceed 30 minutes	70%

Compliance is measured by results from the Provider Appointment Availability Survey (PAAS) and Provider After-Hours Availability Survey (PAHAS) conducted via telephone by Health Net and the Consumer Assessment of Health Care Providers & Systems (CAHPS®[1]) survey.

[1]CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Health Net Commercial (HMO, POS, PPO, EPO, HSP) Plans Appointment Access Standards – Behavioral Health

ACCESS MEASURE	STANDARD	PERFORMANCE GOAL
Urgent care[1]	Within 48 hours	90% or more of members with a clinical risk rating of urgent have access to urgent appointments within 48 hours
Non-life threatening emergency (NLTE)[1]	Within 6 hours	90% or more of members with a clinical risk rating of NLTE have access to an appointment within 6 hours
Access to care for life-threatening emergency[1]	Immediately	100% compliance with immediate referral to care
Rescheduled Appointments[2]	Appointment was scheduled to member's satisfaction	85% or more of members report their appointment was rescheduled to their satisfaction
Non-urgent appointments with behavioral health care physician (psychiatrist) for routine care[3]	Appointment within 15 business days of request	70%
Non-urgent appointment with non-physician behavioral health care provider for routine care[3]	Appointment within 10 business days of request	70%
Urgent care appointment with non-physician behavioral health care provider or behavioral health care physician (psychiatrist) that does not require prior authorization[3]	Appointment within 48 hours of request	70%

ACCESS MEASURE	STANDARD	PERFORMANCE GOAL
Urgent care appointment with non-physician behavioral health care provider or behavioral health care physician (psychiatrist) that requires prior authorization[3]	Appointment within 96 hours of request	70%
Non-urgent follow-up appointment with non-physician behavioral health care provider[3]	Within 10 business days of request	80%

[1]Assessed through care management software.

[2]Assessed through annual BH member experience survey (ECHO).

[3]Assessed through annual Provider Appointment Availability Survey (PAAS).

Corrective Action

Health Net investigates and implements corrective action when timely access to care standards, as required by Health Net's Appointment Accessibility for all lines of businesses appointment access policy and procedure (CA.NM.05), is not met.

Health Net uses the following criteria for identifying PPGs with patterns of noncompliance and will issue a corrective action plan (CAP) when one or more metrics are noted as being noncompliant:

- Appointment access - PPGs that do not meet Health Net's 70% rate of compliance/performance goal in one or more of the appointment access metrics.
- After-hours access - PPGs that do not meet Health Net's 90% rate of compliance/performance goal in one or more of the after-hours metrics.

PPG Notification of CAP

Health Net provides the following:

- PPGs receive a description of the identified deficiencies, the rationale for the corrective action and the contact information of the person authorized to respond to provider concerns regarding the corrective action.
- Feedback to the PPGs regarding the accessibility of primary care, specialty care and telephone services, as necessary.

CAP Minimum Requirements

- Each PPG is required to send in a written improvement plan (IP) to include what interventions will be implemented for each deficiency to improve access availability. The IP must include:
  - Date of implementation of the IP.
  - Department/person responsible for the implementation and follow-up of the IP.
  - Anticipated date that the IP is expected to produce outcomes that result in correcting the deficiency.
- The PPG is to return the IP within 30 calendar days.
- The PPG is to return the signed Provider Notification of Timely Access Results Attestation that attests that the PPG has notified their providers of their individual results and of their responsibilities of compliance related to timely access.
- Providers and PPGs deemed non-compliant will be encouraged to attend a Timely Access Training session as part of the CAP process. Health Net will notify all non-compliant providers/PPGs of the training schedule and will suggest that the provider/PPG sign up for one session. Attendance at the training will be documented. A "Timely Access Provider Training" certificate must be completed after attending the training.

CAP Follow-Up Process

- If the PPG fails to return a completed IP within the prescribed time frame, the Provider Network Management (PNM) Department is asked to intercede.
- PPGs demonstrating a pattern of noncompliance with access regulations and standards are subject to an in-office audit and may be referred to PNM and the Contracting departments for further action.

Availability Corrective Action

Health Net collects and analyzes all data to identify opportunities for improvement, which is communicated to the appropriate quality committee or department to review for recommendations. Health Net implements plan-wide corrective actions based on its assessment. These results and applicable actions for improvement are communicated to practitioners, providers and PPGs through the Quality Improvement Committee or through the activities of Provider Network Management.

Availability Standards

Health Net provides established availability standards and performance goals for providers. At least annually, Health Net measures, evaluates and reports geo-access and provider availability. Listed as follows are Health Net's performance goals for geo-access and provider availability-related criteria:

Health Net EPO and PPO Geo-Access Standards*

Availability Standards	Performance Threshold
One PCP within 15 miles or 30 minutes from residence or workplace	90% or more of practitioner/provider network meet compliance rate
One SCP (including high volume SCP) within 15 miles or 30 minutes from residence or workplace	90% or more of practitioner/provider network meet compliance rate
One behavioral health practitioner (BHP) (including high volume substance abuse providers) within 15 miles or 30 minutes from residence or workplace	90% or more of practitioner/provider network meet compliance rate
One hospital within 15 miles or 30 minutes from residence or workplace	90% or more of practitioner/provider network meet compliance rate
One emergency room within 15 miles or 30 minutes from residence or workplace	90% or more of practitioner/provider network meet compliance rate
One urgent care center (must be available for extended hours to address CDI & T10§2240.1(b)(4) minimum basic health care service hours) within 20 miles or 30 minutes from residence or workplace	90% or more of practitioner/provider network meet compliance rate
One ambulatory clinic (such as urgent care center, ambulatory surgery center and free-standing renal dialysis facility) within 15 miles or 30 minutes from residence or workplace	90% or more of practitioner/provider network meet compliance rate
One ancillary care provider (laboratory, radiology and pharmacy) within 15 miles or 30 minutes from residence or workplace	90% or more of practitioner/provider network meet compliance rate

Provider Availability Standards

Availability Standards	Performance Threshold
Member to full time equivalent (FTE) PCP ratio	2,000:1
Member to FTE physician	1,200:1
Member to SCP ratio	1,200:1
Member to BHP (including substance abuse providers) ratio	5,000:1
Percent PCPs open practice	85% open practice (PCPs accepting new members)
Percent SCPs open practice	85% open practice (SCPs accepting new members)

*Certain rural portions of the plan service area may have a standard that differs from within 15 miles/30 minutes based on lack of practitioner and hospital availability. Regulatory approval is required for areas that vary from within the 15-mile/30-minute standard.

Behavioral Health Access Measurement

Health Net's access and availability policies, procedures and guidelines for providers and health care facilities providing behavioral health care are in accordance with applicable federal and state regulations, contractual requirements, and accreditation standards. These access standards are based on and monitored/regulated by the National Committee for Quality Assurance (NCQA), and the California Department of Insurance (CDI).

Health Net has a documented system for monitoring and evaluating provider availability and accessibility of care. At least annually, Health Net monitors access to care guidelines to measure behavioral health access performance and confirm compliance. Participating physician groups (PPGs) are also responsible to monitor data regarding their adherence to the following performance goals. Listed below are the appointment access provider criteria and performance goals for:

EPO/PPO

Appointment Access Standards - Behavioral Health

Access Type	Provider Guidance	Standard/Performance Goal
Initial non-urgent appointment with physician (Psychiatrist) for routine care	Within 15 business days	90% or more of physicians (psychiatrist) offer an initial non-urgent appointment within 15 business days
Initial non-urgent appointment with non-physician behavioral health care provider for routine care	Within 10 business days	90% or more of non-physicians behavioral health care providers offer an initial non-urgent appointment within 10 business days
Urgent care	Within 48 hours	90% or more of members with a clinical risk rating of urgent have access to urgent appointments within 48 hours
Non-life threatening emergency (NLTE)	Within 6 hours	90% or more of members with a clinical risk rating of NLTE have access to an appointment within 6 hours
Access to care for life-threatening emergency	Immediately	100% compliance with immediate referral to care

Access results are obtained via the Provider Appointment Availability Survey (PAAS), the Health Net Behavioral Health Access SurveyAffiliate Behavioral Health Member Satisfaction Survey and the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®)

Threshold Languages and Language Assistance Codes

Provider Type: Physicians | Participating Physician Groups (PPG) | Ancillary

Health Net established its threshold languages of Spanish, Chinese and Korean through analysis of United States Census data and direct assessment of Health Net members' preferred spoken and written languages through member mailings.

Participating providers may request member race and ethnicity information from Health Net for lawful purposes, and may verify member language preferences by contacting the appropriate Provider Services Center. For reference, the Language Assistance Codes document is located in the Health Net provider portal> Provider Reports under Welcome.

Authorization and Referral Timelines

Participating Physician Groups (PPG) | Hospitals

Hospitals Only

According to the utilization management (UM) standards - Commercial (PDF) or utilization management (UM) standards- Medicare Advantage (PDF), all hospitals are required to:

- Approve or deny and process 95 percent of all elective authorization requests within five days from the time of receipt of all clinical information
- Approve or deny and process 100 percent of all urgent requests for authorization within 24 hours
- Review 90 percent of all inpatient admissions daily
- Initiate 90 percent of all discharge planning within 24 hours of admission

For current standards, refer to the Industry Collaboration Effort (ICE) website at www.iceforhealth.org/library.asp to locate the Approved ICE Documents.

PPGs Only

According to the utilization management (UM) standards, all participating physician groups (PPGs) are required to:

- Approve or deny and process all routine authorization requests within the applicable regulatory time frame of the date of receipt of all information necessary to render a decision.
- If additional clinical information is required, the member and practitioner must be notified in writing within the applicable regulatory time frame of the extension.
- Communicate the decision to the member and practitioner within the applicable regulatory timeframe from the date of the original receipt of the request.
- Approve or deny and process all urgent requests for authorization within 72 hours after the receipt of the request for service.

The regulatory time frames begin when the delegated PPG's UM department receives a request for prior authorization. If the PPG's UM department receives a request for prior authorization of services and it is determined to be the plan's responsibility, the PPG must immediately forward the request to the plan as the regulatory time frames begin at the time of the original request. The commercial Informational Letter to Member

or Provider/Physician carve-out letter(PDF) or Medicare Advantage Informational Letter to Member or Provider/Physician carve-out letter (PDF) serves to advise the member that the PPG's utilization management entity received a prior authorization request for which the PPG is not delegated to conduct a prior authorization review and notifies the member that the request has been forwarded to the plan. The regulatory time frame for the prior authorization review does not reset or stop when this letter is issued.

For additional information, refer to:

- Utilization Management Timeliness Standards - Medicare (PDF)
- Utilization Management Timeliness Standards - Commercial (PDF)

Prior authorization for DSNP services not covered under Medicare but covered under Medi-Cal for members in Exclusively Aligned Enrollment (EAE) counties

Dual Special Needs Plan (DSNP) contractors are required to provide integrated organization determination for the DSNP members in Exclusively Aligned Enrollment (EAE) counties. For DSNP members in EAE counties, you must review **both** Medicare and Medi-Cal benefits to determine eligibility for the service requested. Do not deny prior authorization as “not a covered benefit” without checking both Medicare and Medi-Cal covered services (refer to the list of services below).

DSNP prior authorization timelines

PPGs should forward prior authorizations for the services that are not covered under Medicare but that are covered under Medi-Cal to Health Net within the following timelines:

- For standard requests, forward to Health Net within 1 business day upon receipt of the request.
- For expedited requests, forward to Health Net within 24 hours upon receipt of the request.

Fax authorizations to the Health Net Medi-Cal Prior Authorization Department fax number

Fax prior authorizations to the Medi-Cal fax number listed under Health Net Prior Authorization Department in the Provider Library’s Contacts section and include:

- The date and time that the service request was initially received.
- The clinical decision that was used to make the initial determination.

Services not covered under Medicare but covered under Medi-Cal

- Asthma remediation
- Community Based Adult Services
- Community Supports
- Community transition services/nursing facility transition services to a home
- Day habilitation programs
- Durable medical equipment (DME) that is covered by Medi-Cal
- Environmental accessibility adaptation (home modification)
- Housing deposit (up to $6,000)
- Housing tenancy and sustaining services
- Housing transition navigation
- Long-term care
- Medically tailored meals
- Nursing facility transition/diversion to assisted living facilities
- Personal care services and homemaker services
- Recuperative care
- Respite services

- Short-term post-hospitalization housing
- Sobering centers

Scenarios where PPGs would be responsible for sending out the Applicable Integrated Plan (AIP) Coverage Decision Letter

Refer to the below table to see the scenarios where PPGs are responsible for sending out the AIP Coverage Decision Letter. This will help PPGs determine when to forward the authorizations to the Plan and when to send the Applicable Integrated Plan Coverage Decision Letter for DSNP members in EAE counties.

Scenario	Delegated PPG	Health Plan
Eligibility denial	Deny and send AIP coverage decision letter.	N/A
Medical necessity denial	Deny and send AIP coverage decision letter.	N/A

Scenarios where PPGs would be responsible for forwarding the request to the Health Plan

Scenario	Delegated PPG	Health Plan
Benefit denial	Forward to Health Plan with the Medicare clinical decision.	Deny and send AIP coverage decision letter.
Out of network	Forward to Health Plan with the Medicare clinical decision.	Deny and send AIP coverage decision letter.

The Applicable Integrated Plan Coverage Decision Letter can be found in the Delegation Oversight Interactive Tool (DOIT)/MetricStream.

Credentialing and Recredentialing

Provider Type: Hospitals

Hospitals are required to:

- Assure that the credentialing/recredentialing plan meets 100 percent of National Committee for Quality Assurance (NCQA) credentialing/recredentialing standards, and execute these activities according to that plan.
- Achieve and maintain no less than 70 percent compliance with the plan's medical records criteria for each primary care physician (PCP).
- Measure and report, as a network, data elements necessary to determine compliance with Healthcare Effectiveness Data and Information Set (HEDIS®) quality benchmarks.

- Achieve and maintain compliance with Department of Health and Human Services (HHS) standards.
- Achieve and maintain compliance with Centers for Medicare and Medicaid Services (CMS) standards.
- As applicable, maintain compliance/certification with Joint Commission on Accreditation of Healthcare Organization (JCAHO).

Health Net retains the right, based on quality issues, to terminate or suspend individual practitioners, providers, and sites, regardless of the credentialing delegation status of the PPG, IPA or entity.

Obtaining Interpreter Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Ancillary

To obtain interpreter services for a Health Net member, call the telephone number on the member's identification (ID) card.

Using Family, Friends and Minors and Interpreters Obtaining Interpreter Services

Department of Managed Health Care (DMHC) regulations state that participating providers must fully inform members that they have the right to not use family, friends or minors as interpreters, and that interpreters are available to them at no cost. Providers may not require members to use family, friends and minors as interpreters.

California Department of Insurance (CDI) regulations discourage the use of family members and friends, and strongly discourage the use of minors, as interpreters for members. In an emergency situation, a minor can only be used as an interpreter if the minor demonstrates the ability to interpret complex medical information and the member is fully informed that an interpreter is available to him or her at no cost. Providers must also fully inform the member that the member has the right not to use family, friends or minors as interpreters.

Quality Improvement

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information on Health Net's quality improvement (QI) programs, procedures and policies.

Select any subject below:

- Disease Management Programs
- Language Assistance Program and Cultural Competency

- Quality Improvement Program

Disease Management Programs

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information on Health Net's disease management programs.

Select any subject below:

- Decision Power Disclaimer
- Decision Power Program

Health and Wellness Program Disclaimer

Provider Type: Physicians | Participating Physician Groups (PPG)

Members have access to our wellness programs, including Sharecare, through current enrollment with Health Net of California, Inc. Our wellness programs are not part of Health Net's commercial medical benefit plans. They are not affiliated with Health Net's provider network, and their services may be revised or withdrawn without notice. These programs, including access to any clinicians, are additional resources that Health Net makes available to enrollees.

Decision Power Program

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

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Health Net's Decision Power® (HMO, EPO, PPO, Medicare Advantage) program provides an integrated, health management solution to improve the health and quality of life for Health Net members. Through personalized interventions and contemporary behavior change methodologies, Health Net's experienced clinical staff can assist members at-risk and diagnosed with chronic health conditions to better manage their conditions through education, empowerment and support. Decision Power includes a suite of services including wellness, disease management, care management and education and support tools for members.

Nurse Advice Line

Health Net's nurse advice line provides effective, appropriate and timely triage for health-related problems through experienced registered nurses and industry-approved guidelines and protocols. Nurse advice line registered nurses accurately identify member needs and ensure they are directed to the appropriate level of care for their situation -- whether it be providing self-care guidance or recommending a visit to urgent care or the emergency room. The service is offered 24 hours a day, seven days a week, 365 days a year, in English and Spanish, with translation services available for other languages. The nurse advice line phone number is listed on the back of Health Net members' identification cards.

Wellness Programs

Health Net offers members a number of wellness programs and resources through the Wellness Center on the Health Net member portal at www.healthnet.com. Members have access to the secure Health Profile, RealAge Test (health assessment) and Lifestyle Management Coaching through Sharecare. The Online RealAge program offers a variety of program health topics, including stress, nutrition, sleep and activity. Additional resources include online health challenges, trackers, videos and more.

Providers may refer members using the Care Management Referral form (Commercial/Medicare Advantage (PDF) to:

- The Craving to Quit tobacco cessation program, available to commercial members).
- The Health Coaching Program (available to Commercial and Medicare Advantage members only).

A fax cover sheet must accompany all fax transmissions of Protected Health Information. The cover sheet must be labeled "PROTECTED HEALTH INFORMATION."

Disease Management Program

Health Net's high risk disease management program provides support to members with chronic conditions, including heart failure (HF), chronic obstructive pulmonary disease (COPD), coronary heart disease (CHD), diabetes, and asthma. Health Net disease management helps increase the efficiency and effectiveness of care, leads to more timely actions by the member, and helps develop more personalized and actionable solutions that ultimately lead to improved health outcomes. The goal of the disease management program is to support members' self-care skills, increase their self-confidence and help them work effectively with their providers to manage their health conditions. Health Net provides participants and their providers the programs, tools, connectivity, and information to make better health care decisions to:

- Slow the progression of the disease and the development of complications through proven program interventions.
- Change behaviors and improve lifestyle choices by using demonstrated behavior change methodologies.
- Improve compliance with guidelines and care plans.
- Manage medications and enhance symptom control.
- Educate members regarding recommended preventive screenings and tests in accordance with national clinical guidelines.
- Reduce emergency room visits, hospitalization and medication errors, and prevent future occurrences.

Providers may refer members using Care Management Referral form (Commercial/Medicare Advantage (PDF)). A fax cover sheet must accompany all fax transmissions of Protected Health Information. The cover sheet must be labeled "PROTECTED HEALTH INFORMATION."

Care Management

Health Net's complex care management program targets members with the most complex cases including behavioral health, often those with life-limiting diagnoses, and assists members who have critical barriers to their care. Trained nurse care managers or licensed clinical social workers provide telephonic contact with Health Net members, their families and caregivers. These members often have multiple comorbid conditions and need assistance in planning, managing and executing their care.

Health Net's telephonic case management program is available to high-risk members with less complex needs. The initial assessment and subsequent outreach is conducted over the telephone and may be face-to-face contact as needed. The Case Management department will continue coordination and re-assessments until the member's needs are met and the case can be closed. Use the Health Net Care Management Referral Form (PDF) to refer members for complex case management.

Health Nets Special Needs Plan (SNP) care management (CM)- All SNP and CMC members are automatically assigned CM during the month of CMC membership enrollment with the plan and becoming eligible with Health Net (Health Net or PPG CM assigned per delegation).

Health Net and its contracted providers are responsible for coordination and delivery of all dual special needs plan patients' Medicare and Medi-Cal benefits regardless of how the member receives their Medi-Cal benefits.

Health Education Program

Provider Type: Participating Physician Groups (PPG)

Select any subject below:

- Smoking Cessation Program

Smoking Cessation Program

Provider Type: Physicians | Participating Physician Groups (PPG)

Participating physician groups (PPGs) can implement an ongoing, systematic process for identifying members who smoke. Members may be referred to programs offered by the PPG or the Craving to Quit program.

Craving to Quit Program[1]

Sharecare is a vendor that provides an enhanced wellness program to members. Sharecare's tobacco cessation program is designed to help users who are ready to quit to permanently break their addiction to tobacco. Participants will utilize a digital support approach that provides mobile and online tools, resources and messaging features with trained experts.

Craving to Quit is an evidence-based 21-day smoking and vaping cessation program delivering treatment via app or website. The program helps retrain the brain using mindfulness to break the habit loop.

In the United States, 70 percent of smokers want to quit smoking, but only 10 percent will do so successfully on their own. This program's tools and learning modules can maximize your odds of successfully quitting. Some of the tools available include:

- Daily tracking
- Daily coaching
- Daily nudges
- An online community
- A quitting pact
- 40 additional optional modules
- Mindfulness tools

Enrollment in the tobacco cessation program is initiated by Eligible Users who are ready to quit smoking.

The digital service option provides up to twelve (12) months of unlimited support for eligible participants.

Refer members other than Medicare members to the Craving to Quit telephonic tobacco cessation program to speak to an enrollment specialist.

[1]Craving to Quit is not offered for Health Net Medicare members.

Other Tobacco Cessation Resources

Kick It California (formerly California Smoker's Helpline) is a tobacco cessation program available to Health Net members. The program offers specialized services for teens, pregnant smokers, individuals who chew tobacco, and e-cigarette users, and extends information on how to help a friend or family member quit tobacco use. Telephonic coaching is available in six languages (English, Spanish, Cantonese, Mandarin, Korean, and Vietnamese) and text programs may be obtained in English or Spanish. Members can learn more by calling Kick It California at 800-300-8086 or online at www.kickitca.org.

Recommendations

Providers should assess and document smoking status as part of the vital signs he or she collects at each clinical visit for every member. Adding smoking status to the vital signs assessment, an activity usually completed by a nurse or medical assistant prior to the physician's encounter, ensures that all smokers are identified.

Nicotine Replacement Therapy

Health Net is responsible for the approval of nicotine replacement therapy (NRT) for prescription-only and other smoking cessation products for members who have smoking cessation benefits. If applicable, providers can

complete the Prescription Drug Prior Authorization or Step Therapy Exception Request Form (PDF) (for approval of NRT), indicating that the member is using it for smoking cessation and is enrolled in a smoking cessation program.

Language Assistance Program and Cultural Competency

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information on Health Net's cultural and linguistic services.

Select any subject below:

- Language Assistance Program and Cultural Competency
- Language Assistance Program and Cultural Competency (Hospitals only)

Language Assistance Program and Cultural Competency

Provider Type: Physicians | Participating Physician Groups (PPG) | Ancillary

The Health Care Language Assistance Regulations require all health plans to provide language assistance and culturally responsive services to members with limited English proficiency (LEP), limited reading skills, who are deaf or have a hearing impairment, or who have diverse cultural and ethnic backgrounds. To comply with this requirement, Health Net created the Language Assistance Program (LAP). Health Net's LAP offers interpreter services to members to ensure that Health Net members with LEP are able to obtain language assistance while accessing health care services. Health Net's LAP supports Health Net members' linguistic and cultural needs. Additionally, Health Net offers interpreter support and requires all participating providers to take evidence-based cultural competency courses. Providers are encouraged to take courses through the U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH) as part of their continuing education. For more information, refer to OMH Think Cultural Health.

Health Net participating providers must comply with Health Net's LAP as defined in this section.

Compliance Requirements

Health Net participating providers, including case management and utilization management (UM)-delegated providers, are required to comply with Health Net's LAP by using the following:

- Interpreter services - Use qualified interpreters for members with LEP. Interpreter services are provided by Health Net at no cost to providers or members. Interpretation services include face-to-face (in-person), telephone, video remote, sign language (including American Sign Language and tactile), and closed captioning interpretation. Please request interpretation services at least 5-10 days before the scheduled appointment.
    - Telephone interpreters are available in more than 150 languages. Advance notice for telephone interpreters is not required.
- Translation services - Provide Health Net, upon request and in a timely manner, with the documents sent to members. If a Health Net member requests translation or an alternative format of an English document that was produced by a delegated PPG on Health Net's behalf, the provider must refer the member to the Health Net Member Services phone number listed on the member's identification (ID) card. When Member Services receives the request from the member, Health Net contacts the provider requesting a copy of the specific English document for translation or alternative format. The provider must submit the document within 48 hours of Health Net's request. Translation is only available in threshold languages
- Tagline and non-discrimination notice - Include a Health Net-specific tagline and non-discrimination notice with all member informing materials going to Health Net members.

Commercial	CalViva Health	Community Health Plan of Imperial Valley	Medi-Cal
Commercial Non-discrimination Notice (PDF)	Non-discrimination Notice CalViva Health (English) (PDF)	Non-discrimination Notice Community Health Plan of Imperial Valley (English) (PDF)	Non-discrimination Notice Medi-Cal (English) (PDF)
	Non-discrimination Notice CalViva Health (Hmong) (PDF)	Non-discrimination Notice Community Health Plan of Imperial Valley (Spanish) (PDF)	Non-discrimination Notice Medi-Cal (Arabic) (PDF)
	Non-discrimination Notice CalViva Health (Spanish) (PDF)		Non-discrimination Notice Medi-Cal (Armenian) (PDF)
			Non-discrimination Notice Medi-Cal (Cambodian) (PDF)
			Non-discrimination Notice Medi-Cal (Chinese) (PDF)

Commercial	CalViva Health	Community Health Plan of Imperial Valley	Medi-Cal
			Non-discrimination Notice Medi-Cal (Farsi) (PDF)
			Non-discrimination Notice Medi-Cal (Hmong) (PDF)
			Non-discrimination Notice Medi-Cal (Korean) (PDF)
			Non-discrimination Notice Medi-Cal (Russian) (PDF)
			Non-discrimination Notice Medi-Cal (Spanish) (PDF)
			Non-discrimination Notice Medi-Cal Tagalog) (PDF)
			Non-discrimination Notice Medi-Cal (Vietnamese) (PDF)

- Member complaint/grievance forms - Provide translated member grievance forms (provided under the Forms section of the provider library) to members upon request.
- Independent Medical Review (IMR) Application - Locate translated IMR applications on the Department of Managed Health Care (DMHC) website at www.dmhc.ca.gov and make them available to members upon request.
- Medical record documentation - Document the member's language preference (including English) and the refusal or use of interpreter services in the member's medical record.

Interpreter Services

Health Net offers 24-hour access to interpreter services at no cost. To obtain interpreter services, members and providers can contact Health Net Member Services at the phone number located on the member's ID card. Telephone interpreters are available at the time of the appointment without prior arrangement. Allow adequate time before the appointment to get the telephone interpreter on the line.

Language assistance services include:

- Qualified interpreters trained on health care terminology and a wide range of interpreting protocols and ethics.
- Telephone interpreters available in more than 150 languages and on short notice in support of last-minute appointments to meet the revised access and availability standards.

- Face-to-face (in person), telephone, video remote, and sign language interpreter services, closed captioning interpretation services are available when requested a minimum of 10 business days in advance of the appointment.

- Support to address common communication challenges across cultures.
- Oral translations of member materials in more than 150 languages.

Provider Responsibilities

Participating providers must ensure that language services meet the established requirements as follows:

- Ensure that interpreters are available at the time of the appointment.
- Ensure that members with LEP are not subject to unreasonable delays in the delivery of services, including accessing providers after hours.
- Provide interpreter services at no cost to members.
- Extend the same participation opportunities in programs and activities to all members regardless of their language preferences.
- Provide services to members with LEP that are as effective as those provided to members without LEP.
- Record the language needs of each member, as well as the member's request or refusal of interpreter services, in their medical record. Providers are strongly encouraged to document the use of any interpreter in the member's record.
- Provide translated member grievance forms to members upon request.

Providers are prohibited from:

- Requesting or requiring an individual with LEP to provide their own interpreter.
- Relying on staff other than qualified bilingual/multilingual staff to communicate directly with individuals with LEP.
- Relying on an adult or minor accompanying an individual with LEP to interpret or facilitate communication except in the following scenarios:
    - An accompanying adult may be used to interpret or facilitate communication when the individual with LEP specifically requests that the accompanying adult interpret, the accompanying adult agrees to provide such assistance and reliance on that adult for such assistance is appropriate under the circumstances. Providers are encouraged to document in the member's medical record the circumstances that resulted in the use of a minor or accompanying adult as an interpreter.
    - A minor or an adult accompanying the patient may be used as an interpreter in an emergency involving an imminent threat to the safety or welfare of the individual or the public where there is no qualified interpreter for the individual with LEP immediately available.
- Providers are encouraged to document in the member's medical record the circumstances that resulted in the use of a minor or accompanying adult as an interpreter.

Providers are responsible to provide translated care plans in threshold languages to members with LEP and/or their caretakers. Care plans must be written at a 6th grade reading level for Medi-Cal and 8th grade reading level for Commercial members. Health Net provides the translations in threshold languages upon request with documentation that the content is at the applicable reading level. Refer to the provider Interpreter Services Quick Reference Guide for assistance.

- Interpreter Services Flyer (PDF) (Commercial and Medi-Cal)
- Interpreter Services Flyer (PDF) (CalViva Health)
- Interpreter Services Flyer (PDF) (Community Health Plan of Imperial Valley)

A Language Identification Poster is available to print and post in providers' offices.

- Commercial, Medi-Cal Language Identification Poster (PDF)
- CalViva Health Language Identification Poster (PDF)
- Community Health Plan of Imperial Valley Language Identification Poster (PDF)

For more information about how to work with an interpreter, refer to the Health Industry Collaboration Effort (ICE): Provider Tools to Care for Diverse Populations – Health Net (PDF), Health Industry Collaboration Effort: Provider Tools to Care for Diverse Populations – Community Health Plan of Imperial Valley (PDF) or Health Industry Collaboration Effort: Provider Tools to Care for Diverse Populations – CalViva Health Industry Collaboration Effort (PDF).

Cultural Competency Training

All Health Net participating providers must take cultural competency training. We suggest that you take one of the trainings offered by the Office of Minority Health (OMH). The trainings are computer-based training for health care providers. OMH developed these no-cost trainings to give providers competencies to better treat an increasingly diverse population. The general training is available at Think Cultural Health. OMH also has a no-cost, accredited maternal health care training available at Think Cultural Health Education. Health Net does not sponsor these trainings or materials.

The Institute for Healthcare Improvement has free downloads to improve plain language communication with patients under the Ask Me 3® program.

You can also access Health Net's cultural competency training for providers and PPG staff or contact Health Net's Health Equity Department for customized training to meet your needs.

Medi-Cal providers may have the completion of cultural competency training listed in the provider directory. The provider directory indicates a "Y" if the provider has completed two hours of cultural competency training within the last 24 months.

Providers who would like information about interpreter services, cross-cultural communication, health literacy or to schedule a training, can contact Health Net's Health Equity Department.

Language Assistance Program and Cultural Competency

Provider Type: Hospitals

Health Net maintains an ongoing Language Assistance Program (LAP) to ensure members with limited English proficiency (LEP), limited reading skills, who are deaf or have hearing impairment, or who have diverse cultural and ethnic backgrounds have appropriate access to language assistance while accessing health care services. Health Net encourages providers to consider evidence-based cultural competency courses through the U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH) as part of their continuing education. For more information, refer to OMH Think Cultural Health.

Hospital Requirements

Health Net's participating hospitals are subject to requirements to provide language interpreter services for their patients pursuant to federal and state law. Health Net expects its participating hospitals to fully meet these obligations, notwithstanding Health Net's separate obligations to meet all requirements under the Health Care Language Assistance Regulations to provide language interpreter services for its members at all points of contact.

Interpreter Services Requirements

Section 1557 of the Affordable Care Act (published as 45 CFR 92) provides guidance on interpreter services, including the use of bilingual staff that act as interpreters. The guidance is summarized below.

- Provide services to individuals with LEP and individuals with a hearing incapacity that are as effective as those provided to members without LEP.
- Providers may not request or require an individual with LEP to provide their own interpreter.
- Providers may not rely on staff other than qualified bilingual/multilingual staff to communicate directly with individuals with LEP.
- Providers may not rely on an adult or minor accompanying an individual with LEP to interpret or facilitate communication except in the following scenarios:
    - A minor or an adult accompanying the patient may be used as an interpreter in an emergency involving an imminent threat to the safety or welfare of the individual or the public where there is no qualified interpreter for the individual with LEP immediately available.
    - An accompanying adult may be used to interpret or facilitate communication when the individual with LEP specifically requests that the accompanying adult interpret, the accompanying adult agrees to provide such assistance and reliance on that adult for such assistance is appropriate under the circumstances. Providers are encouraged to document in the member's medical record the circumstances that resulted in the use of a minor or accompanying adult as an interpreter.
    - Health Net members have the right to file a grievance with Health Net if their language needs are not met. Members can also file a discrimination complaint with the Office of Civil Rights if their language needs are not met.

Health Net has processes in place to ensure that members with LEP can obtain Health Net's assistance in arranging for the provision of timely interpreter services to the extent its participating hospitals are not required under state and federal law to provide a particular Health Care Language Assistance Regulations-required interpreter service.

Health Net monitors its participating hospitals for deficiencies in interpreter services and takes appropriate corrective action to address these deficiencies in the delivery of interpreter services to Health Net members.

Providers who would like to schedule trainings on topics such as cross-cultural communication, health literacy or accessing interpreter services should contact Health Net's Health Equity Department.

For additional information, refer to Health Net's Interpreter Services or the Health Industry Collaboration Effort (HICE): Provider Tools to Care for Diverse Populations (PDF).

Quality Improvement Program

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information on the Health Net Quality Improvement (QI) program.

Select any subject below:

- Participation in Public Reporting of Hospital Performance
- Quality Improvement HAC Program
- Quality of Care Issues

Participation in Public Reporting of Hospital Performance

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net requires that all urban, acute care participating hospitals annually report safety and quality data results to at least one readily available consumer outlet, such as the Leapfrog Group Patient Safety Survey and the Centers for Medicare & Medicaid Services (CMS) Hospital Compare website.

WebMD’s Hospital Advisor and publiclyavailable hospital quality information

Health Net's Hospital Advisor Tool from WebMD offers members a wide range of details about the quality performance of individual hospitals, including rates of complications and mortality, the quantity of specific procedures performed at the facility, typical lengths of stay, average cost, and a variety of quality and patient safety indicators. The data is based on sources such as state reporting, survey results from The Leapfrog Group, CMS hospital quality indicators, and hospital patient satisfaction information. Health Net promotes

member use of hospital quality data in mailed member letters and newsletters, online, by email, and in paid social media campaigns.

Similar data can be accessed by providers at the following publicly available websites:

- Cal Hospital Compare
- The Centers for Medicare and Medicaid Services resource Care Compare
- The Leapfrog Group (see below) for hospital ratings and Hospital Safety Grades

The Leapfrog Group

The Leapfrog Group is an organization founded to promote patient safety and improve quality of care. As a Leapfrog Partner, Health Net promotes participation in the Leapfrog hospital and ambulatory surgery center (ASC) surveys, which offer consumers key information about a facility's quality and safety performance with respect to established patient safety practices and progress toward national quality standards. Examples of hospital survey measures include:

- Computerized physician order entry.
- Intensive care unit physician staffing.
- Evidence-based hospital referral.
- Safe practices score based on National Quality Forum standards.

Participation in Leapfrog's surveys offers hospitals and ASCs the ability to assess their strengths and weaknesses in areas such as hospital-acquired infection scores and evidence-based care to address common acute conditions. In addition to making these survey findings publicly available, Leapfrog publishes a Hospital Safety Grade. This composite score assigns individual hospitals a letter grade to indicate hospital performance on patient safety according to an analysis of up to 27 quality measures. For more information, visit The Leapfrog Group.

Quality Improvement HAC Program

Provider Type: Hospitals

Health Net's Quality Improvement (QI) Hospital-Acquired Condition (HAC) program is designed to monitor patient care and to encourage quality improvement efforts in hospitals. The QI HAC program assesses member claims data to identify potential HACs; conducts outreach to hospitals to request details about each case; and follows up with further investigation through Potential Quality Issue referrals when appropriate. In the event that problems are identified, Health Net requests that hospitals assess their programs so that protocols can be revised to prevent such events in the future. The program is informed by guidance from CMS and The Leapfrog Group, which represents purchasers and employer groups, to help ensure that evidence-based protocols are followed for all members to ensure safe patient care. Refer to hospital-acquired conditions for more information on the HAC process and billing.

Quality of Care Issues

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Potential quality of care issues are reviewed by a Health Net medical director and, based on findings, are given a severity level and, as indicated, submitted to the peer review committee (PRC) for appropriate resolution. At a minimum annually, the number, severity, actions taken, and trends noted are aggregated and reported to the Health Net Quality Improvement Committee.

Providers use the Potential Quality Issue (PQI) Referral form Health Net Referral Form (PDF), Potential Quality Issue (PQI) Referral form – Community Health Plan of Imperial Valley (PDF) or CalViva Health Referral Form (PDF) to fax reports of potential or suspected deviation from standards of care that cannot be justified without additional review or investigation.

Referrals

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information on referrals.

Select any subject below:

- Direct Network Referral Process
- Investigational and Experimental Treatment
- OB/GYN Self-Referrals

Direct Network Referral Process

Provider Type: Physicians | Ancillary | Hospitals

Primary care physicians (PCPs) are responsible for coordinating member care and initiating specialty services. PCPs may refer a member directly to a participating specialist for specialty consultation, in-office services and selected outpatient services that do not require prior authorization.

Investigational and Experimental Treatment

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG)

All participating providers must immediately inform Health Net when there is a request for investigational or experimental treatment. All pertinent documentation for investigational or experimental treatments must be sent to the Health Net Medical Management Department by fax or mail.

In accordance with standards established by the Department of Managed Health Care (DMHC), Health Net has five business days to respond to member requests for review of investigational or experimental treatment. Health Net is required to review all requests for these procedures and is responsible for issuing the denial letter if the treatment is denied.

Health Net's denial letter states the medical and, if applicable, scientific reasons for the denial and any alternative treatment that Health Net does cover. The denial letter also includes an application and instructions for the member to utilize the DMHC Independent Medical Review (IMR) Program.

Participating providers should not direct members to contact Health Net for approval of these services. It is the requesting provider's responsibility to provide all pertinent information and documentation directly to Health Net.

Experimental medical and surgical procedures, equipment and medications, are not covered by Original Medicare or under a Medicare-approved clinical research study. Experimental procedures and items are those items and procedures determined by Health Net and Original Medicare to not be generally accepted by the medical community.

DMHC Notices of Translation Assistance, Forms and Applications

DMHC Notices of Translation Assistance

Participating providers are required to insert a notice of translation assistance when corresponding with applicable members. DMHC Health Net-specific notices of translation assistance are available on the Health Industry and Collaboration Effort (ICE) website at www.ICEforhealth.org > Library > Approved ICE Documents > Cultural and Linguistic Services. For additional information, providers can contact Health Net Cultural and Linguistic Services Department.

Translated DMHC Complaint (Grievance) Forms

Physicians and ancillary providers must know how to locate and provide translated DMHC complaint (grievance) forms to members upon request. These forms are available in English, Chinese and Spanish and other languages on the DMHC website at www.dmhc.ca.gov located under File a Complaint.

Translated DMHC IMR Applications

Physicians and ancillary providers must know how to locate and provide translated DMHC IMR applications to members upon request. This application is available in English, Chinese and Spanish on the DMHC website at www.dmhc.ca.gov and search for IMR applications.

OB/GYN Self-Referrals

Provider Type: Physicians | Participating Physician Groups (PPG)

PPG Information

Health Net members have the right to self-refer for a screening mammography. In addition, members have direct access to participating women's health specialists for routine and preventive health care services provided as basic benefits.

If a member needs OB/GYN preventive care, is pregnant or has a gynecological concern, she may self-refer to an OB/GYN or family practice physician who provides such services within the member's participating physician group (PPG). If these services are not available within the PPG, the member may go to one of the PPG's referred physicians who provide OB/GYN services. Each PPG must be able to assist members by maintaining a list of its referral physicians. The OB/GYN consults with the member's PCP regarding the member's condition, treatment and any need for follow-up care.

Physician Information

A female member may obtain obstetrician and gynecologist (OB/GYN) services without first contacting her primary care physician (PCP). If the member needs OB/GYN preventive care, is pregnant or has a gynecological concern, she may self-refer to an OB/GYN or family practice physician who provides such services within Health Net's participating provider network.

If these services are not available within Health Net's participating provider network, Health Net authorizes services to a qualified non-participating provider of OB/GYN services in accordance with the Health Net prior authorization procedures.

The OB/GYN consults with the member's PCP regarding the member's condition, treatment and any need for follow-up care.

Third-Party Liability

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information on third-party liability responsibilities.

Select any subject below:

- Coverage Explanation

Coverage Explanation

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

If a subscriber or member is injured through an act or omission of another person, the participating provider must provide benefits in accordance with the Evidence of Coverage (EOC) or Certificate of Insurance (COI). If the injured member is entitled to recovery, the plan and the participating provider rendering services to the member are entitled to recover and retain the value of the services provided from any amounts received by the member from third-party sources.

When the plan pays a claim with an injury or trauma diagnosis code that may be related to a motor vehicle accident, employment or possible other third-party liability, the plan may use an outside vendor, the Rawlings Company, to investigate for determination of other coverage liability. Rawlings' expertise and automated system capabilities are used to identify claims where a third party may be responsible for payment. Rawlings may directly correspond with providers requesting refunds when another liability coverage is determined to be primary. If a provider receives a refund request letter from the Rawlings Company that includes the primary coverage insurance information in the event that the provider has not already been provided the other coverage information by the member or billed the primary carrier, the provider is expected to bill the other coverage and refund the plan, via the Rawlings Company, within a reasonable time period. Failure to comply with timely filing guidelines when overpayment situations are the result of another carrier being responsible does not release the participating provider from liability.

Reimbursement to the plan or the participating provider under this lien is based on the value of the services the member receives and the costs of perfecting the lien. The value of the services depends on how the participating provider was paid and the lien amount is determined as permitted by law. Unless the money that the member receives comes from a workers' compensation claim, the following applies:

- The amount of the reimbursement that the member owes the plan or the participating provider is reduced by the percentage that the member's recovery is reduced if a judge, jury or arbitrator determines that the member was responsible for some portion of the member's injuries.
    - For plans subject to state law, when the member is represented by an attorney: the lien will be the lesser of a *pro rata* reduction for the member's reasonable attorney fees and costs paid by the member from the money received in the underlying third-party case, or one-third of the member's recovery.
    - For plans subject to state law, when the member is not represented by an attorney: the lien will be the lesser of the full amount of the lien otherwise due or one-half of the member's recovery.

Provider and Member and Responsibilities

Provider Responsibility

The participating provider must question the member for possible third-party liability (TPL) in injury cases. Often, the member does not mention that this liability exists, having received complete care without charge from the participating provider and may not feel that it is necessary. The participating provider must check for this liability where treatment is being provided. The participating provider must develop procedures to identify

these TPL cases. After TPL has been established, the participating provider must provide the plan with the information using the Authorization to Treat a Member form or other correspondence.

Submit Itemized Charges and Member's Statement of Liability for Reimbursement

When the participating provider seeks reimbursement from the third-party payer, it must do so by filing an appropriate lien. This may be done by submitting an itemized statement for paid claims or value of services rendered, whichever is appropriate, and a member's statement of third-party liability to any person or entity which may receive payments made in a settlement or judgment in the TPL case.

Lien Coordination

The participating provider must coordinate with any participating providers that assert a lien and ensure that all communication received by the member in this regard is consistent. In the event that the PPG is assigned recovery of a hospital lien, the plan must be advised promptly.

Calculation of Lien Amount

The participating providers' staff is responsible for remaining current on legal developments regarding TPL recoveries. In determining the amount of the lien, follow guidelines prepared by counsel. Recoveries for coordination of benefits (COB), duplicate payments and the like should be reconciled promptly. Where the participating provider asserts the contractual lien based on Evidence of Coverage (EOC) or Certificate of Insurance (COI), it is subject to:

- A reduction by the percentage that the member's recovery is reduced if a judge, jury or arbitrator determines the member is responsible for some portion of the member's injuries.
    - For plans subject to state law, when the member is represented by an attorney: the lien will be lesser of a pro ratareduction for the member's reasonable attorney fees and costs paid by the member from the money received in the underlying third-party case, or one-third of the member's recovery.
    - For plans subject to state law, when the member is not represented by an attorney: the lien will be the lesser of the full amount of the lien otherwise due or one-half of the member's recovery.

It is the participating provider's responsibility to act reasonably in pursuing a lien.

Member Responsibility

An injured member entitled to recovery is required to:

- Inform the plan and participating providers of the name and address of the third party, if known, the name and address of the member's attorney, if using an attorney, and describe how the injuries were caused.
- Complete any paperwork that the plan or the participating providers may reasonably require to assist in enforcing the lien.

- Promptly respond to inquiries from lien holders about the status of the case and any settlement discussions.
- Notify lien holders immediately upon the member or the member's attorney receiving any money from third parties or their insurance companies.
- Hold any money that the member or the member's attorney receives from third parties or their insurance companies in trust, and reimburse the plan and the participating providers for the amount of the lien as soon as the member is paid by the third party.

Utilization Management

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section describes Health Net's utilization management program and processes.

Select any subject below:

Overview

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net's utilization management (UM) program is designed to ensure that members receive timely, medically necessary and cost-effective health care services at the correct level of care. The scope of the program includes all members and network providers. Prior authorization, concurrent review, discharge planning, care management, and retrospective review are elements of the UM process.

Refer to definition of medical necessity or definition of investigational services for additional information.

Care Management

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information on care management.

Select any subject below:

Overview

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG)

Health Net's care management program is available to all members to:

- Create a comprehensive system of medical management,
- Use resources and managed health care expertise collaboratively, and
- Provide a full complement of coordinated cost-effective care.

The Health Net care management program provides individualized assistance to members experiencing complex, acute or catastrophic illnesses. The focus is on early identification of and engagement with high-risk members, applying a systematic approach to coordinating care and developing treatment plans that increase satisfaction, control costs and improve health and functional status, resulting in favorable outcomes.

Health Net's care management program uses qualified nurses, social workers and medical directors to provide a fully integrated network of programs and services for the management of high-risk, chronic and catastrophically ill or injured individuals.

High and moderate risk Special Needs Plans (SNPs) members who are actively engaged are managed by the health plan’s case manager in order to implement their individual care plan which is designed to support the member’s optimal level of wellness.

Program Goals

The Health Net care management program goals are to achieve, in collaboration with providers, the following:

- **Quality health outcomes** - Identifies, manages, measures, and evaluates the quality of health care delivered to high-risk populations. This is accomplished by using identification tools and

performance benchmarks that continually evaluate clinical, functional, satisfaction, and cost indicators.

- **Cost effectiveness** - Health Net is committed to measuring the effectiveness of the care management program. Additionally, with timely and accurate encounter reporting from participating physician groups (PPGs), Health Net can provide clinical and cost information feedback to PPGs to assist them in enhancing the performance of their medical management and disease-state management programs.
- **Resource efficiency** - The Health Net care management team works with internal and external stakeholders to develop outcome studies and educational programs to improve the efficiency and effectiveness of Health Net's and the PPG's care management activities.

Program Description

Provider Type: Participating Physician Groups (PPG)

The Health Net care management program integrates the care management process, eliminates duplication of services between Health Net and its participating physician groups (PPGs), and facilitates communication and cooperation between Health Net, PPGs and members.

Health Net case managers, or delegated PPGs, assure that potential medically catastrophic cases are managed in cooperation with the member's primary care physician (PCP) to achieve optimum care and coverage benefits for the member. Case managers provide assistance by working with members, caregivers, physicians, and other members of the care team.

The following criteria are used for case management:

1. Lack of an established or ineffective treatment plan – for example, a member with multiple providers and multiple services who continues to use the emergency room or continues to have multiple admissions for the same conditions.
2. Over-, under- or inappropriate utilization of services – for example, a member who inappropriately over-utilizes emergency room services, or who does not have an established PCP or specialty care provider, when appropriate.
3. Permanent or temporary alteration of functional status – for example, a member with a hip replacement who is discharged with no home support or is unable to get to medical appointments and/or physical therapy.
4. Medical/psychosocial/functional complications – for example, an elderly member with multiple medical conditions (comorbidity) and depression who is unable to manage activities of daily living, medications and diet.
5. Barriers to receiving appropriate care within the system – for example, a newly diagnosed cancer patient who has been educated by coaches, but who would also benefit from coordination of care services through Health Net's case management.
6. Nonadherence to treatment or medication regimens, or missed appointments – for example, a member with transportation needs who is unable to get to physician appointments, or who has transportation or financial barriers to filling medication prescriptions.
7. Compromised patient safety – for example, an elderly member, post hip replacement, who lives on the second floor requires home evaluation for safety concerns.

8. High-cost injury or illness – for example, a member in a severe motor vehicle accident with multiple injuries would require coordination of and authorization for multiple services for an extended period of time.
9. Lack of family or social support – for example, a post-operative member with wound care, but without family support to assist with dressing needs.
10. Lack of financial resources to meet health needs – for example, a member requiring extensive wound vacuum services but who has exhausted benefits, or a senior member who needs transportation, home help or other noncovered items.
11. Exhaustion of benefits – for example, a member with medical necessity for a specialized hospital bed, but the member's durable medical equipment (DME) benefit is exhausted.

Health Net case management functions operate according to Case Management Society of America standards.

Assessment

Assessment is the first step in the care management process. The Health Net care management team gathers information to assess the member's care gaps and needs. Information may include health risk assessment results, medical records and interviews with the member and health care team. The care manager utilizes the results of the assessment to develop a care management plan in collaboration with the member, or their designated representative, to address care needs. For additional information, refer to Case Management at PPG > Initial Assessment and Ongoing Management.

Evaluation and Monitoring

The care management process continually evaluates quality of care, efficiency of services and cost-effectiveness. Monitoring occurs at:

- Plan level - oversight of the member's care through periodic reviews of health status and needs, evaluation of satisfaction with and use of services, and reports on the ongoing savings of disease-specific care
- Member level - review of clinical status and problems, communication with the physician and other members of the health care team, and use of satisfaction surveys

Implementation

Actions are taken to address the care needs identified in the assessment process and documented in the care management plan. The implementation of these actions includes working with the member's PPG to provide the needed services, referring members to community services or advocating provision of informal services by family and friends. The care manager supports the physician's plan of care through continually monitoring and finding new available resources.

Planning

Successful planning involves a multi-disciplinary approach developed by the provider and the care manager. This may include disciplines from both internal and key external parties, because each brings a unique

perspective. Planning can occur formally in a care conference or informally through working individually with other providers. A care plan may be limited to arranging temporary home care after a hospital discharge or it may serve to integrate long-term health care, social services and informal care.

Care Management at PPG

Provider Type: Participating Physician Groups (PPG)

The following information is not applicable to Dual Special Need Plans.

Health Net members who are experiencing catastrophic and chronic injuries or illnesses are evaluated for care management services. Health Net delegated participating physician groups (PPGs) can use a variety of population data sources to identify members for care management, including, but not limited to:

- Data collected through utilization management (UM) processes, such as prior authorization and concurrent review
- Hospital admission data
- Hospital discharge data
- Claims and encounter data
- Pharmacy data

In addition to data identification, the care management program must have multiple avenues for members to be referred for care management services. This includes discharge planner referral, UM or concurrent review referral, member self-referral, and practitioner referral.

Care Management Vendors

For some conditions, ancillary providers contracting with Health Net to provide services can provide member care management related to those conditions. For specific ancillary provider information, contact the Health Net Care Management Department.

Initial Assessment and Ongoing Management

The care management process should be problem-focused and address risks. Goals should be actionable and address the member's needs. Documentation, typically kept in a care plan, needs to define issues, problems and appropriate interventions, and include follow-up evaluations. The care manager must document that the member was contacted and notified of their right to decline or disenroll from care management services.

The care management process must consider all of the following elements:

- Initial assessments of members' health status, including condition-specific issues
- Documentation of clinical history, including medications
- Initial assessment of activities of daily living (ADLs)
- Initial assessment of behavioral health status, including cognitive functioning
- Initial assessment of life-planning activities

- Evaluation of cultural and linguistic needs, preferences or limitations
- Evaluation of caregiver resources and involvement
- Evaluation of available benefits within the organization and from community resources
- Development of care management plan with prioritized goals that consider the member and caregivers' preferences and desired level of involvement in the care plan
- Identification of barriers to meeting goals or complying with the plan
- Development of a schedule for follow-up and communication
- Development and communication of self-management plans
- Process to assess progress in care management plans
- Evaluation of visual and hearing needs and limitations
- Facilitation of member referrals to resources and follow-up process to determine whether the members act on referrals

In addition, Health Net may request feedback on members referred by the health plan to the PPG for care management screening.

Providing Tools to Care Managers

To assist care managers in monitoring cases, Health Net can provide PPGs with forms, tracking tools and information on how to access community resources for its members. Care management must be evidence-based and the systems and processes to support care management should use algorithmic logic, such as scripts or other prompts to guide care managers through the assessment and ongoing management of members.

Health Net care managers and provider service specialists can assist PPGs in obtaining tools and information necessary to direct Health Net members through the care continuum.

PPG Screening Criteria

Health Net members who meet the following criteria should be screened for care management services:

- Members with multiple admissions (two or more hospitalizations) within six months
- Members with multiple emergency room (ER) visits (three or more), or two hospital admissions, for the same condition within six months
- Members with multiple ER visits (five or more) for multiple conditions within six months
- Members who are eligible for public health programs
- Members who are accepted into clinical trials
- Pregnant members with high-risk conditions who require home health services
- Members identified through the health risk questionnaire process
- Members referred from Health Net's Care Management Department

For additional information, refer to Care Management Program Description.

Note: All Health Net Special Needs Plan (SNP) members are assigned a care manager; therefore, screening to meet specific criteria for program participation is not necessary.

Delineation of Care Management Responsibilities

To achieve the goals of the Health Net care management program, Health Net monitors care management processes to ensure there is no duplication of efforts between Health Net and participating physician groups (PPGs).

In some instances, the PPG or associated hospital has direct responsibility for specific tasks, such as authorization of professional services and on-site concurrent review. Other tasks are Health Net's responsibility, such as education of various key parties in the care management of members. Where shared responsibilities occur, communication between Health Net and the PPG becomes especially vital in ensuring that each operates as efficiently as possible.

Health Net Care Management Responsibilities

Health Net is responsible for the following care management activities when the PPG completes the member's care management functions:

- Provide oversight as required by regulatory agencies, such as the California Department of Managed Health Care (DMHC), the Centers for Medicare and Medicaid Services (CMS), and by accrediting entities, such as the National Committee for Quality Assurance (NCQA)
- Inform referral source of member's participation in the Health Net care management program
- Notify the provider that the member is assigned to the Health Net care management program
- Review the proposed plan of care with a Health Net regional medical director, as requested or indicated based on established processes
- Encourage providers and members to take responsibility for implementation of the care plan
- Monitor progress and service provided to the member
- Offer suggestions for revisions to the care plan to meet the changing health care needs of the member
- Serve as a source of information for the availability and costs of community resources within each geographic area
- Participate in meetings at hospitals, skilled nursing facilities (SNFs) and home health agencies as indicated when they pertain to member care management
- Evaluate the services provided and, with the provider and member, determine when the member should be discharged from the Health Net care management program (not applicable for SNP)
- Incorporate disease management into the care management program, as appropriate

PPG Care Management Responsibilities

The PPG is responsible for the following care management activities:

- Utilize the Health Net designated care management program for members who meet guidelines, such as state management and transplants
- Provide care management program activities meeting Health Net and regulatory standards
- Provide treatment and member-care documentation to Health Net when requested
- Participate in Health Net's care management program evaluation activities when requested by Health Net
- Provide feedback to Health Net on members referred by Health Net to the PPG for care management

Prospective Care Management

The Health Net prospective care management process begins with identification of at-risk members. Throughout this phase of the program, multiple modalities are used to evaluate the member's clinical and psychosocial status. Some of these modalities include health risk assessments, wellness programs, preventive measures, and evaluation of Healthcare Effectiveness Data and Information Set (HEDIS®) and risk management information. Identification and intervention is integrated with disease management programs.

Health Net's care managers collaborate with a team of Health Net medical directors, the primary care physician (PCP) and participating physician group (PPG) staff to coordinate identification and arrangement of care, the care plan, evaluation of the effectiveness of the care plan, and communication with the interdisciplinary team during all phases of treatment.

NICU Levels of Care Criteria

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals

Health Net's neonatal intensive care unit (NICU) levels of care criteria (PDF) is used by delegated participating physician groups (PPGs), contracting vendors and concurrent review staff when assessing, documenting and authorizing NICU care. These criteria apply to the HMO, PPO and Point of Service (POS) lines of business.

Health Net contracts with Alere care management services to provide NICU services for those PPGs who participate in the program. Alere provides onsite case management services for newborns who require admission into the NICU. Health Net's concurrent review department continues oversight and works collaboratively with Alere staff to ensure ongoing delivery of appropriate care, services and safe discharges when the infant is ready to transition from the hospital setting.

Targeting and Clinical Data Analysis

Provider Type: Physicians | Participating Physician Groups (PPG)

Initial identification of high-risk members is accomplished prospectively using health risk assessments, concurrently through Health Net's online databases of diagnostic information, and retrospectively based on medical and pharmacy claims and other data.

With early identification of potentially high-risk members, resources may be directed to those members at greater risk for poor health and higher costs. Certain factors, such as chronic health problems, lifestyle risks, family health, and quality-of-life considerations, influence medical care use. The Health Net care management program helps the member become a better-educated health care consumer and supports the provider by supplying vital information regarding the member and the member's care.

Clinical Criteria for Medical Management Decision Making

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Clinical policies are one set of guidelines used to assist in administering health plan benefits, either by prior authorization or payment rules. They include, but are not limited to, policies relating to medical necessity clinical criteria for the evaluation and treatment of specific conditions and evolving medical technologies and procedures. Clinical policies help identify whether services are medically necessary based on information found in generally accepted standards of medical practice; peer-reviewed medical literature; government agency/ program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by the policy; and other available clinical information.

Clinical polices do not constitute a description of plan benefits nor can they be construed as medical advice. These policies provide guidance as to whether or not certain services or supplies are cosmetic, medically necessary or appropriate, or experimental and investigational. The policies do not constitute authorization or guarantee coverage for a particular procedure, device, medication, service, or supply. In the event a conflict of information is present between a clinical policy, member benefits, legal and regulatory mandates and requirements, Medicare or Medicaid (as applicable) and any plan document under which a member is entitled to covered services, the plan document and regulatory requirements take precedence. Plan documents include, but are not limited to, subscriber contracts, summary plan documents and other coverage documents.

Clinical policies may have either a Health Net Health Plan or a “Centene” heading. Health Net utilizes InterQual® criteria for those medical technologies, procedures or pharmaceutical treatments for which a specific health clinical policy does not exist. InterQual is a nationally recognized evidence-based decision support tool. Clinical policies are reviewed annually and more frequently as new clinical information becomes available.

Continuity of Care

Provider Type: Physicians | Participating Physician Groups (PPG) (does not apply to HSP)| Hospitals

Health Net provides for continuity of care (COC) for new and existing members due to termination of prior coverage and any health plan withdrawn from any portion of the market for a currently enrolled Health Net member. Health Net members who have been receiving care that meets certain criteria may continue with their existing out-of-network providers for up to 12 months.

A current member may also request COC to complete care with a departing Health Net provider after that provider leaves Health Net's network. Covered services are provided for the period of time necessary to complete a course of treatment and to arrange for safe transition of care to another provider. Health Net makes the decision in consultation with the member and the terminated provider or nonparticipating provider, and consistent with good professional practice.

Continuity of Care

Member requests for COC assistance must meet certain criteria:

- There are no documented quality-of-care issues, or state or federal exclusion requirements where Health Net has determined the provider is ineligible to continue providing services to Health Net members.
- Compensated rates and methods of payment are the same as those currently used by Health Net or the participating physician group (PPG) unless a letter of agreement or letter of understanding is executed.
- Copayments, deductibles or other cost-sharing components during the period of completion of covered services with a terminated provider or a nonparticipating provider are the same the member would pay if receiving care from a provider currently contracting with Health Net.

Types of clinical criteria where a member may be eligible for COC

- Acute condition – a sudden onset of symptoms due to an illness, injury, or other medical problem.
- Serious chronic condition – a medical condition due to a disease, illness, or other medical problem or medical disorder, not to exceed 12 months from the member's effective date of coverage.
- Pregnancy – for the duration of the pregnancy and the immediate postpartum period.
    - A maternal mental health condition is a mental health condition that can impact a woman during pregnancy, peri- or post-partum, or that arises during pregnancy, in the peri- or post-partum period, up to one year after delivery.
- Terminal illness – an incurable or irreversible condition that has a high probability of causing death within one year or less. COC applies for the duration for the terminal illness.
- Newborn care – birth to 36 months, not to exceed 12 months from the member's effective date of coverage under the plan.
- Performance of a surgery or other procedure that has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered enrollee.
- Behavioral health conditions – all acute, serious or chronic mental health conditions, including treatment for children diagnosed with autism spectrum disorder (ASD). These services include applied behavioral analysis (ABA) – for up to 12 months.

Exceptions

Some of the circumstances where COC is not available are:

- Services that are not a covered benefit of the plan.
- Out-of-network provider does not agree to Health Net's utilization management (UM) policies and payment rates.
- Provider type or service is for durable medical equipment (DME), transportation, other ancillary services, or carved-out services.

Requesting Continuity of Care

New and existing members, their authorized representatives on file with Health Net, or their providers may request COC directly from Health Net. Refer to the Health Net Member Services Department for assistance.

Health Net reviews and completes COC requests within five business days after receipt of the request. When additional clinical information is necessary to make a decision, the COC request can be pended for an additional 45 days. The pend letter for the required information is generated and faxed to the requested provider. A hard copy will follow by mail to the provider and the member.

If there is an imminent and serious threat to the member's health, requests are completed within three calendar days.

Upon completion of the COC review, the provider and the member will be notified of the decision within 24 hours of the decision.

Applies to EPO and PPO members only: Health Net accepts and approves retroactive requests for COC that meet all requirements. The services must have occurred after the member's enrollment in the plan and Health Net must have the ability to demonstrate that there was an existing relationship between the member and provider prior to the member's enrollment into the plan.

Out-of-network providers cannot refer the member to another out-of-network provider without authorization from Health Net or a delegated PPG.

PPG Process

Health Net forwards the COC request to the delegated PPG's UM department if the PPG termed the requested provider. The delegated PPG:

- Works with the out-of-network provider to secure a care plan for the member
- Makes the decision whether to extend the COC services, or to redirect the services in-network.
- Works with the out-of-network provider to make sure they are willing to work with the PPG and Health Net.

Economic Profiling

Provider Type: Physicians | Participating Physician Groups (PPG)

Economic profiling is defined as any evaluation of a provider or participating physician group (PPG) based in whole or in part on the economic costs or use of services associated with medical care provided or authorized by the provider or PPG.

To the extent that a PPG maintains economic profiles of its individual providers, it must provide on request a copy of the individual economic profiling information to the individual providers who are profiled. This

information must be provided on request until 60 days after the contract between the PPG and provider terminates.

Hospital and Inpatient Facility Discharge Planning

Participating Physician Groups (PPG) (does not apply to HSP) | Ancillary | Hospitals

Participating providers are required to work with hospitals and inpatient facilities (general acute care hospitals, long-term acute care hospitals and skilled nursing facilities) to create an appropriate discharge plan and care transition protocol for members, including post-hospital care and member notification of patient rights within seven days of post-hospitalization. For any concurrent authorization that is denied, care cannot be discontinued until the treating provider has been notified and agreed to an appropriate discharge or transition of care plan.

Each hospital or inpatient facility must have a written discharge planning policy and process that includes:

- Counseling for the member or family members to prepare them for post-hospital or post-inpatient facility care, if needed.
- A transfer summary that accompanies the member upon transfer to a skilled nursing facility (SNF), intermediate-care facility, or a part-skilled nursing or intermediate care service unit of the hospital.
- Information regarding each medication dispensed must be given to the member upon discharge.

The Transitional Care Services program is designed to aid in the transitional period immediately after hospital discharge, focusing on critical post-discharge follow-up appointments.

Members have the right to:

- Be informed of continuing health care requirements following discharge from the hospital or inpatient facility.
- Be informed that, if the member authorizes, a friend or family member may be provided information about the member's continuing health care requirements following discharge from the hospital or inpatient facility.
- Actively participate in decisions regarding medical care. To the extent permitted by law, participation includes the right to refuse treatment.
- Appropriate pain assessment and treatment.

Electronic medical records or administrative system (Medi-Cal providers only)

In accordance with the Provider Participating Agreement (PPA) and Federal regulation 42 CFR 482.24 section (d), hospitals and facilities must ensure compliance and prompt electronic notification of patient discharges and

transfers. The following organizations have been designated as qualified health information organizations (QHIOs) and are available to assist with Data Exchange Framework (DxF) requirements:

- Los Angeles Network for Enhanced Services (LANES)
- Manifest MedEx
- SacValley MedShare
- San Diego Health Connect
- Applied Research Works, Inc.
- Health Gorilla, Inc.
- Long Health, Inc.
- Orange County Partners in Health-Health Information Exchange (OCPH-HIE)
- Serving Communities Health Information Organization (SCHIO)

Medical Data Management System

Provider Type: Physicians | Participating Physician Groups (PPG)

The Health Net utilization management (UM) program is supported by Unity, Health Net's medical management system. Unity provides an integrated database for Health Net UM activities. The system supports business management, drives regulatory compliance, and optimizes automation. It also provides medical management with the data to identify trends or patterns.

Health Net reviews encounter data to determine whether membership is accurately represented, to confirm that the data is submitted within contractual time frames and is within normative rates; for example, if an encounter rate is greater than 10 percent of a normative standard or the services provided per member per year is below six encounters. Health Net discusses actions for improved utilization management with the participating physician group (PPG).

Non-Delegated Medical Management

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Health Net does not delegate performance of the utilization management (UM) function to fee-for-service (FFS) participating providers. Health Net performs UM, quality improvement (QI) and care management functions.

Health Net uses InterQual criteria, Medicare guidelines, Hayes Medical Technology Directory®, Health Net medical policies, and MHN level-of-care criteria as the basis for making utilization decisions. Case-specific determinations of medical necessity are based on the needs of the individual member and the characteristics of the local network. Appropriate providers are involved in the adoption, development, updating (as needed), and annual review of medical policies and criteria. Delegated participating physician groups (PPGs) and MHN are required to use approved scientifically based criteria. Health Net national medical policy statements are currently available on the Health Net provider portal. Medical policy statements and other clinical criteria, such as InterQual and Hayes Technology Assessments, are available to all Health Net PPGs upon request by calling the Health Net Provider Services Center.

Non-Delegated Concurrent Review

Health Net's concurrent review staff perform clinical reviews when UM functions are not delegated. The objective of concurrent review is to review clinical information for medical necessity during a member's hospital confinement, coordinate discharge plans, and screen for quality of care concerns.

The hospital is required to notify Health Net's Hospital Notification Unit within 24 hours of admission or one business day when an admission occurs on a weekend, whenever a Health Net member is admitted. Failure to notify according to the requirements in the Provider Participation Agreement (PPA) may result in a denial of payment. The first review occurs within 24 hours or one business day of admission and is performed either on-site or over the telephone by a Health Net concurrent review nurse.

Use of standardized review criteria is required to ensure consistency of decision-making. Health Net's concurrent review nurses use InterQual guidelines to determine medical necessity of the inpatient stay. Review of the medical records is performed as required on an ongoing basis.

If, based on available information, an acute level of care is determined to be no longer necessary, Health Net's concurrent review nurse reviews the clinical information with a Health Net regional medical director. The Health Net concurrent review nurse also notifies the Hospital Utilization Review Department that the continued stay is in question. Discussion with the Health Net regional medical director focuses on alternate levels of care and discharge plans.

If the Health Net regional medical director determines that based on available medical information the member is ready for discharge, the attending physician is contacted to discuss alternatives. If the attending physician agrees with the Health Net regional medical director, the member is discharged to home or transferred to an appropriate, lower level of care. Concurrent review staff work with the PPG staff to monitor the member's care, and coordinate transfers and any needed post-discharge services.

If the attending physician and the Health Net regional medical director disagree, Health Net may issue a denial letter to the hospital, with copies to the attending physician, the PPG or the member. A denial letter contains the basis for the denial and information on the appeals and grievance process, as required by state and federal law. For Medicare Advantage (MA) members, Health Net follows the Centers for Medicare and Medicaid Services (CMS) guidelines when issuing a denial letter.

Non-Delegated Prospective Review

Under the terms of a member's coverage with Health Net, Health Net must provide pre-service authorization for elective inpatient services and selected outpatient procedures for PPO providers and participating fee-for-service (FFS) HMO providers. This also applies to contracting providers rendering services under Tier 2 Point of Service (POS) benefits. Following review by a Health Net medical director, authorization is approved or denied and communicated in writing to the PPG or requesting physician and the member.

When requesting a pre-service authorization for elective services or selected outpatient procedures, documentation by the referring participating physician must include:

- Prior written authorization request for specified outpatient services, specifying:
  - Services requested and number of visits
  - Information about previously attempted but unsuccessful treatments
  - Sufficient clinical information to establish medical necessity

Providers may use the appropriate forms below or refer to the Prior Authorization topic for additional information.

Inpatient California Health Net Commercial Prior Authorization (PDF)

Outpatient California Health Net Commercial Prior Authorization (PDF)

Inpatient California Health Net Medicare Authorization Form (PDF)

Outpatient California Health Net Medicare Authorization Form (PDF)

- Prior written authorization request for hospitalization which is submitted by the PCP or specialist must include:
  - Necessity of admission
  - Pre-admission work-up
  - Number of medically necessary inpatient days
- If admission is denied, the requesting physician and member is sent the following information:
  - Written rationale for denial with the specific reason delineated
  - Information as to how to appeal Health Net's determination
  - Suggestions for alternative treatment

Health Net does not pay claims without a Health Net authorization number. Authorization and claims dates must correspond, and the service type must match before payment can be rendered. If the dates of service change after the authorization number has been issued, the provider is required to notify Health Net. When a claim is received without a Health Net authorization number or the dates and services do not match the recorded authorization, further investigation is conducted by the Medical Review Unit (MRU). MRU examines hospital records and authorization notes in Unity to reconcile the discrepancies.

Non-Delegated Retrospective Review

Retrospective review is the review of medical services after care has been rendered. Retrospective review involves an evaluation of services that fall outside Health Net's established guidelines for coverage or require a medical necessity or benefit determination to authorize a request for payment of a claim.

Notification of Hospital Admissions

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Hospitals are required to report any Health Net member's inpatient admissions (including Individual & Family Plan (IFP) within 24 hours (or one business day when an admission occurs on a weekend or holiday), seven days a week. To report an admission, contact the Health Net Hospital Notification Unit. Failure to notify according to requirements in the Provider Participation Agreement (PPA) may result in a denial of payment.

On receipt of admission notification, Health Net creates a tracking number and provides to the reporting party. The tracking number is not an authorization that services are covered under a member's benefit plan. Any services authorized by Health Net at the time of notification or thereafter are noted in the Health Net notification

system. The tracking number is also transferred electronically to the Health Net claims processing system. To report a Health Net member inpatient admission, contact the Health Net Hospital Notification Unit.

Notification of after-hours admissions may be made by phone (the information is recorded by voicemail), fax, or web. On the next business day, a Health Net representative verifies eligibility, obtains information regarding the admission and, if applicable, provides a tracking number for the case.

When reporting inpatient admissions, providers must have the following information:

- Member name.
- Subscriber identification (ID) number.
- Attending and admitting physicians' first name, last name and contact information.
- Admission date and time of admission.
- Admission type (such as emergency room, elective or urgent).
- Facility name and contact information.
- Level of care.
- Admitting diagnosis code.
- CPT procedure code, if available.
- Facility medical record number.
- Participating physician group (PPG) authorization number.
- For obstetrical (OB) delivery admissions, include newborn sex, weight, apgar score, time of birth, and medical record number.
- Discharge date, if applicable.
- Other insurance information, if applicable.

Timely notification of Health Net member inpatient admissions assists with timely payment of claims, reduces retroactive admission reviews and enables Health Net to concurrently monitor member progress. Health Net requires the following facilities to notify BOTH the Health Net Hospital Notification Unit AND the PPG (if applicable) or provider of a member's inpatient admission within 24 hours (or one business day when an admission occurs on a weekend or holiday) for the following services:

- All inpatient hospitalizations.
- Skilled nursing facility (SNF) admissions.
- Inpatient rehabilitation admissions.
- Inpatient hospice services.
- Emergency room admissions.

Requests for Authorization for Post-Stabilization Care at Non-Participating and Participating Hospitals

Health Net is responsible for the coverage and payment of emergency services and post-stabilization care services to the provider that furnishes the services. This can be a participating provider, subcontractor, downstream subcontractor, or nonparticipating provider.

Requests for post-stabilization authorization

The requirement to request authorization applies to both in-network and out-of-network hospitals when treating members.

The hospital’s request for authorization is required once the Health Net member is stabilized following their initial emergency treatment and before the hospital admits them to the hospital for inpatient post-stabilization care. A patient is “stabilized,” or “stabilization” has occurred, when, in the opinion of the treating provider, the

patient's medical condition is such that, within reasonable medical probability, no material deterioration of the patient's condition is likely to result from, or occur during, the release or transfer of the patient.

Hospitals are required to provide the treating physician and/or surgeon's diagnosis and any other relevant information reasonably necessary for Health Net to decide whether to authorize post-stabilization care or to assume management of the patient's care by prompt transfer.

How to request post-stabilization authorization

To request authorization for post-stabilization care, the hospital must **call** the Hospital Notification Unit.

A hospital's notification to Health Net of emergency room treatment or admission **does not** satisfy the requirement to request post-stabilization care. Post-stabilization requirements do not apply if the member has **not** been stabilized after emergency services and requires medically necessary continued stabilizing care.

A hospital's contact with any other phone or fax number or website, or the patient's participating physician group (PPG), to request authorization to provide post-stabilization care does not satisfy the requirements of the above required procedures. Do not contact the member's PPG or any other Health Net phone, fax number or website to request Health Net's authorization for post-stabilization care.

Behavioral health emergencies

Marketplace/IFP (Ambetter HMO and PPO) and Employer Group HMO/POS and PPO members: Health Net covers mental health and substance use disorder treatment that includes behavioral health crisis services provided to a member by a 988 crisis call center, mobile crisis team or other behavioral health crisis services providers, regardless of whether that provider or facility is in network or out of network. Hospitals must use the above number to request authorization for members' post-stabilization care once they are deemed stable but require facility-based care.

Providers can access the Transitions of Care Management (TRC) Worksheet to:

- Help support transitions of care to ensure appropriate documentation and timely report of the notification of a Medicare patient's inpatient admission, receipt of discharge information, and patient engagement after inpatient discharge.
- Reconcile discharge medications with the most recent medication lists to optimize HEDIS® and Star Rating scores and improve care coordination.

Response time to requests

Health Net must approve or disapprove a request for post-stabilization care within 30 minutes. The post-stabilization care must be medically necessary for covered medical care. If the response to approve or disapprove the request is not given within 30 minutes, the post-stabilization care request is considered authorized.

Failure to request post-stabilization authorization

Health Net may contest or deny claims for post-stabilization care following treatment in the emergency department or following an admission through a hospital's emergency department when Health Net does not have a record of the hospital's request for post-stabilization care via phone or a record that Health Net provided the hospital an authorization for such services.

Required documentation

All requests for authorization, and responses to requests, must be documented. The documentation must include, but is not limited to:

- Date and time of the request.
- Name of the provider making the request.
- Name of the Health Net representative responding to the request.

Conditions of financial responsibility

Health Net is financially responsible for post-stabilization care services that are not pre-authorized, but are administered to maintain, improve, or resolve the member's stabilized condition if the Plan:

- Does not approve or disapprove a request for post-stabilization care within 30 minutes.
- Cannot be contacted.
- Is unable to reach an agreement with the treating provider concerning the member's care and a Plan physician is not available for consultation.

If this situation applies, the Plan must give the treating provider the opportunity to consult with a Plan physician. The treating provider may continue with care of the member until a Plan physician is reached or one of the following criteria is met:

- A Plan physician with privileges at the treating provider's hospital assumes responsibility for the member's care;
- A Plan physician assumes responsibility for the member's care through transfer;
- The Plan and the treating provider reach an agreement concerning the member's care; or
- The member is discharged.

Wellcare By Health Net Medicare Dual Special Needs (D-SNP)

Per the State Medicaid Agency Contract (SMAC) with Department of Health Care Services (DHCS) contracted hospitals and SNFs must use one of the following methods, in a timely manner, to inform the member's D-SNP and the Medi-Cal plan of any hospital or SNF admission, transfer or discharge. Hospitals and SNFs must use either:

- A secure email or data exchange through a Health Information Organization or,
- An electronic process approved by DHCS.

This information must be shared to the extent allowed, under applicable federal and state law and regulations, and not be inconsistent with the member's expressed privacy preferences.

Contracted hospital	Must notify the D-SNP member's MCP either immediately prior to, or at the time of, the member's discharge or transfer from the hospital's inpatient services, if applicable.
Contracted SNFs	Must notify the D-SNP member's MCP within 48 hours after any SNF admission.

	For discharges or transfers, SNFs must notify the D-SNP member's MCP in advance if possible, or at the time of the member's discharge or transfer from the SNF

Facilities can identify the member's Medi-Cal plan by using the State online eligibility system (AEVS).

Out-of-Area Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals

Health Net provides authorization, concurrent and retrospective utilization review, and care management assistance to members who receive emergency inpatient care outside their service area. Members are encouraged, when possible, to contact their primary care physician (PCP) or participating physician group (PPG) to determine the best plan for obtaining medical care and follow-up when out of the service area. When Health Net is contacted, the Utilization Management (UM) Department notifies the PPG of the member's location and clinical condition. The Health Net UM staff assists the member's PCP, PPG and receiving facility in determining whether the member, in the opinion of the treating provider, can safely be transferred to a Health Net participating facility provider. If it is determined that the member can be safely transferred, Health Net nurses assist as needed with the transfer.

Separation of Medical Decisions and Financial Concerns

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

Under California Health & Safety Code Section 1367(g), medical decisions regarding the nature and level of care to be provided to a member, including the decision of who renders the service (for example, primary care physician (PCP) instead of specialist or in-network provider instead of out-of-network provider), must be made by qualified medical providers, unhindered by fiscal or administrative concerns. Utilization management (UM) decisions are, therefore, made by medical staff and based solely on medical necessity. Providers may openly discuss treatment alternatives (regardless of coverage limitations) with members without being penalized for discussing medically necessary care with the member. Health Net requires that each participating physician group (PPG) and hospital's UM program include provisions to ensure that financial and administrative concerns do not affect UM decisions, and that each member of the PPG's UM staff sign an acknowledgment of this. Failure to comply may result in withdrawal of delegated UM and ultimately, termination of the Provider Participation Agreement (PPA) with Health Net.

Medicare Benefits and Beneficiary Protections

Health Net provides members, at a minimum, with all basic Medicare-covered services by furnishing benefits directly or through our PPG arrangements, or by paying for benefits. Health Net also provides mandatory and optional supplemental benefits. In addition, as a Medicare Advantage Organization (MAO), Health Net and its delegated PPGs must comply with Centers for Medicare and Medicaid Services (CMS) national coverage decisions, general coverage guidelines included in original Medicare manuals and instructions (unless superseded by regulations), and written coverage decisions of local Medicare contractors. Given that Health Net covers geographic areas encompassing more than one local coverage policy area, Health Net and its PPGs must apply the Medicare coverage policy specific to the member's service area

Utilization Management Goal

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | Ancillary

The goal of the Health Net Utilization Management (UM) and care management (CM) programs is to provide members with access to the health services delivery system in order to receive timely and necessary medical care in the correct setting. Health Net's UM and CM programs comply with all applicable federal and state laws, regulations and accreditation requirements. The UM system is also intended to analyze and measure effectiveness while striving for improvement of services. Health Net's UM system separates medical decisions from fiscal and administrative management to assure that medical decisions are not unduly influenced by fiscal and administrative management.

Health Net gathers encounter data from participating physician groups (PPGs) (if applicable) and data from the Health Net Medical Management System to monitor potential indicators over- and under-utilization. Based on the classification of delegation, the following types of data are collected:

- System-wide data:
  - Member services complaints
  - Member satisfaction surveys
  - PPG transfer rates
- PPG data:
  - Encounter data
  - Unity system reports (such as Monthly Census and Detail reports)
  - PPG report card (profile reports of utilization statistics)
  - UM denial and appeal logs

Utilization Management Program Components

Physicians | Participating Physician Groups (PPG)

Utilization management (UM) is provided through a comprehensive, multi-level and flexible managed care delivery system. Health Net delegates the UM function to participating physician groups (PPGs) and Molina Health Care in Los Angeles County for Medi-Cal. Following an evaluation of the operational capabilities of their

UM program, Health Net's decision to delegate UM is based on results of pre-delegation reviews and committee approval. Health Net does not delegate UM functions to individual participating providers. Health Net staff perform UM functions when operational functions are not delegated.

When Health Net delegates UM operational functions to PPGs, or Molina Health Care in Los Angeles County, PPGs (or Molina as applicable) are required to establish a formal UM program that describes how the delegated UM processes are performed and monitored. Health Net evaluates the effectiveness of the PPG program via ongoing monthly performance reporting, quarterly system validation reviews and annual reviews. Corrective actions are issued for below standard performance and when necessary, decisions regarding continued delegation will be reviewed by the Health Net Delegation Oversight Committee.

Health Net regional medical directors and clinical program managers are the principal liaisons between Health Net medical management and PPGs. Health Net UM and QI staff located in the corporate and regional offices support these directors and managers. They play an integral part in helping PPGs meet the expectations of Health Net and its members.

Contacts in Alphabetical Order

A | B | C | D | E | F | G | H | I | J | K | L | M | N | O | P | Q | R | S | T | U | V | W | X | Y | Z

A

- AcariaHealth
- Access to Interpreter Services
- American Specialty Health Plans
- Animas Diabetes Care, LLC
- Apria Healthcare, Inc
- ATG Rehab Specialists, Inc

B

Behavioral Health Provider Services

C

- Case Management Department
- Coram
- Custom Rehab Network

D

Department of Insurance

E

- Electronic Claims Clearinghouse Information
- EviCore Healthcare

F

G

H

- Health Net Care Management Department
- Health Net Claims Submission
- Health Net Credentialing Department
- Health Net Decision Power Referral Fax
- Health Net Delegation Oversight Department
- Health Net EDI Claims Department
- Health Net Encounter Department
- Health Net Fraud Hotline
- Health Net Health Equity Department
- Health Net Hospital Notification Unit
- Health Net Mail Order Prescription Drug Program
- Health Net Member Appeals and Grievances Department
- Health Net Member Services Department
- Health Net Provider Communications Department
- Health Net Prior Authorization Department
- Health Net Program Accreditation Department
- Health Net Provider Services Center
- Health Net Quality Improvement Department
- Health Net Wellness and Prevention Department
- Hoveround, Inc

I

J

K

Kick It California

L

- LabCorp

- Linkia, LLC

M

- Matria Health Care, Inc
- MiniMed Distribution Corp, Inc

N

- National Imaging Associates, Inc
- National Seating and Mobility
- Nurse Advice Line

O

P

- Pharmacy Services
- Provider Disputes and Appeals - Commercial
- Provider Network Management Department
- Pumping Essentials

Q

Quest Diagnostics

R

- Reinsurance Claims Unit
- Roche

S

T

- Transplant Team
- TurningPoint Healthcare Solutions, LLC

U

V

W

X

Y

Z

Glossary

PDF Forms and References in Alphabetical Order

#| A | B | C | D | E | F | G | H | I | J | K | L | M | N | O | P | Q | R | S | T | U | V | W | X | Y | Z

#

- 837 5010 Professional and Institutional Standards (PDF)
- 837 Institutional Companion Guide (PDF)
- 837 Professional Companion Guide (PDF)

A

- AAP Recommendations for the Preventive Pediatric Health Care (PDF)
- Adult AIDS/HIV Confidential Case Report (PDF)
- After-Hours Sample Script - Chinese (PDF)
- After-Hours Sample Script - English (PDF)
- After-Hours Sample Script - Spanish (PDF)
- Autoclave Log (PDF)

B

Bariatric Surgery Performance Centers (PDF)

C

- Care Management Referral Form - Commercial Medicare and CMC (PDF)
- Certification for Contracts Grants, loans, and Cooperative Agreements (PDF)
- Clinical Payment Policy CP.MP.152 - Measurement of Serum 1 25-dihydroxyvitamin D (PDF)
- Clinical Payment Policy CP.MP.153 - Helicobacter Pylori Serology Testing (PDF)
- Clinical Payment Policy CP.MP.154 - Thyroid Hormones and Insulin Testing in Pediatrics (PDF)
- Clinical Payment Policy, CCP.MP.155 - EEG in the Evaluation of Headache (PDF)
- Clinical Payment Policy CP.MP.156 - Cardiac Biomarker Testing for Acute Myocardial In farction (PDF)
- Clinical Payment Policy CP.MP.157 - 25-hydroxyvitamin D Testing in Children and Adolescents (PDF)

- Clinical Payment Policy CP.MP.38 - Ultrasound in Pregnancy (PDF)
- Cold Sterilization Log (PDF)
- Confidential Morbidity Report (PDF)

D

- Decision Power Referral Fax Form - Commercial and Medicare (PDF)
- Diagnostic Procedures Requiring Prior Authorization for Health Net of California (PDF)
- Directory Removal for At-Risk Providers Form (PDF)
- Disclosure of Lobbying Activities Form and Disclosure Form Instructions (PDF)
- Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Coding Policies (PDF)

E

- Edinburgh Perinatal/Postnatal Depression Scale (EPDS) Questionnaire (PDF)
- Eligibility Report Field Descriptions (PDF)

F

G

H

Hepatitis B Vaccination Declination (PDF)

I

- ICD-10-CM Codes for Abortion-Related Services (PDF)
- Identification card (Primary EPO) (PDF)
- Individual Family Plan member eligibility status displayed on the secure provider portal (PDF)
- Injectable Medication HCPCS/DOFR Crosswalk (PDF)
- Inpatient California Health Net Commercial Prior Authorization (PDF)
- Interpreter Service Quick Reference Card (PDF)

J

K

L

Language Identification Poster (PDF)

M

- Medical Record - Adult Health Maintenance Checklist With Standards (PDF)
- Medical Record - Advance Directive Labels (PDF)
- Medical Record - Audiometric Screening (PDF)
- Medical Record - History Spanish (PDF)
- Medical Record - Medication and Chronic Problem Summary (PDF)
- Medical Record - Signature Page (PDF)
- Medical/Behavioral Comanagement/Coordination of Care Form (PDF)

N

Nondiscrimination Notice and Taglines (PDF)

O

- Offshore Subcontracting Attestation: Participating Provider (PDF)
- Outpatient California Health Net Commercial Prior Authorization (PDF)

P

- Palliative Care Providers (contracted)
- Physical or Speech Therapy (PDF)
- Potential Quality Issue Referral Form (PDF)
- PPG Professional Batch Form (PDF)
- Prescription Drug Prior Authorization or Step Therapy Exception Form (PDF)
- Prostate Cancer Treatment Information Sign (PDF)
- Provider Dispute Resolution Request - Commercial and Medi-Cal (PDF)
- Provider Dispute Resolution Request - IFP (PDF)

Q

Quick Reference Guide (PDF)

R

- Reconstructive Surgery Decision Tree (PDF)
- Reportable Diseases (PDF)
- Request for Confidential Communication Form (PDF)

S

Sample - Hospital Refusal Letter (PDF)

T

- Transition of Care Management Worksheet
- Transplant Performance Centers (PDF)

U

- Urgent Request for Continuing Home Health Services (PDF)
- Urgent Request for Continuing Occupational, Physical or Speech Therapy (PDF)
- Utilization Management Timeliness Standards - Commercial (PDF)

V

Verifying Eligibility (Individual and Family Plans) (PDF)

W

X

Y

Z

Health Net* of California, Inc. Bariatric Surgery Performance Centers				
Northern California				
Surgeon name and group	**Physician address**	**Phone number**	**Center name**	**Center address**
Ali, M.D., Mohamed	2221 Stockton Blvd., Ste. E Sacramento, CA 95817	(916) 734-2680	U.C. Davis Medical Center[1]	2315 Stockton Blvd. Sacramento, CA 95817
Azagury, M.D., Dan	300 Pasteur Dr. Stanford, CA 94305	(650) 725-9777	Stanford Hospital and Clinic	300 Pasteur Dr. Stanford, CA 94305
Boone, M.D., Keith Valley Surgical Specialists	205 East River Park Circle, Ste. 460 Fresno, CA 93710	(559) 261-4500	Fresno Heart and Surgical Hospital	15 East Audubon Rd. Fresno, CA 93720
Carter, M.D., Jonathan	400 Parnassus Ave., 2nd Floor San Francisco, CA 94143-0338	(415) 353-2161	U.C. San Francisco Medical Center	505 Parnassus Ave., 4th Floor San Francisco, CA 94143
Coirin, M.D., Antonio	1329 Spanos Court, Ste. B4 Modesto, CA 95355	(209) 300-7947	Memorial Medical Center	1700 Coffee Rd. Modesto, CA 95355
Eslami, M.D., Afshin	1737 Creekside Dr. Folsom, CA 95630	(916) 932-0315	Methodist Hospital	7500 Hospital Dr. Sacramento, CA 95823
Esquivel, M.D., Micaela	300 Pasteur Dr., H3680 Stanford, CA 94305	(408) 396-7669	Stanford Hospital and Clinic	300 Pasteur Dr. Stanford, CA 94305
Feng, M.D., John J.[2]	790 El Camino Real Palo Alto, CA 94301	(650) 853-6600 (650) 596-4120	El Camino Hospital	2500 Grant Rd. Mountain View, CA 94040
			Mills Peninsula	1783 El Camino Real Burlingame, CA 94010
Higa, M.D., Kelvin Valley Surgical Specialists	205 East River Park Circle, Ste. 460 Fresno, CA 93710	(559) 261-4500	Fresno Heart and Surgical Hospital	15 East Audubon Rd. Fresno, CA 93720

Health Net of California, Inc. Bariatric Surgery Performance Centers				
Northern California, continued				
Surgeon name and group	**Physician address**	**Phone number**	**Center name**	**Center address**
Khalil, M.D., Beeman[2]	795 El Camino Real Palo Alto, CA 94301	(650) 853-5340	El Camino Hospital	2500 Grant Rd. Mountain View, CA 94040
	3200 Kearney St. Fremont, CA 94538	(510) 490-1222		
Kim, M.D., Teresa[2]	365 Hawthorne Ave., Ste. 101 Oakland, CA 94609	(510) 465-5523	Alta Bates Summit	350 Hawthorne Ave. Oakland, CA 94609
Legha, M.D., Prithvi[2]	701 E. El Camino Real Mountain View, CA 94040	(650) 404-8400	El Camino Hospital	2500 Grant Rd. Mountain View, CA 94040
Patching, M.D., Steven C. [2]	800 Howe Ave, Ste. 300 Sacramento, CA 95825	(916) 568-5564	Sutter General Hospital	2801 L St. Sacramento, CA 95816
Posselt, M.D., Andrew	400 Parnassus Ave., 2nd Floor San Francisco, CA 94143	(415) 353-2161	UCSF Medical Center	505 Parnassus Ave., 4th Floor San Francisco, CA 94143
Reddy, M.D., Subhash[2]	3 Medical Plaza, Ste. 200 Roseville, CA 95661	(916) 773-8750	Sutter Roseville Medical Center	1 Medical Plaza Roseville, CA 95661
Rogers, M.D., Stanley	400 Parnassus Ave., 2nd Floor San Francisco, CA 94143	(415) 353-2161	UCSF Medical Center	505 Parnassus Ave., 4th Floor San Francisco, CA 94143
Shadle, M.D., Benjamin D.	3 Medical Plaza, Ste. 200 Roseville, CA 95661	(916) 773-8750	Sutter Roseville Medical Center	1 Medical Plaza Roseville, CA 95661
	400 Plumas Blvd., Ste. 215 Yuba City, CA 95991			
Upadhyay, M.D., Ajay	365 Hawthorne Ave., Ste. 101 Oakland, CA 94609	(510) 465-5523	Alta Bates Summit	350 Hawthorne Ave. Oakland, CA 94609

Health Net of California, Inc. Bariatric Surgery Performance Centers				
Southern California				
Surgeon name and group	**Physician address**	**Phone number**	**Center name**	**Center address**
Ali, M.D., Mir B. LePort Surgical Associates	18111 Brookhurst St., Ste. 5600 Fountain Valley, CA 92708	(714) 861-4666	Fountain Valley Regional Hospital	17100 Euclid St. Fountain Valley, CA 92708
			Orange Coast Memorial Medical Center	9920 Talbert Ave. Fountain Valley, CA 92708
Bernstein, M.D, David	401 East Highland Ave., Ste. 351 San Bernardino, CA 92404	(909) 475-8611	St. Bernardine Medical Center	2101 North Waterman Ave. San Bernardino, CA 92404
Bhoyrul, M.D., Sunil	9850 Genesee Ave., Ste. 570 La Jolla, CA 92037	(858) 457-4917	Scripps La Jolla	10140 Campus Point Dr. San Diego, CA 92121
Billy, M.D., Helmuth	3200 Telegraph Rd. Ventura, CA 93003	(805) 676-9100	St. John's Regional Hospital	1600 N. Rose St. Oxnard, CA 93030
Braverman, M.D., Justin	12462 Putnam St., Ste. 500 Whittier, CA 90602	(562) 789-5449	PIH Whittier	12401 Washington Blvd. Whittier, CA 90602
Broderick, M.D., Ryan	9300 Campus Point Drive Ste. #7220 La Jolla, CA, 92037	(858) 657-7146	University of California, San Diego Health Jacobs Medical Center	9300 Campus Point Dr. La Jolla, CA 92037
Chen, M.D., Yijun	200 UCLA Medical Plaza Ste. 214 Los Angeles, CA 90095	(310) 794-7788	Ronald Regan UCLA Medical Center	757 Westwood Plaza Los Angeles, CA 90095
Daly, M.D., Shaun	101 The City Drive Bldg., 22C, 3rd Floor Orange, CA 92868	(888) 717-4463	University of California, Irvine	333 City Blvd. Orange, CA 92868
Dobrowolsky, M.D., Adrian	1510 San Pablo St., HCC I, Ste. 514 Los Angeles, CA 90033	(323) 442-6868	University of Southern California (USC)	1500 San Pablo St. Los Angeles, CA 90033

Health Net of California, Inc. Bariatric Surgery Performance Centers				
Southern California, continued				
Surgeon name and group	**Physician address**	**Phone number**	**Center name**	**Center address**
Dutson, M.D., Erik	200 UCLA Medical Plaza, Ste. 214 Los Angeles, CA 90095	(310) 794-7788	Ronald Reagan UCLA Medical Center	757 Westwood Plaza Los Angeles, CA 90095
Ellner, M.D., Julie	5555 Reservoir Dr., Ste. 203 San Diego, CA 92120	(619) 229-3340	Alvarado Hospital Medical Center	6655 Alvarado Rd. San Diego, CA 92120
Francis, M.D., Kelly	18111 Brookhurst St., Ste. 6400 Fountain Valley, CA 92708	(714) 350-7258	Fountain Valley Regional Hospital	17100 Euclid St. Fountain Valley, CA 92708
			Orange Coast Memorial Medical Center	9920 Talbert Ave. Fountain Valley, CA 92708
Francis, M.D., Kelly	18111 Brookhurst St., Ste. 6400 Fountain Valley, CA 92708	(714) 350-7258	Fountain Valley Regional Hospital	17100 Euclid St. Fountain Valley, CA 92708
			Orange Coast Memorial Medical Center	9920 Talbert Ave. Fountain Valley, CA 92708
Fuller, M.D., William	10666 N. Torrey Pines Rd., MS 213 La Jolla, CA 92037	(714) 861-4666	Scripps Mercy Hospital	4077 Fifth Ave., Mer 7 San Diego, CA 92103
			Scripps Green Hospital	10666 North Torrey Pines Rd. La Jolla, CA 92037
Hanna, M.D., Karen	2385 S. Melrose Dr. Vista, CA 92081	(760) 300-3647	Palomar Medical Center (aka Pomerado)	15615 Pomerado Rd. Poway, CA 92064
Hinojosa, M.D., Marcelo	101 The City Drive Bldg., 22C, 3rd Floor Orange, CA 92868	(888) 717-4463	University of California, Irvine	333 City Blvd. Orange, CA 92868

Health Net of California Bariatric Surgery Performance Centers				
Southern California, continued				
Surgeon name and group	**Physician address**	**Phone number**	**Center name**	**Center address**
Horgan, M.D., Santiago	UCSD Health – La Jolla UTC 4303 La Jolla Village Dr STE 2110 La Jolla, CA 92112	(858) 657-8860	University of California, San Diego Health Jacobs Medical Center	9300 Campus Point Dr. La Jolla, CA 92037
Jacobsen, M.D., Garth	UCSD Health – La Jolla UTC 4303 La Jolla Village Dr STE 2110 La Jolla, CA 92112	(858) 657-8860	University of California, San Diego Health Jacobs Medical Center	9300 Campus Point Dr. La Jolla, CA 92037
Krahn, M.D., Douglas	401 East Highland Ave., Ste. 351 San Bernardino, CA 92404	(909) 475-8611	Chapman Medical Center	2601 E. Chapman Ave. Orange, CA 92869
			St. Bernardine Medical Center	2101 North Waterman Ave. San Bernardino, CA 92404
Lamar, M.D., Troy California Bariatric & General Surgery	51 N. 5th Ave., Ste. 202 Arcadia, CA 91006	(626) 445-0600	Methodist Hospital	300 West Huntington Dr. Arcadia, CA 91007
Lim, M.D., Lian	10666 N. Torrey Pines Rd., MS 213 La Jolla, CA 92037	(858) 554-8984	Scripps Mercy Hospital	4077 Fifth Ave., Mer 7 San Diego, CA 92103
Mueller, M.D., George	7910 Frost St., Ste. 250 San Diego, CA 92123	(858) 565-0104	Sharp Memorial Hospital	7901 Frost St. San Diego, CA 92123
Nguyen, M.D., James	1510 San Pablo St., Ste. 6200 Los Angeles, CA 90033	(800) 872-2273	University of Southern California (USC)	1500 San Pablo St. Los Angeles, CA 90033
Nguyen, M.D., Ninh	101 The City Drive Bldg., 22C, 3rd Floor Orange, CA 92868	(888) 717-4463	University of California, Irvine	333 City Blvd. Orange, CA 92868

Health Net of California, Inc. Bariatric Surgery Performance Centers				
Southern California, continued				
Surgeon name and group	**Physician address**	**Phone number**	**Center name**	**Center address**
Oliak, M.D., David	255 West Central Ave., Ste. 203 Brea, CA 92821	(714) 582-2530	Chapman Medical Center	2601 E. Chapman Ave. Orange, CA 92869
Paya, M.D., Mahbod	7320 Woodlake Ave., Ste. 170 West Hills, CA 91307	(818) 888-7090	West Hills Hospital Medical Center	7300 Medical Center Dr. West Hills, CA 91307
Powell, M.D., Wes	950 S. Arroyo Parkway, 3rd Floor Pasadena, CA 91105	(626) 449-0694	Methodist Hospital	300 West Huntington Dr. Arcadia, CA 91007
Quilici, M.D., Philippe	201 South Buena Vista St., Ste. 425 Burbank, CA 91505	(818) 848-8311	Providence St. Joseph Medical Center	501 S. Buena Vista Burbank, CA 91505
Russo, M.D., Michael	18111 Brookhurst St., Ste. 5600 Fountain Valley, CA 92708	(714) 861-4666	Fountain Valley Regional Hospital	17100 Euclid St. Fountain Valley, CA 92708
			Orange Coast Memorial Medical Center	9920 Talbert Ave. Fountain Valley, CA 92708
Samakar, M.D., Kamran	1450 San Pablo St., 6th Floor Los Angeles, CA 90033	(800) 872-2273	University of Southern California (USC)	1500 San Pablo St. Los Angeles, CA 90033
Smith, M.D., Brian	101 The City Drive Bldg., 22C, 3rd Floor Orange, CA 92868	(888) 717-4463	University of California, Irvine	333 City Blvd. Orange, CA 92868
Suh, M.D., David	2083 Compton Ave., Ste. 104 Corona, CA 92881	(951) 256-8191	Inland Regional Valley Medical Center	36485 Inland Valley Dr. Wildomar, CA 92595
	25495 Medical Center Dr., Ste.203 Murietta, CA 92562			

Health Net of California, Inc. Bariatric Surgery Performance Centers				
Southern California, continued				
Surgeon name and group	**Physician address**	**Phone number**	**Center name**	**Center address**
Takata, M.D., Mark	10666 N. Torrey Pines Rd., MS 213 La Jolla, CA 92037	(714) 861-4666	Scripps Green Hospital	10666 North Torrey Pines Rd. La Jolla, CA 92037
Thoman, M.D., David	520 W. Junipero St. Santa Barbara, CA 93105	(805) 730-1470	Santa Barbara Cottage Hospital	2400 Bath St. Santa Barbara, CA 93105
Wittgrove, M.D., Alan	12865 Point Del Mar Way, Ste. 130 Del Mar, CA 92014	(858) 350-4700	Scripps La Jolla	10140 Campus Point Dr. San Diego, CA 92121

[1]U.C. Davis Medical Center is limited to performing Roux-en-y gastric bypass and revision gastric bypass surgeries for participating Health Net members not capitated by U.C. Davis Medical Group.
[2]Limited to providing bariatric surgery services to Sutter Health Net members only.

Care Management Referral Form

DIRECTIONS: Select the member's plan below and email or fax the completed referral.

- **CA Commercial (Ambetter HMO/PPO, Employer Group plans (HMO, PPO, POS)) and Medicare Employer Groups** – Email completed form to Case.Management.Referrals@healthnet.com or fax completed form to **800-745-6955**.
- **CA Medicare** (including Medicare Advantage) for shared risk non-delegated plans. – Email completed form to Medicare_CM@healthnet.com or fax completed form to **866-290-5957** for physical health care management. Note: For behavioral health care management, refer special needs plan members to MHN via email to mhn.snp@healthnet.com.
- **CA Medi-Cal** – Email completed form to **CASHP.ACM.CMA@healthnet.com** or fax completed form to **866-581-0540**.

☐ *URGENT Request* ☐ UC Blue & Gold Plan Member

Part 1: Referring Source

First and last name:		Referral date:
Office contact person:	Phone number:	Fax number:

Part 2: Member Information

Member first and last name:	Member ID#:	Date of birth:
Member address:	City:	ZIP Code:

Member phone number:

Member Diagnosis/Health Condition (check all that apply):

☐ Asthma
☐ Back pain
☐ Behavioral health
  ☐ Anxiety
  ☐ Autism
  ☐ Depression
  ☐ Other (specify) _____
☐ Bursitis/tendonitis
☐ CAD
☐ Cancer
☐ Carpal tunnel syndrome
☐ Clinical Trials
☐ COPD
☐ Cystic fibrosis
☐ Diabetes
☐ Fibromyalgia
☐ Frozen shoulder
☐ Golf/tennis elbow
☐ Heart failure
☐ Hemophilia
☐ Hepatitis
☐ High risk pregnancy
  Estimated date of delivery __/__/__
☐ HIV/AIDS
☐ Hypertension
☐ Kidney disease
☐ Migraine/tension headache
☐ Musculoskeletal
☐ Obesity-weight management
☐ Osteoarthritis
☐ Prematurity and/or developmental delay
☐ Rheumatoid arthritis
☐ Sickle cell
☐ Transplant
☐ Traumatic brain injury
☐ Other: _____

Please check if any of the following referral reasons apply to the member:

☐ Concerned about high emergency room utilization or frequent hospitalizations.
☐ Exhaustion of benefits
☐ Member needs assistance with behavioral health needs.
☐ Member needs assistance with medical equipment.
☐ Member needs assistance with resources for: ☐ housing/shelter, ☐ food, ☐ other (specify) _____.
☐ Member needs education on prescriptions and compliance.
☐ Member needs education/support with managing his/her chronic condition(s).
☐ Member needs prenatal care education and support services.
☐ Member needs transportation to medical appointments.
☐ Safety concerns.
☐ Other (specify) _____

Please use this page to provide additional information (as needed).

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

_____	_____
Authorized Representative	Date
_____	_____
Type or Print Name	Name of Provider
_____	_____
Title	Address

CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Use this form for reporting all conditions except Tuberculosis and conditions reportable to DMV.

DISEASE BEING REPORTED

Patient Name - Last Name | **First Name** | **MI**

Home Address: Number, Street | **Apt./Unit No.**

City | **State** | **ZIP Code**

Home Telephone Number | **Cell Telephone Number** | **Work Telephone Number**

Email Address | **Primary Language** ☐ English ☐ Spanish ☐ Other: _____

Birth Date *(mm/dd/yyyy)* | **Age** | ☐ Years ☐ Months ☐ Days

Gender ☐ Male ☐ Female ☐ M to F Transgender ☐ F to M Transgender ☐ Other: _____

Pregnant? ☐ Yes ☐ No ☐ Unknown | **Est. Delivery Date** *(mm/dd/yyyy)* | **Country of Birth**

Ethnicity (check one)
☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown

Race (check all that apply)
☐ African-American/Black
☐ American Indian/Alaska Native
☐ Asian *(check all that apply)*
- ☐ Asian Indian ☐ Hmong ☐ Thai
- ☐ Cambodian ☐ Japanese ☐ Vietnamese
- ☐ Chinese ☐ Korean ☐ Other *(specify)*: _____
- ☐ Filipino ☐ Laotian

☐ Pacific Islander *(check all that apply)*
- ☐ Native Hawaiian ☐ Samoan
- ☐ Guamanian ☐ Other *(specify)*: _____

☐ White
☐ Other *(specify)*: _____
☐ Unknown

Occupation or Job Title

Occupational or Exposure Setting (check all that apply): ☐ Food Service ☐ Day Care ☐ Health Care ☐ Correctional Facility ☐ School ☐ Other *(specify)*: _____

Date of Onset *(mm/dd/yyyy)* | **Date of First Specimen Collection** *(mm/dd/yyyy)* | **Date of Diagnosis** *(mm/dd/yyyy)* | **Date of Death** *(mm/dd/yyyy)*

Reporting Health Care Provider | **Reporting Health Care Facility**

Address: Number, Street | **Suite/Unit No.**

City | **State** | **ZIP Code**

Telephone Number | **Fax Number**

Submitted by | **Date Submitted** *(mm/dd/yyyy)*

REPORT TO:

(Obtain additional forms from your local health department.)

Laboratory Name | **City** | **State** | **ZIP Code**

SEXUALLY TRANSMITTED DISEASES (STDs)

Gender of Sex Partners *(check all that apply)*
☐ Male ☐ M to F Transgender
☐ Female ☐ F to M Transgender
☐ Unknown ☐ Other: _____

STD TREATMENT ☐ Treated in office ☐ Given prescription
Drug(s), Dosage, Route | **Treatment Began** *(mm/dd/yyyy)*

☐ ***Untreated***
☐ Will treat
☐ Unable to contact patient
☐ Patient refused treatment
☐ Referred to: _____

If reporting Syphilis, Stage:
☐ Primary (lesion present)
☐ Secondary
☐ Early latent < 1 year
☐ Latent (unknown duration)
☐ Late latent > 1 year
☐ Late (tertiary)
☐ Congenital

Neurosyphilis?
☐ Yes ☐ No ☐ Unknown

Syphilis Test Results | **Titer**
- ☐ RPR ☐ Pos ☐ Neg _____
- ☐ VDRL ☐ Pos ☐ Neg _____
- ☐ FTA-ABS ☐ Pos ☐ Neg
- ☐ TP-PA ☐ Pos ☐ Neg
- ☐ EIA/CLIA ☐ Pos ☐ Neg
- ☐ CSF-VDRL ☐ Pos ☐ Neg _____
- ☐ Other: _____

If reporting Chlamydia and/or Gonorrhea:
Specimen Source(s) *(check all that apply)*
☐ Cervical
☐ Pharyngeal
☐ Rectal
☐ Urethral
☐ Urine
☐ Vaginal
☐ Other: _____

Symptoms?
☐ Yes
☐ No
☐ Unknown

Partner(s) Treated?
☐ Yes, treated in this clinic
☐ Yes, Meds/Prescription given to patient for their partner(s)
☐ Yes, other: _____
☐ No, instructed patient to refer partner(s) for treatment
☐ No, referred partner(s) to: _____
☐ Unknown

If reporting Pelvic Inflammatory Disease: *(check all that apply)*
☐ Gonococcal PID
☐ Chlamydial PID
☐ Other/Unknown Etiology PID

VIRAL HEPATITIS

Diagnosis (check all that apply)
☐ Hepatitis A
☐ Hepatitis B (acute)
☐ Hepatitis B (chronic)
☐ Hepatitis B (perinatal)
☐ Hepatitis C (acute)
☐ Hepatitis C (chronic)
☐ Hepatitis D
☐ Hepatitis E

Is patient symptomatic? ☐ Yes ☐ No ☐ Unknown

Suspected Exposure Type(s)
☐ Blood transfusion, dental or medical procedure
☐ IV drug use
☐ Other needle exposure
☐ Sexual contact
☐ Household contact
☐ Perinatal
☐ Child care
☐ Other: _____

ALT (SGPT) Result: _____ Upper Limit: _____
AST (SGOT) Result: _____ Upper Limit: _____
Bilirubin result: _____

		Pos	Neg
Hep A	anti-HAV IgM	☐	☐
Hep B	HBsAg	☐	☐
	anti-HBc total	☐	☐
	anti-HBc IgM	☐	☐
	anti-HBs	☐	☐
	HBeAg	☐	☐
	anti-HBe	☐	☐
	HBV DNA: _____		

		Pos	Neg
Hep C	anti-HCV	☐	☐
	RIBA	☐	☐
	HCV RNA (e.g., PCR)	☐	☐
Hep D	anti-HDV	☐	☐
Hep E	anti-HEV	☐	☐

Remarks:

Title 17, California Code of Regulations (CCR) §2500, §2593, §2641.5-2643.20, and §2800-2812 Reportable Diseases and Conditions*

§ 2500. REPORTING TO THE LOCAL HEALTH AUTHORITY.

- **§ 2500(b)** It shall be the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or condition listed below, to report to the local health officer for the jurisdiction where the patient resides. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed below may make such a report to the local health officer for the jurisdiction where the patient resides.
- **§ 2500(c)** The administrator of each health facility, clinic, or other setting where more than one health care provider may know of a case, a suspected case or an outbreak of disease within the facility shall establish and be responsible for administrative procedures to assure that reports are made to the local officer.
- **§ 2500(a)(14)** "Health care provider" means a physician and surgeon, a veterinarian, a podiatrist, a nurse practitioner, a physician assistant, a registered nurse, a nurse midwife, a school nurse, an infection control practitioner, a medical examiner, a coroner, or a dentist.

URGENCY REPORTING REQUIREMENTS [17 CCR §2500(h)(i)]

✆ ! = Report immediately by telephone (designated by a ♦ in regulations).
† = Report immediately by telephone when two or more cases or suspected cases of foodborne disease from separate households are suspected to have the same source of illness (designated by a ● in regulations.)
FAX ✆ ✉ = Report by electronic transmission (including FAX), telephone, or mail within one working day of identification (designated by a + in regulations).
= All other diseases/conditions should be reported by electronic transmission (including FAX), telephone, or mail within seven calendar days of identification.

REPORTABLE COMMUNICABLE DISEASES §2500(j)(1)

Acquired Immune Deficiency Syndrome (AIDS)
(HIV infection only: see "Human Immunodeficiency Virus")
FAX ✆ ✉ Amebiasis
Anaplasmosis/Ehrlichiosis
✆ ! Anthrax, human or animal
FAX ✆ ✉ Babesiosis
✆ ! Botulism (Infant, Foodborne, Wound, Other)
Brucellosis, animal (except infections due to *Brucella canis*)
✆ ! Brucellosis, human
FAX ✆ ✉ Campylobacteriosis
Chancroid
FAX ✆ ✉ Chickenpox (Varicella) (only hospitalizations and deaths)
Chlamydia trachomatis infections, including lymphogranuloma venereum (LGV)
✆ ! Cholera
✆ ! Ciguatera Fish Poisoning
Coccidioidomycosis
Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE)
FAX ✆ ✉ Cryptosporidiosis
Cyclosporiasis
Cysticercosis or taeniasis
✆ ! Dengue
✆ ! Diphtheria
✆ ! Domoic Acid Poisoning (Amnesic Shellfish Poisoning)
FAX ✆ ✉ Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
✆ ! *Escherichia coli*: shiga toxin producing (STEC) including *E. coli* O157
† FAX ✆ ✉ Foodborne Disease
Giardiasis
Gonococcal Infections
FAX ✆ ✉ *Haemophilus influenzae*, invasive disease (report an incident of less than 15 years of age)
✆ ! Hantavirus Infections
✆ ! Hemolytic Uremic Syndrome
FAX ✆ ✉ Hepatitis A, acute infection
Hepatitis B (specify acute case or chronic)
Hepatitis C (specify acute case or chronic)
Hepatitis D (Delta) (specify acute case or chronic)
Hepatitis E, acute infection
Influenza, deaths in laboratory-confirmed cases for age 0-64 years
✆ ! Influenza, novel strains (human)
Legionellosis
Leprosy (Hansen Disease)
Leptospirosis
FAX ✆ ✉ Listeriosis
Lyme Disease
FAX ✆ ✉ Malaria
✆ ! Measles (Rubeola)
FAX ✆ ✉ Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
✆ ! Meningococcal Infections
Mumps
✆ ! Paralytic Shellfish Poisoning
Pelvic Inflammatory Disease (PID)
FAX ✆ ✉ Pertussis (Whooping Cough)
✆ ! Plague, human or animal
FAX ✆ ✉ Poliovirus Infection
FAX ✆ ✉ Psittacosis
FAX ✆ ✉ Q Fever
✆ ! Rabies, human or animal
FAX ✆ ✉ Relapsing Fever
Rickettsial Diseases (non-Rocky Mountain Spotted Fever), including Typhus and Typhus-like Illnesses
Rocky Mountain Spotted Fever
Rubella (German Measles)
Rubella Syndrome, Congenital
FAX ✆ ✉ Salmonellosis (Other than Typhoid Fever)
✆ ! Scombroid Fish Poisoning
✆ ! Severe Acute Respiratory Syndrome (SARS)
✆ ! Shiga toxin (detected in feces)
FAX ✆ ✉ Shigellosis
✆ ! Smallpox (Variola)
FAX ✆ ✉ *Staphylococcus aureus* infection (only a case resulting in death or admission to an intensive care unit of a person who has not been hospitalized or had surgery, dialysis, or residency in a long-term care facility in the past year, and did not have an indwelling catheter or percutaneous medical device at the time of culture)
FAX ✆ ✉ Streptococcal Infections (Outbreaks of Any Type and Individual Cases in Food Handlers and Dairy Workers Only)
FAX ✆ ✉ Syphilis
Tetanus
Toxic Shock Syndrome
FAX ✆ ✉ Trichinosis
FAX ✆ ✉ Tuberculosis
Tularemia, animal
✆ ! Tularemia, human
FAX ✆ ✉ Typhoid Fever, Cases and Carriers
FAX ✆ ✉ *Vibrio* Infections
✆ ! Viral Hemorrhagic Fevers, human or animal (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses)
FAX ✆ ✉ West Nile virus (WNV) Infection
✆ ! Yellow Fever
FAX ✆ ✉ Yersiniosis
✆ ! OCCURRENCE of ANY UNUSUAL DISEASE
✆ ! OUTBREAKS of ANY DISEASE (Including diseases not listed in **§ 2500**). Specifiy if institutional and/or open community.

HIV REPORTING BY HEALTH CARE PROVIDERS § 2641.5-2643.20

Human Immunodeficiency Virus (HIV) infection is reportable by traceable mail or person-to-person transfer within seven calendar days by completion of the HIV/AIDS Case Report form (CDPH 8641A) available from the local health department. For completing HIV-specific reporting requirements, see Title 17, CCR, § 2641.5-2643.20 and http://www.cdph.ca.gov/programs/aids/Pages/OAHIVReporting.aspx

REPORTABLE NONCOMMUNICABLE DISEASES AND CONDITIONS §2800–2812 and §2593(b)

Disorders Characterized by Lapses of Consciousness (§2800-2812)
Pesticide-related illness or injury (known or suspected cases)**
Cancer, including benign and borderline brain tumors (except (1) basal and squamous skin cancer unless occurring on genitalia, and (2) carcinoma in-situ and CIN III of the Cervix) (§2593)***

LOCALLY REPORTABLE DISEASES (If Applicable):

* This form is designed for health care providers to report those diseases mandated by Title 17, California Code of Regulations (CCR). Failure to report is a misdemeanor (Health & Safety Code §120295) and is a citable offense under the Medical Board of California Citation and Fine Program (Title 16, CCR, §1364.10 and 1364.11).
** Failure to report is a citable offense and subject to civil penalty ($250) (Health and Safety Code §105200).
*** The Confidential Physician Cancer Reporting Form may also be used. See Physician Reporting Requirements for Cancer Reporting in CA at: www.ccrcal.org.

health net

Decision Power®

Referral to Health Net Fax Form

- **California – HMO/Point-of-Service (POS)/HSP, EPO, PPO, Medicare Advantage (MA) HMO**

Decision Power® clinicians are available 24 hours a day, 365 days a year to provide education and support to eligible Health Net members who have chronic conditions. **To refer a patient to Health Net's Decision Power Disease Management or Wellness programs, please complete this form and fax it to Decision Power at 1-800-451-4730. Note: Do not mail this completed form; fax only please.**

Provider Information:

Name:	
Office telephone:	
Email address:	
Date of referral:	
Reason for referral:	

Member Information:

First and Last Name	Subscriber ID #	Gender	DOB	Telephone #	Program Referred For

Referrals are accepted for the following:

Targeted disease management conditions

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Artery Disease (CAD)
- Diabetes
- Heart Failure (HF)

Types of Support

- Adherence to treatment plan
- Gap closure
- High-risk chronic condition management
- Medication persistence
- Nutrition/lifestyle changes

Lifestyle programs

- Quit For Life™ (tobacco cessation)
- Wellness Health Coaching (weight loss, stress management, exercise and/or healthy eating)

Note: This form should not be used to refer Medi-Cal members.

****For case management needs, please refer to the Healthcare Services Department Case Management Referral Form, available in the Forms section of the Provider Library on the Health Net provider website at provider.healthnet.com, and fax to 1-800-745-6955.***

Revised – July 2019

DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action:	2. Status of Federal Action:	3. Report Type:
☐ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	☐ a. bid/offer/application b. initial award c. post-award	☐ a. initial filing b. material change **For Material Change Only:** year _____ quarter _____ date of last report _____

4. Name and Address of Reporting Entity:	5. If Reporting Entity in No. 4 is a Subawardee, Enter Name and Address of Prime:
☐ **Prime** ☐ **Subawardee** Tier _____, *if known*: **Congressional District**, *if known*:	 **Congressional District**, *if known*:
6. Federal Department/Agency:	**7. Federal Program Name/Description:** CFDA Number, *if applicable*: _____
8. Federal Action Number, *if known*:	**9. Award Amount,** *if known*: $
10. a. Name and Address of Lobbying Registrant (*if individual, last name, first name, MI*):	**b. Individuals Performing Services** (*including address if different from No. 10a*) (*last name, first name, MI*):
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	Signature: _____ Print Name: _____ Title: _____ Telephone No.: _____ Date: _____

Federal Use Only:	Authorized for Local Reproduction Standard Form LLL (Rev. 7-97)

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a followup report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, State and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks "Subawardee," then enter the full name, address, city, State and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizationallevel below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency). Include prefixes, e.g., "RFP-DE-90-001."

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, State and zip code of the lobbying registrant under the Lobbying Disclosure Act of 1995 engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10 (a). Enter Last Name, First Name, and Middle Initial (MI).

11. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

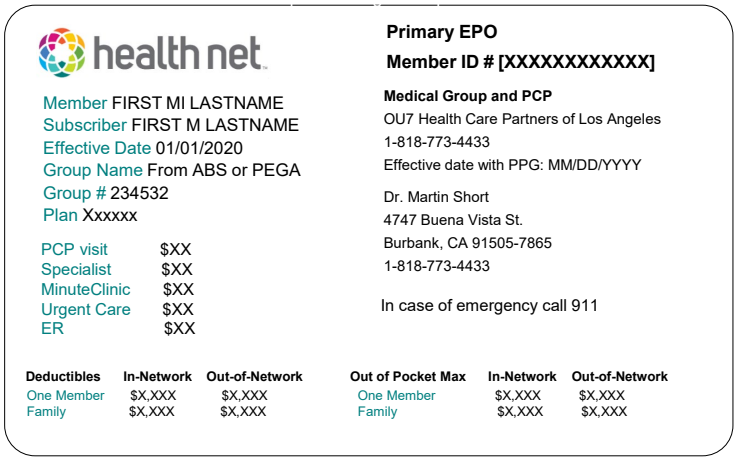
ICD-10-CM Codes for Abortion-Related Services

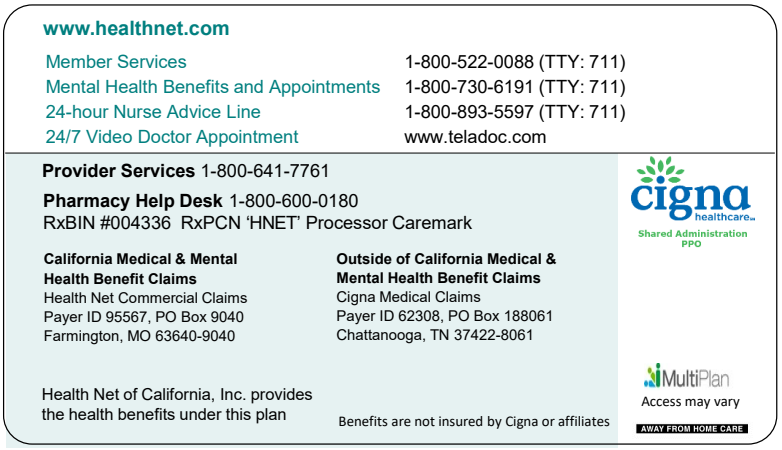
This list contains principal diagnosis codes for abortion and abortion-related services. If a code from this list is used as the principal diagnosis code, the services related to abortion will be processed by our claims processing systems at zero cost share to the member in accordance with Senate Bill 245 (the Abortion Accessibility Act). **Note: This list may not be all-inclusive and is subject to change.**

ICD-10 Codes	Descriptions
O00.00	Abdominal pregnancy without intrauterine pregnancy.
O00.01	Abdominal pregnancy with intrauterine pregnancy.
O00.101	Right tubal pregnancy without intrauterine pregnancy.
O00.102	Left tubal pregnancy without intrauterine pregnancy.
O00.109	Unspecified tubal pregnancy without intrauterine pregnancy.
O00.111	Right tubal pregnancy with intrauterine pregnancy.
O00.112	Left tubal pregnancy with intrauterine pregnancy.
O00.119	Unspecified tubal pregnancy with intrauterine pregnancy.
O00.201	Right ovarian pregnancy without intrauterine pregnancy.
O00.202	Left ovarian pregnancy without intrauterine pregnancy.
O00.209	Unspecified ovarian pregnancy without intrauterine pregnancy.
O00.211	Right ovarian pregnancy with intrauterine pregnancy.
O00.212	Left ovarian pregnancy with intrauterine pregnancy.
O00.219	Unspecified ovarian pregnancy with intrauterine pregnancy.
O00.80	Other ectopic pregnancy without intrauterine pregnancy.
O00.81	Other ectopic pregnancy with intrauterine pregnancy.
O00.90	Unspecified ectopic pregnancy without intrauterine pregnancy.
O00.91	Unspecified ectopic pregnancy with intrauterine pregnancy.
O01.1	Incomplete and partial hydatidiform mole.
O01.9	Hydatidiform mole, unspecified.
O02.1	Missed abortion.
O03.0	Genital tract and pelvic infection following incomplete spontaneous abortion.
O03.1	Delayed or excessive hemorrhage following incomplete spontaneous abortion.
O03.2	Embolism following incomplete spontaneous abortion.
O03.30	Unspecified complication following incomplete spontaneous abortion.
O03.32	Renal failure following incomplete spontaneous abortion.
O03.33	Metabolic disorder following incomplete spontaneous abortion.

ICD-10 Codes	Descriptions
O03.34	Damage to pelvic organs following incomplete spontaneous abortion.
O03.35	Other venous complications following incomplete spontaneous abortion.
O03.36	Cardiac arrest following incomplete spontaneous abortion.
O03.37	Sepsis following incomplete spontaneous abortion.
O03.38	Urinary tract infection following incomplete spontaneous abortion.
O03.39	Incomplete spontaneous abortion with other complications.
O03.4	Incomplete spontaneous abortion without complication.
O03.5	Genital tract and pelvic infection following complete or unspecified spontaneous abortion.
O03.6	Delayed or excessive hemorrhage following complete or unspecified spontaneous abortion.
O03.7	Embolism following complete or unspecified spontaneous abortion.
O03.80	Unspecified complication following complete or unspecified spontaneous abortion.
O03.81	Shock following complete or unspecified spontaneous abortion.
O03.82	Renal failure following complete or unspecified spontaneous abortion.
O03.83	Metabolic disorder following complete or unspecified spontaneous abortion.
O03.84	Damage to pelvic organs following complete or unspecified spontaneous abortion.
O03.85	Other venous complications following complete or unspecified spontaneous abortion.
O03.86	Cardiac arrest following complete or unspecified spontaneous abortion.
O03.87	Sepsis following complete or unspecified spontaneous abortion.
O03.88	Urinary tract infection following complete or unspecified spontaneous abortion.
O03.89	Complete or unspecified spontaneous abortion with other complications.
O03.9	Complete or unspecified spontaneous abortion without complication.
O04.5	Genital tract and pelvic infection following (induced) termination of pregnancy.
O04.6	Delayed or excessive hemorrhage following (induced) termination of pregnancy.
O04.7	Embolism following (induced) termination of pregnancy.
O04.80	(Induced) termination of pregnancy with unspecified complications.
O04.81	Shock following (induced) termination of pregnancy.
O04.82	Renal failure following (induced) termination of pregnancy.
O04.83	Metabolic disorder following (induced) termination of pregnancy.
O04.84	Damage to pelvic organs following (induced) termination of pregnancy.
O04.85	Other venous complications following (induced) termination of pregnancy.
O04.86	Cardiac arrest following (induced) termination of pregnancy.
O04.87	Sepsis following (induced) termination of pregnancy.
O04.88	Urinary tract infection following (induced) termination of pregnancy.

ICD-10 Codes	Descriptions
O04.89	(Induced) termination of pregnancy with other complications.
O07.0	Genital tract and pelvic infection following failed attempted termination of pregnancy.
O07.1	Delayed or excessive hemorrhage following failed attempted termination of pregnancy.
O07.2	Embolism following failed attempted termination of pregnancy.
O07.30	Failed attempted termination of pregnancy with unspecified complications.
O07.31	Shock following failed attempted termination of pregnancy.
O07.32	Renal failure following failed attempted termination of pregnancy.
O07.33	Metabolic disorder following failed attempted termination of pregnancy.
O07.34	Damage to pelvic organs following failed attempted termination of pregnancy.
O07.35	Other venous complications following failed attempted termination of pregnancy.
O07.36	Cardiac arrest following failed attempted termination of pregnancy.
O07.37	Sepsis following failed attempted termination of pregnancy.
O07.38	Urinary tract infection following failed attempted termination of pregnancy.
O07.39	Failed attempted termination of pregnancy with other complications.
O07.4	Failed attempted termination of pregnancy without complication.
O08.2	Embolism following ectopic and molar pregnancy.
O08.3	Shock following ectopic and molar pregnancy.
O08.4	Renal failure following ectopic and molar pregnancy.
O08.82	Sepsis following ectopic and molar pregnancy.
O08.83	Urinary tract infection following an ectopic and molar pregnancy.
O08.89	Other complications following an ectopic and molar pregnancy.
O20.0	Threatened abortion.
O20.8	Other hemorrhage in early pregnancy.
O20.9	Hemorrhage in early pregnancy, unspecified.
Q89.7	Multiple congenital malformations, not elsewhere classified.
Z33.2	Encounter for elective termination of pregnancy.
Z64.0	Problems related to unwanted pregnancy.





Your Health Net ID card

Attached is a new Health Net ID card. If there is an error on this card, or you have any questions about your coverage, please call Health Net's Member Services and provide them with your Group and Subscriber ID number. You will find the Member Services phone number on the back of this card and your Group and Subscriber ID number on the face of this card.

Carry this ID Card with you at all times, and present it to your health care provider when getting the care you need.

See your plan documents for a description of your benefits.

Your Primary Care Physician

Your PCP oversees all your health care and provides referrals if specialty care is needed. Your health plan uses the EPO provider network. In order to be covered please make sure you use doctors, hospitals, etc. that are in the EPO provider network. If your situation is an emergency, call 911 or go to the nearest hospital or emergency care facility.

Teladoc 24/7 Video Doctor Visits

Your new telehealth service provider is Teladoc. Teladoc gives you 24/7 access to U.S. board-certified doctors. You can access them with ease – either through the web, your phone or through the Teladoc app. Get the care you need in minutes from the comfort of home or at work. Or, get care even while traveling!

You may receive services on an in-person basis or via telehealth, if available, from your primary care provider, a treating specialist or from another contracting individual health professional, contracting clinic, or contracting health facility consistent with the service and existing timeliness and geographic access standards required under California law. Any cost share for services received through Teladoc will accrue toward your out-of-pocket maximum and deductible (if your plan has a deductible).By scheduling through Teladoc, you consent to receive services via telehealth through Teladoc. See your health plan coverage document for coverage information and for the definition of telehealth services. You have a right to access your medical records for services received through Teladoc. Unless you choose otherwise, any services provided through Teladoc shall be shared with your primary care provider.

Examples of IFP member eligibility status displayed on the secure provider portal

The image below shows examples of how member status displays when verifying eligibility for Individual and Family Plan (IFP) members on the secure provider portal. Status displays as “eligible” (thumbs up icon), “ineligible,” “delinquent,” or “suspended”:

INJECTABLE MEDICATION HCPCS / DOFR CROSSWALK

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
Q2055	ABECMA	Idecabtagene vicleucel, suspension for intravenous infusion	THERAPEUTIC INJ	CHEMOTHERAPY*
J0287	ABELCET	Amphotericin B lipid complex	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0400	ABILIFY	Aripiprazole, intramuscular, 0.25 mg	THERAPEUTIC INJ	
J0402	ABILIFY ASIMTUFII®	Aripiprazole IM ER Susp Prefilled Syringe	THERAPEUTIC	
J0401	ABILIFY MAINTENA	Apriprazole 300mg, IM injection	THERAPEUTIC INJ	
J9264	ABRAXANE	Paclitaxel protein-bound particles, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9258	ABRAXANE®	Paclitaxel Protein-Bound Particles for Injectable Suspension (albumin-bound). Mfg.Teva	THERAPEUTIC INJ	CHEMOTHERAPY*
Q5132	ABRILADA™	Injection, adalimumab-afzb , biosimilar, 10 mg- 0069-0347-02; 40mg 0069-0319-01.	THERAPEUTIC INJ	
Q5132	ABRILADA™	Injection, adalimumab-afzb , biosimilar, 20, 40mg - 00069-0333-02; 00069-0325-01; 00069-0325-02; 00069-0328-02; 00025-0325-02 ; 00025-0328-02; 00025-0333-02; 00025-0325-01	SELF-INJECTABLE	
TBD	ABRYSVO™	Respiratory Syncytial Virus Vaccine solution for intramuscular injection	THERAPEUTIC INJ	IMMUNIZATION
J0137	Acetaminophen	Injection, acetaminophen (Hikma) not therapeutically equivalent to J0131, 10 mg	THERAPEUTIC INJ	
J0134	Acetaminophen 10mg/ml solution	Injection, acetaminophen (fresenius kabi) not therapeutically equivalent to j0131, 10 mg	THERAPEUTIC INJ	
J0136	Acetaminophen 10mg/ml solution	Injection, acetaminophen (b braun) not therapeutically equivalent to j0131, 10 mg	THERAPEUTIC INJ	
J1120	ACETAZOLAMIDE SODIUM	Acetazolamide sodium injection	THERAPEUTIC INJ	
J0132	ACETYLCYSTEINE INJ	Acetylcysteine injection, 10 mg	THERAPEUTIC INJ	
J3262	ACTEMRA 162mg/0.9ml Syringe (50242-0138-01)	Tocilizumab, 1 mg	SELF-INJECTABLE	
J3262	ACTEMRA INJECTION (50242-0136-01, 50242-0137-01)	Tocilizumab 200mg, 400mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0802	ACTHAR® HP	Corticotropin injection, 40 MG	THERAPEUTIC INJ	
J0801	ACTHAR® HP	Corticotropin injection, 80 MG	THERAPEUTIC INJ	
90648	ACTHIB	Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4-dose schedule), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J0795	ACTHREL	Corticorelin Ovine Triflutal	THERAPEUTIC INJ	
J9216	ACTIMMUNE	Interferon gamma 1-b 3 miillion units	SELF-INJECTABLE	CHEMO ADJUNCT*
J2997	ACTIVASE	Alteplase recombinant, 1mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0133	ACYCLOVIR SODIUM	Acyclovir, 5 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90715	ADACEL	Tdap vaccine, > 7 yrs, IM	THERAPEUTIC INJ	IMMUNIZATION
J2504	ADAGEN	Pegademase bovine, 25 IU	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0791	ADAKVEO	Crizanlizumab-tmca IV Solution	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3590	ADBRY™	Tralokinumab-ldrm injection, for subcutaneous use	SELF-INJECTABLE	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

Rev. Aug 28, 2024

Effective December 6, 2024

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J9042	ADCETRIS	Brentuximab vedotin Injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J0153	ADENOCARD	Adenosine 6 MG	THERAPEUTIC INJ	
C9399, J3490	ADLYXIN	Lixisenatide Solution	SELF-INJECTABLE	
J0171	ADRENALIN	Adrenalin (epinephrine) inject	THERAPEUTIC INJ	
J9000	ADRIAMYCIN	Doxorubicin hcl 10 MG	THERAPEUTIC INJ	CHEMOTHERAPY*
J9190	ADRUCIL	Fluorouracil injection, 500 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9029	ADSTILADRIN®	Nadofaragene firadenovec-vncg) suspension, for intravesical use	THERAPEUTIC	CHEMOTHERAPY*
J7192	ADVATE	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J7207	ADYNOVATE	Antihemophilic Factor (Recombinant), PEGylated, is a human antihemophilic factor	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J7171	ADZYNMA®	Adamts13 recombinant-krhn	THERAPEUTIC INJ	
90685	AFLURIA® Peds Quadrivalent	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.25 mL dosage, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90688	AFLURIA® Quadrivalent	Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.5 mL dosage, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J7210	AFSTYLA	Injection, factor VIII, antihemophilic factor,recombinant	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J3246	AGGRASTAT	Tirofiban HCl, 0.25 mg	THERAPEUTIC INJ	
Q2034	AGRIFLU	Influenza virus vaccine, split virus, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J1720	A-HYDROCORT	Hydrocortisone sodium succinate	THERAPEUTIC INJ	CHEMO ADJUNCT*
J3590	AIMOVIG	Erenumab-aooe injection, for subcutaneous use	SELF-INJECTABLE	
J3031	AJOVY	Fremanezumab-vfrm	SELF-INJECTABLE	
J0190	AKINETON	Biperiden lactate, per 5 mg	THERAPEUTIC INJ	
J3490	AKOVAZ	Ephedrine sulfate injection, USP for intravenous use	THERAPEUTIC INJ	
J1454	AKYNZEO	Fosnetupitant and palonsetron) for injection, for intravenous use	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1931	ALDURAZYME	Laronidase injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0216	Alfentanil	Alfentanil HCl injection	THERAPEUTIC INJ	
J9215	ALFERON N	Interferon alfa-N3 (human leukocyte derived), 250,000 IU inj	SELF-INJECTABLE	CHEMO ADJUNCT*
J9305	ALIMTA	Pemetrexed, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9057	ALIQOPA	Copanlisib for injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J9245	ALKERAN	Melphalan hydrochl 50 MG	THERAPEUTIC INJ	CHEMOTHERAPY*
J0206	Allopurinol	Injection, allopurinol sodium, 1 mg	THERAPEUTIC INJ	
J2469	ALOXI	Palonosetron HCl, 25 mcg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J7190	ALPHANATE	Factor VIII (antihemophilic Factor [human]) per IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J7186	ALPHANATE VWF	Von Willebrand Factor complex, human, ristocetin coFactor (not otherwise specified), per I.U.	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J7193	ALPHANINE SD	Factor IX (antihemophilic Factor, purified, non-recombinant) per IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J7201	ALPROLIX	Coagulation Factor IX (Recombinant), Fc Fusion Protein], Lyophilized Powder for Solution for Intravenous Injection	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J0270	Alprostadil 500	Injection, alprostadil, 1.25 mcg (code may be used for Medicare when drug administered under direct physician supervision, not for use when drug is self-administered)	SELF-INJECTABLE	
J7214	ALTUVIIIO™	Antihemophilic factor (recombinant) DNA-derived, Factor VIII concentrate, lyophilized powder for solution, for intravenous use	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
Q1256	ALYMSYS®	Bevacizumab-maly injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J0289	AMBISOME	Amphotericin B liposome inj	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2920	A-METHAPRED	Methylprednisolone injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J2930	A-METHAPRED	Methylprednisolone injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J0215	AMEVIVE	Alefacept	THERAPEUTIC INJ	
S0017	AMICAR	Aminocaproic acid	THERAPEUTIC INJ	
J0278	AMIKACIN SULF INJ USP 1GRAM/4ML FLIPTOP VIAL	Amikacin sulfate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0278	AMIKIN	Amikacin sulfate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0280	AMINOPHYLLINE	Aminophyllin 250 MG inj	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0282	AMIODARONE HCL	Amiodarone hcl	THERAPEUTIC INJ	
C9399, J3490	AMJEVITA	Adalimumab-atto injection for subcutaneous use	SELF-INJECTABLE	
J1426	AMONDYS 45™	Casimersen injection, for intravenous use	THERAPEUTIC INJ	
J3470	AMPHADASE 150 UNIT/ML SOLN	Hyaluronidase, up to 150 units	THERAPEUTIC INJ	
J0285	AMPHOCIN	Amphotericin B	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0288	AMPHOTEC	Ampho b cholesteryl sulfate	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0285	AMPHOTERICIN B	Amphotericin B	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0290	AMPICILLIN SODIUM	Ampicillin 500 MG inj	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0295	AMPICILLIN-SULBACTAM	Ampicillin sodium per 1.5 gm	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3590	AMTAGVI™	Lifileucel IV Susp 72,000,000,000 Cells	THERAPEUTIC INJ	CHEMOTHERAPY
J0225	AMVUTTRA™	Vutrisiran injection, for subcutaneous use	THERAPEUTIC INJ	
J0300	AMYTAL SODIUM	Amobarbital 125 MG inj	THERAPEUTIC INJ	
J0716	ANASCORP	Centruroides immune f(ab)2, up to 120 milligrams	THERAPEUTIC INJ	
J0841	ANAVIP	Injection, crotalidae immune f(ab')2 (equine), 120 mg	THERAPEUTIC INJ	
J0690	ANCEF	Cefazolin sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J7169	ANDEXXA	Coagulation factor Xa (recombinant), inactivated-zhzo) Lyophilized Powder for Solution For Intravenous Injection	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J0330	ANECTINE	Succinycholine chloride inj	THERAPEUTIC INJ	
J0583	ANGIOMAX	Bivalirudin, 1mg	THERAPEUTIC INJ	
J1738	ANJESO	Meloxicam injection, for intravenous use	THERAPEUTIC INJ	
J9999	ANKTIVA®	Nogapendekin alfa inbakicept-pmln solution, for intravesical use	THERAPEUTIC INJ	
90581	ANTHRAX VACCINE	Anthrax vaccine, sc	THERAPEUTIC INJ	IMMUNIZATION
J1451	ANTIZOL	Fomepizole, 15 mg	THERAPEUTIC INJ	
J1260	ANZEMET	Dolasetron mesylate	THERAPEUTIC INJ	CHEMO ADJUNCT*
J2277	APHEXDA™	Motixafortide for injection, for subcutaneous use	THERAPEUTIC INJ	CHEMO ADJUNCT*
J0364	APOKYN	Apomorphine hydrochloride, 1mg	SELF-INJECTABLE	
C9145	APONVIE™	Injection, aprepitant, 1 mg	THERAPEUTIC	
J0739	APRETUDE™	Cabotegravir extended-release injectable suspension), for intramuscular use	THERAPEUTIC INJ	
J3430	AQUA-MEPHYTON	Vitamin K phytonadione inj	THERAPEUTIC INJ	
J0256	ARALAST	Alpha 1 proteinase inhibitor	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0390	ARALEN	Chloroquine injection	THERAPEUTIC INJ	
J0380	ARAMINE	Metaraminol bitartrate	THERAPEUTIC INJ	
J0881	ARANESP	Darbepoetin alfa, 1 microgram (non-ESRD use)	SELF-INJECTABLE	CHEMO ADJUNCT*
J0882	ARANESP	Darbepoetin alfa, 1 microgram (for ESRD on dialysis	SELF-INJECTABLE	CHEMO ADJUNCT*
J2793	ARCALYST	Rilonacept Injection 220 mg Solr	SELF-INJECTABLE	
90679	AREXVY	Respiratory Syncytial Virus Vaccine, Adjuvanted	THERAPEUTIC INJ	IMMUNIZATION
J0883	ARGATROBAN	Injection, argatroban, 1 mg (for non-ESRD use)	THERAPEUTIC INJ	
J0884	ARGATROBAN	Injection, argatroban, 1 mg (for ESRD on dialysis)	THERAPEUTIC INJ	
J0891	ARGATROBAN	Injection, argatroban (accord), not therapeutically equivalent to j0883, 1 mg (for non-esrd use)	THERAPEUTIC INJ	
J0892	ARGATROBAN	Injection, argatroban (accord), not therapeutically equivalent to j0884, 1 mg (for esrd on dialysis)	THERAPEUTIC INJ	
J0898	ARGATROBAN	Injection, argatroban (AuroMedics), not therapeutically equivalent to J0883, 1 mg (for non-ESRD use)	THERAPEUTIC INJ	
J0899	ARGATROBAN	Injection, argatroban (AuroMedics), not therapeutically equivalent to J0884, 1 mg (for ESRD on dialysis)	THERAPEUTIC INJ	
J1944	ARISTADA	Aripprazole lauroxilextended release suspension	THERAPEUTIC INJ	
J1943	ARISTADA INITIO	Aripiprazole lauroxil extended-release injectable suspension	THERAPEUTIC INJ	
J3302	ARISTOCORT FORTE	Triamcinolone diacetate inj	THERAPEUTIC INJ	
J3303	ARISTOSPAN INTRA-ARTICULAR	Triamcinolone hexacetonl inj	THERAPEUTIC INJ	
J3303	ARISTOSPAN INTRALESIONAL	Triamcinolone hexacetonl inj	THERAPEUTIC INJ	

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J1652	ARIXTRA	Fondaparinux sodium, 0.5 mg	SELF-INJECTABLE	
J9261	ARRANON 5 MG/ML SOLN	Nelarabine, 50 Mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0391	ARTESUNATE	Artesunate 110MG Solution Reconstituted	THERAPEUTIC INJ	
J9302	ARZERRA	Ofatumumab	THERAPEUTIC INJ	CHEMOTHERAPY*
J1554	ASCENIV	Injection, immune globulin, intravenous, non-lyophilized (e.g. liquid),	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
C9399, J3490	ASCLERA	Polidocanol Injection	THERAPEUTIC INJ	
J9118	ASPARLAS	Calaspargase pegol-mknl, 10 units	THERAPEUTIC INJ	CHEMOTHERAPY*
J2275	ASTRAMORPH	Morphine sulfate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7504	ATGAM	Lymphocyte immune globulin, antithymocyte globulin, equine, parenteral, 250 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2060	ATIVAN	Lorazepam injection	THERAPEUTIC INJ	
J0461	ATROPINE SULFATE	Atropine sulfate injection	THERAPEUTIC INJ	
90705	ATTENUVAX	Measles vaccine, SC	THERAPEUTIC INJ	IMMUNIZATION
C9257	AVASTIN	Bevacizumab, 0.25 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9035	AVASTIN	Bevacizumab injection, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J3145	AVEED	Testosterone undecanoate 250 mg/ml	THERAPEUTIC INJ	
J2280	AVELOX	Moxifloxacin 100 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1826	AVONEX	Interferon beta-1A, 11 mcg for intramuscular use (See also J1825)	SELF-INJECTABLE	
Q3027	AVONEX	Interferon beta-1a, 33 mcg	SELF-INJECTABLE	
Q5121	AVSOLA	Injection, infliximab-axxq, biosimilar, 10mg	THERAPEUTIC INJ	
J0714	AVYCAZ	Ceftazidime-avibactam Injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3590	AVZIVI®	Bevacizumab-tnjn	THERAPEUTIC INJ	CHEMOTHERAPY*
S0073	AZACTAM	Aztreonam, 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7501	AZATHIOPRINE SODIUM	Azathioprine parenteral	THERAPEUTIC INJ	TRANSPLANT*
J0457	Aztreonam	Injection, aztreonam, 100 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0475	BACLOFEN	Baclofen 10 MG injection	THERAPEUTIC INJ	
J2700	BACTOCILL IN DEXTROSE	Oxacillin sodium injeciton	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0470	BAL IN OIL	Dimecaprol injection	THERAPEUTIC INJ	
J1412	BALFAXAR®	Injection, prothrombin complex concentrate (human), per IU of Factor IX activity	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J0184	BARHEMSYS	Amisulpride (antiemetic) IV soln 10 mg/4ml	THERAPEUTIC INJ	
J9023	BAVENCIO	Avelumab injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
C9462	BAXDELA	Delafloxacin for injection, for intravenous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q0222	BEBTELOVIMAB	BEBTELOVIMAB IV SOLN 175 MG/2ML	THERAPEUTIC INJ	
J7194	BEBULIN VH	Factor IX, complex, per IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J9032	BELEODAQ	Belinostat Injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J9036	BELRAPZO	Bendamustine hydrochloride injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J1200	BENADRYL	Diphenhydramine hcl injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J9058	Bendamustine	Injection, bendamustine HCl (Apotex), 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9059	Bendamustine	Injection, bendamustine HCl (Baxter), 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9034	BENDEKA	Bendamustine HCl Injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J7195	BENEFIX	Factor IX (antihemophilic Factor, recombinant) per IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J0490	BENLYSTA	Belimumab 10 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3590	BENLYSTA SubQ INJ	Belimumab subcutaneous solution auto-injector	SELF-INJECTABLE	
J0500	BENTYL	Dicyclomine injection	THERAPEUTIC INJ	
J0179	BEOVU	Brolucizumab-dbll, 1 mg Injection	THERAPEUTIC INJ	
J3590	BEQVEZ™	Fidanacogene elaparvovec-dzkt injection, for intravenous infusion	THERAPEUTIC INJ	
J0597	BERINERT	C1 Esterase Inhibitor (Human)	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9229	BESPONSA	Inotuzumab ozogamicin for IV soln	THERAPEUTIC INJ	CHEMOTHERAPY*
C9999	BESREMi®	Ropeginterferon alfa-2b-njft) injection, for subcutaneous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J1830	BETASERON	Interferon beta-1b / .25 MG	SELF-INJECTABLE	
90620	BEXSERO	Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B, 2 dose schedule, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90381	BEYFORTUS™	Nirsevimab-alip IM Soln Prefilled Syringe 100 MG/ML	THERAPEUTIC INJ	
90380	BEYFORTUS™	Nirsevimab-alip IM Soln Prefilled Syringe 50 MG/ML	THERAPEUTIC INJ	
J0558	BICILLIN C-R (25000)	Penicillin G benzathine and penicillin G procaine, 25,000U	THERAPEUTIC INJ	
J0561	BICILLIN L-A	Penicillin G benzathine, up to 600,000 units	THERAPEUTIC INJ	
J0561	BICILLIN L-A	Penicillin G benzathine, up to 1,200,000 units	THERAPEUTIC INJ	
J0561	BICILLIN L-A	Penicillin G benzathine, up to 2,400,000 units	THERAPEUTIC INJ	
J9050	BICNU	Carmustine, 100 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J3590	BIMZELX®	Bimekizumab-bkzx	SELF-INJECTABLE	
J1556	BIVIGAM	Immune Globulin Intravenous (Human), 10% liquid	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9040	BLENOXANE	Bleomycin sulfate injection, 15 units	THERAPEUTIC INJ	CHEMOTHERAPY*
J9037	BLENREP	Belantamab mafodotin-blmf for iv soln 100 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9040	BLEOMYCIN SULFATE	Bleomycin sulfate injection, 15 units	THERAPEUTIC INJ	CHEMOTHERAPY*
J9039	BLINCYTO	Blinatumomab for Injection, IV	THERAPEUTIC INJ	CHEMOTHERAPY*
J1740	BONIVA	Ibandronate sodium Injection, 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90715	BOOSTRIX	Tdap vaccine	THERAPEUTIC INJ	IMMUNIZATION

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J9046	Bortezomib	Injection, bortezomib (Dr. Reddy's), not therapeutically equivalent to J9041, 0.1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9048	Bortezomib	Injection, bortezomib (Fresenius Kabi), not therapeutically equivalent to J9041, 0.1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9049	Bortezomib	Injection, bortezomib (Hospira), not therapeutically equivalent to J9041, 0.1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9051	Bortezomib	Inj, bortezomib (maia)	THERAPEUTIC INJ	CHEMOTHERAPY*
J0585	BOTOX	OnabotulinumtoxinA, 1 unit	THERAPEUTIC INJ	
90287	BOTULINIM ANTITOXIN	Botulinim antitoxin, equine, any route	THERAPEUTIC INJ	
90288	BOTULISM	Botulism immune globulin, human, IV	THERAPEUTIC INJ	
J3355	BRAVELLE	Urofollitropin, 75 iu	SELF-INJECTABLE	INFERTILITY
J3105	BRETHINE	Terbutaline sulfate inj	THERAPEUTIC INJ	
Q2054	BREYANZI	Lisocabtagene maraleucel suspension for intravenous infusion	THERAPEUTIC INJ	CHEMOTHERAPY*
J0567	BRINEURA	Cerliponase alfa for intraventricular use	THERAPEUTIC INJ	
J2329	BRIUMVI™	Ublituximab-xiiy	THERAPEUTIC	
C9399, J3490	BRIVIACT	Brivaracetam injection, for intravenous use, CV-	THERAPEUTIC INJ	
J0576	BRIXADI™	Buprenorphine extended release subcutaneous injection	THERAPEUTIC INJ	
J0945	BROMPHENIRAMINE MALEATE	Brompheniramine maleate inj	THERAPEUTIC INJ	
J1939	BUMETANIDE	Injection, bumetanide, 0.5 mg	THERAPEUTIC INJ	
S0020	Bupivicaine	Bupivicaine hydro	THERAPEUTIC INJ	
J0665	Bupivicaine	Injection, bupivicaine, not otherwise specified, 0.5 mg	THERAPEUTIC INJ	
J0592	BUPRENEX	Buprenorphine hydrochloride	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0594	BUSULFEX 6MG/ML	Busulfan injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J0595	BUTORPHANOL TARTRATE	Butorphanol tartrate 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3490	BYDUREON	Exenatide extended release	SELF-INJECTABLE	
J3490	BYDUREON BCise	Exenatide extended release injectable suspension 2 mg	SELF-INJECTABLE	
J3490	BYETTA	Exenatide Injection	SELF-INJECTABLE	
J2249	BYFAVO®	Injection, remimazolam, 1 mg	THERAPEUTIC INJ	
Q5124	BYOOVIZ	Ranibizumab-nuna Intravitreal Injection	THERAPEUTIC INJ	
J0741	CABENUV	CABOTEGRAVIR & RILPIVIRINE	THERAPEUTIC INJ	HIV/AIDS
C9047	CABLIVI	Caplacizumab-yhdp	SELF-INJECTABLE	
J0706	CAFCIT	Caffeine citrate injection, 5 MG	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0636	CALCIJEX	Calcitriol per 0.1 mcg	THERAPEUTIC INJ	
S0161	CALCITROL	Calcitrol, 0.25 mg	THERAPEUTIC INJ	
J0600	CALCIUM DISODIUM VERSENATE	Edetate calcium disodium inj	THERAPEUTIC INJ	
J0610	CALCIUM GLUCONATE	Calcium gluconate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J0612	Calcium gluconate	Injection, calcium gluconate (Fresenius Kabi), per 10 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0613	Calcium gluconate	Injection, calcium gluconate (WG Critical Care), per 10 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0611	Calcium gluconate	Injection, calcium gluconate (wg critical care), per 10 ml	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1741	CALDOLOR	Injection, ibuprofen, 100 mg	THERAPEUTIC INJ	
J0620	CALPHOSAN	Calcium glycer & lact/10 ML	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1952	CAMCEVI	Leuprolide injectable, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9010	CAMPATH	Alemtuzumab, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9206	CAMPTOSAR	Irinotecan injection, 20mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0637	CANCIDAS	Caspofungin acetate	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3590	CAPVAXIVE™	Pneumococcal 21-valent Conjugate Vaccine Injection, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J0670	CARBOCAINE	Mepivacaine HCL/10 ml	THERAPEUTIC INJ	
J9045	CARBOPLATIN	Carboplatin injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J1566	CARIMUNE NF	Immune globulin, intravenous, lyophilized (eg powder), 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9052	Carmustine	Injection, carmustine (Accord), not therapeutically equivalent to J9050, 100 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J1955	CARNITOR	Levocarnitine per 1 gm	THERAPEUTIC INJ	
Q2056	CARVYKTI	Ciltacabtagene autoleucel suspension for intravenous infusion	THERAPEUTIC INJ	CHEMOTHERAPY*
J3590	CASGEVY™	Exagamglogene autotemcel, suspension for intravenous infusion	THERAPEUTIC INJ	
J2997	CATHFLO ACTIVASE	Alteplase recombinant, 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0270	CAVERJECT	Alprostadil for injection	SELF-INJECTABLE	
J0710	CEFADYL	Cephapirin sodium	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0688	CEFAZOLIN	Injection, cefazolin sodium (Hikma), not therapeutically equivalent to J0690, 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0690	CEFAZOLIN SODIUM	Cefazolin sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0689	Cefazolin sodium	Injection, cefazolin sodium (baxter), not therapeutically equivalent to j0690, 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0701	Cefepime	Injection, cefepime HCl (Baxter), not therapeutically equivalent to Maxipime, 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0703	Cefepime	Injection, cefepime HCl (B. Braun), not therapeutically equivalent to Maxipime, 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0783	Cefepime	Cefepime hydrochloride (baxter), not therapeutically equivalent to maxipime, 500 mg J0703 Injection	THERAPEUTIC INJ	
J0715	CEFIZOX	Ceftizoxime sodium / 500 MG	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0715	CEFIZOX IN D5W	Ceftizoxime sodium / 500 MG	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
S0021	CEFOPERAZONE	Cefoperazone sodium	THERAPEUTIC INJ	HOME HEALTH / INFUSION**

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J0698	CEFOTAXIME SODIUM	Cefotaxime sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
S0074	CEFOTETAN	Cefotetan disodium	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0694	CEFOXITIN SODIUM	Cefoxitin sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0713	CEFTAZIDIME	Ceftazidime per 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0697	CEFUROXIME SODIUM	njection, sterile cefuroxime sodium, per 750 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0697	CEFUROXIME-DEXTROSE	Sterile cefuroxime injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0702	CELESTONE SOLUSPAN	Betamethasone acetate 3 mg and betamethasone sodium phosphate 3 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J7599	CELLCEPT 500MG	Immunosuppressive drug, not otherwise classified	THERAPEUTIC INJ	TRANSPLANT*
J1890	CEPHALOTHIN SODIUM	Cephalothin sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2724	CEPROTIN	Protein C concentrate, intravenous, human, 10 IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J0713	CEPTAZ	Ceftazidime per 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q2009	CEREBYX	Fosphenytoin, 50 mg phenytoin equivalent	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0205	CEREDASE	Alglucerase injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1786	CEREZYME	Imiglucerase, per unit	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9150	CERUBIDINE	Daunorubicin, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
90650	CERVARIX	Human Papillomavirus Bivalent (Types 16 and 18) Vaccine, Recombinant	THERAPEUTIC INJ	IMMUNIZATION
J3490	CETROTIDE	Cetrorelix acetate for inj kit 0.25 mg	SELF-INJECTABLE	INFERTILITY
J0720	CHLORAMPHENICOL SOD SUCCINATE	Chloramphenicol sodium inject	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0720	CHLOROMYCETIN	Chloramphenicol sodium inject	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2401	Chloroprocaine	Chloroprocaine hydrochloride, per 1 mg	THERAPEUTIC INJ	
J3230	CHLORPROMAZINE HCL	Chlorpromazine hcl injection	THERAPEUTIC INJ	
90725	CHOLERA VACCINE	Cholera vaccine, injectable	THERAPEUTIC INJ	IMMUNIZATION
J0725	CHORIONIC GONADOTROPIN	Chorionic gonadotropin/1000u	SELF-INJECTABLE	INFERTILITY
Q5128	CIMERLI™	Injection, ranibizumab-eqrn , biosimilar, 0.1 mg	THERAPEUTIC INJ	
J0717	CIMZIA® Prefilled Syr KIT 200MG NDC 50474-710-81; 50474-710-79	Certolizumab, 200 mg/mL solution in a single-dose prefilled syringe	SELF-INJECTABLE	
J0717	CIMZIA® Vial NDC 50474-700-62	Certolizumab, 200 mg lyophilized powder in a single-dose vial	THERAPEUTIC INJ	
J2786	CINQAIR	Reslizumab	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0598	CINRYZE	Injection, C-1 esterase inhibitor (human), 10 units	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0185	CINVANTI	Aprepitant, Injection, 1 MG	THERAPEUTIC INJ	CHEMO ADJUNCT*
J0744	CIPRO	Ciprofloxacin for intravenous infusion, 200 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0744	CIPRO IN D5W	Ciprofloxacin for intravenous infusion, 200 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9060	CISPLATIN	Cisplatin 10 mg injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J9060	CISPLATIN	Cisplatin 50 mg injection	THERAPEUTIC INJ	CHEMOTHERAPY*

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J9065	CLADRIBINE	Cladribine per 1 MG	THERAPEUTIC INJ	CHEMOTHERAPY*
J0698	CLAFORAN	Cefotaxime sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0698	CLAFORAN IN D5W	Cefotaxime sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
S0077	CLEOCIN	Clindamycin phosphate	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
C9248	CLEVIPREX	Clevidipine butyrate, 1 mg	THERAPEUTIC INJ	
J0736	Clindamycin	Injection, clindamycin phosphate, 300 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0737	Clindamycin	Injection, clindamycin phosphate (Baxter), not therapeutically equivalent to J0736, 300 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9027	CLOLAR	Clofarabine injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J2402	CLOROTEKAL®	Chloroprocaine hydrochloride injection, for intrathecal use	THERAPEUTIC INJ	
J7175	COAGADEX	Injection, factor X, (human), 1 IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J0745	CODEINE PHOSPHATE	Codeine phosphate /30 MG	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0515	COGENTIN	Benztropine mesylate, 1 mg	THERAPEUTIC INJ	
J0760	COLCHICINE	Colchicine injection	THERAPEUTIC INJ	
J0770	COLISTIMETHATE SODIUM	Colistimethate sodium inj	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9286	COLUMVI™	Glofitamab-gxbm injection for intravenous (IV) infusion	THERAPEUTIC INJ	CHEMOTHERAPY*
J0770	COLY-MYCIN M	Colistimethate sodium inj	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
91320	COMERNATY® 2024-25	Covid-19 Vaccine, mRNA, 24-25 Formula	THERAPEUTIC INJ	IMMUNIZATION
J0780	COMPAZINE	Prochlorperazine, up to 10 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1595	COPAXONE	Glatiramer acetate	SELF-INJECTABLE	
J0282	CORDARONE IV	Amiodarone hcl	THERAPEUTIC INJ	
J7180	CORIFACT	Factor XIII Concentrate	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J0834	CORTROSYN	Cosyntropin per 0.25 MG	THERAPEUTIC INJ	
J1742	CORVERT	Ibutilide fumarate injection	THERAPEUTIC INJ	
J1448	COSELA	Trilaciclib for injection, for intravenous	THERAPEUTIC INJ	CHEMO ADJUNCT*
J3247	COSENTYX®	Injection, secukinumab, IV, 1 mg	SELF-INJECTABLE	
J3590	COSENTYX® IV	Secukinumab IV Soln 125 Mg/5ml	THERAPEUTIC INJ	
J3590	COSENTYX® UNOREADY®	Secukinumab Subcutaneous Soln Auto-Injector 300 Mg/2ml	SELF-INJECTABLE	
J9120	COSMEGEN	Dactinomycin, 0.5 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0834	Cosyntropin 0.25 MG (generic)	Cosyntropin, not otherwise specified, 0.25 mg	THERAPEUTIC INJ	
J2650	COTOLONE	Prednisolone acetate inj	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1833	CRESEMBA	Isavuconazonium sulfate Injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0840	CROFAB	Injection, crotalidae polyvalent immune fab (Ovine), up to 1 gram	THERAPEUTIC INJ	
J0584	CRYSVITA	Burosumab-twza injection, for subcutaneous use	THERAPEUTIC INJ	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J0878	CUBICIN	Daptomycin injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3590	CUROSURF	Poractant alfa intratracheal suspension	THERAPEUTIC INJ	
J1551	CUTAQUIG	Immune Globulin Subcutaneous (Human) - hipp	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1555	CUVITRU	Immune Globulin Subcutaneous 20% Solution	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3420	CYANOCOBALAMIN	Vitamin B-12 cyanocobalamin, up to 1000mcg	THERAPEUTIC INJ	
J9070	CYCLOPHOSPHAMIDE	Cyclophosphamide 100 MG inj	THERAPEUTIC INJ	CHEMOTHERAPY*
J9080	CYCLOPHOSPHAMIDE	Cyclophosphamide 200 MG inj	THERAPEUTIC INJ	CHEMOTHERAPY*
J9090	CYCLOPHOSPHAMIDE	Cyclophosphamide 500 MG inj	THERAPEUTIC INJ	CHEMOTHERAPY*
J9091	CYCLOPHOSPHAMIDE	Cyclophosphamide 1.0 grm inj	THERAPEUTIC INJ	CHEMOTHERAPY*
J9092	CYCLOPHOSPHAMIDE	Cyclophosphamide 2.0 grm inj	THERAPEUTIC INJ	CHEMOTHERAPY*
C9087	CYCLOPHOSPHAMIDE	Injection, cyclophosphamide, (AuroMedics), 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9072	CYCLOPHOSPHAMIDE	Injection, cyclophosphamide, (Dr. Reddy's), 5 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9074	CYCLOPHOSPHAMIDE	Injection, cyclophosphamide (sandoz), 5 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9075	CYCLOPHOSPHAMIDE	Injection, cyclophosphamide, 5 mg, Not otherwise specified	THERAPEUTIC INJ	CHEMOTHERAPY*
J7516	CYCLOSPORINE	Cyclosporine, parenteral, 250mg	THERAPEUTIC INJ	TRANSPLANT*
J3590	CYLTEZO	Adalimumab-adbm injection, for subcutaneous use	SELF-INJECTABLE	
J9308	CYRAMZA	Ramucirumab injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J9100	CYTARABINE	Cytarabine hcl 100 MG inj	THERAPEUTIC INJ	CHEMOTHERAPY*
J9110	CYTARABINE	Cytarabine, 500mg	THERAPEUTIC INJ	CHEMOTHERAPY*
90291	CYTOGAM	Injection, cytomegalovirus, immune globulin intravenous (human), CMV-IgIV intravenous, human, per vial	THERAPEUTIC INJ	
J0850	CYTOGAM	Injection, cytomegalovirus, immune globulin intravenous (human), CMV-IgIV intravenous, human, per vial	THERAPEUTIC INJ	
J1570	CYTOVENE	Ganciclovir sodium injection	THERAPEUTIC INJ	HIV/AIDS
J9070	CYTOXAN	Cyclophosphamide 100 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J9080	CYTOXAN	Cyclophosphamide 200 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J9090	CYTOXAN	Cyclophosphamide 500 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J9091	CYTOXAN	Cyclophosphamide 1.0 grm injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J9092	CYTOXAN	Cyclophosphamide 2.0 grm injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J1110	D.H.E. 45	Dihydroergotamine mesyltate	SELF-INJECTABLE	
J9130	DACARBAZINE	Dacarbazine 100 mg injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J9140	DACARBAZINE	Dacarbazine 200 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J0894	DACOGEN	Decitabine for Injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J0875	DALVANCE	Dalbavancin hcl for iv soln 500 mg	THERAPEUTIC INJ	
J9348	DANYELZA	Naxitamab-gqgk 40MG/10ML Solution Injection, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
90700	DAPTACEL	Diphtheria and Tetanus Toxoids and Acellular Pertussis Vaccine Adsorbed	THERAPEUTIC INJ	IMMUNIZATION

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J0878	Daptomycin	Injection, daptomycin (hospira), not therapeutically equivalent to J0878, 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0877	Daptomycin	Daptomycin (hospira), not therapeutically equivalent to j0878, 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0874	DAPTOMYCIN	Inj, daptomycin (baxter), not therapeutically equivalent to J0878	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0873	DAPTOMYCIN	Injection, daptomycin, not therapeutically equivalent to J0878, 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0872	Daptomycin for Injection (room temperature)	Injection, daptomycin, unrefrigerated, not therapeutically equivalent to J0878 or J0873, 1 mg, Xellia	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9145	DARZALEX	Daratumumab injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J9144	DARZALEX FASPRO	Injection, daratumumab 10 mg and hyaluronidase-fihj	THERAPEUTIC INJ	CHEMOTHERAPY*
J9150	DAUNORUBICIN HCL	Daunorubicin, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9151	DAUNOXOME	Daunorubicin citrate liposomal formulation, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0589	DAXXIFY	DaxibotulinumtoxinA-lanm for injection, for intramuscular use	THERAPEUTIC INJ	
J2597	DDAVP	Desmopressin acetate, per 1 mcg	THERAPEUTIC INJ	
90714	DECAVAC	Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, when administered to individuals 7 years or older, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J0893	Decitabine	Injection, decitabine (Sun Pharma) not therapeutically equivalent to J0894, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0911	DEFENCATH®	Heparin-Taurolidine Lock Flush Soln	THERAPEUTIC INJ	
J0895	DEFEROXAMINE MESYLATE	Deferoxamine mesylate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3490	DEFITELIO	Defibrotide sodium injection, for intravenous use	THERAPEUTIC INJ	
J1100	DEKASOL	Dexamethasone sodium phosphate 1 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1094	DEKASOL LA	Dexamethasone acetate	THERAPEUTIC INJ	CHEMO ADJUNCT*
J3265	DEMADEX	Torsemide 10 mg/ml	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2175	DEMEROL	Meperidine hydrochlide /100 MG	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9098	DEPOCYT	Cytarabine liposome, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J1000	DEPO-ESTRADIOL	Depo-estradiol cypionate injection	THERAPEUTIC INJ	
J1020	DEPO-MEDROL 20	Methylprednisolone 20 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J1030	DEPO-MEDROL 40	Methylprednisolone 40 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J1040	DEPO-MEDROL 80	Methylprednisolone 80 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J3490	DEPO-PROVERA 150 MG	Medroxyprogesterone contraceptive injection	THERAPEUTIC INJ	
J1053	DEPO-PROVERA 400 MG	Medroxyprogesterone injection 1 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1050	DEPO-SUBQ PROVERA 104®	Medroxyprogesterone acetate Injection	THERAPEUTIC INJ	
J1071	DEPO-TESTOSTERONE	Testosterone cypionate, 1mg	THERAPEUTIC INJ	TRANSGENDER HORMONES

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J0895	DESFERAL	Deferoxamine mesylate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2597	DESMOPRESSIN ACETATE	Desmopressin acetate	THERAPEUTIC INJ	
J1094	DEXAMETHASONE ACETATE	Dexamethasone acetate	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1100	DEXAMETHASONE SODIUM PHOSPHATE	Dexamethasone sodium phosphate 1 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1100	DEXAMETHASONE SODIUM PHOSPHATE	Dexamethasone sodium phos	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1094	DEXASONE L.A.	Dexamethasone acetate	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1750	DEXFERRUM	Iron dextran, 50 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1190	DEXRAZOXANE	Dexrazoxane hcl injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
C9048	DEXTENZA	Dexamethasone Ophthalmic Insert.	THERAPEUTIC INJ	
J7100	DEXTRAN 40 IN D5W	Dextran 40 infusion	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7100	DEXTRAN 40 IN NACL	Dextran 40 infusion	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7110	DEXTRAN 75 IN D5W	Dextran 75 infusion	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7110	DEXTRAN 75 IN NACL	Dextran 75 infusion	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7060	DEXTROSE	5% Dextrose/water	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7070	DEXTROSE	Infusion, D5W, 1000 cc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7121	DEXTROSE in LACTATED RINGERS 5%	5% dextrose in lactated ringer's, 1000 mL	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
S5010	DEXTROSE-NaCL 5 – 0.45% SOLUTION	5% dextrose and 0.45% normal saline, 1000 mL	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
C9034	DEXYCU	Dexamethasone intraocular suspension	THERAPEUTIC INJ	
J3360	DIAZEPAM	Diazepam, up to 5 mg	THERAPEUTIC INJ	
J0500	DICYCLOMINE HCL	Dicyclomine injection	THERAPEUTIC INJ	
J1450	DIFLUCAN IN SODIUM CHLORIDE	Fluconazole	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1162	DIGIBIND	Digoxin immune fab (ovine)	THERAPEUTIC INJ	
J1162	DIGIFAB	Digoxin immune fab (ovine)	THERAPEUTIC INJ	
J1160	DIGOXIN	Digoxin injection	THERAPEUTIC INJ	
J1110	DIHYDROERGOTAMINE MESYLATE	Dihydroergotamine mesyltate	SELF-INJECTABLE	
J1170	DILAUDID	Hydromorphone injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
S0092	DILAUDID	Hydromorphone injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1180	DILOR	Dyphylline injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1240	DIMENHYDRINATE	Dimenhydrinate injection	THERAPEUTIC INJ	
J1200	DIPHENHYDRAMINE HCL	Diphenhydramine hcl injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
90719	DIPHTHERIA TOXOID	Diphtheria toxoid, IM	THERAPEUTIC INJ	IMMUNIZATION
90702	DIPHTHERIA-TETANUS TOXOIDS	DT vaccine < 7 yrs, IM	THERAPEUTIC INJ	IMMUNIZATION
90718	DIPHTHERIA-TETANUS TOXOIDS	Td vaccine > 7, IM	THERAPEUTIC INJ	IMMUNIZATION

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J2704	DIPRIVAN	Propofol, 10 mg	THERAPEUTIC INJ	
90296	DIPTHERIA ANTITOXIN	Diptheria antitoxin, equine any route	THERAPEUTIC INJ	
J1245	DIPYRIDAMOLE INJECTION	Dipyridamole injection	THERAPEUTIC INJ	
J1205	DIURIL IV	Chlorothiazide sodium, per 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1250	DOBUTAMINE HCL	Dobutamine HCL 250 mg	THERAPEUTIC INJ	
J9172	Docetaxel	Injection, docetaxel (Ingenus), not therapeutically equivalent to J9171, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J1265	DOPAMINE HCL	Dopamine hcl, 40 mg injection	THERAPEUTIC INJ	
J1265	DOPAMINE HCL 200MG IN 5% DEXTROSE	Dopamine injection	THERAPEUTIC INJ	
J1265	DOPAMINE HCL 800MG IN 5% DEXTROSE	Dopamine injection	THERAPEUTIC INJ	
J1265	DOPAMINE IN D5W	Dopamine injection	THERAPEUTIC INJ	
J1267	DORIBAX	Doripenem, 10 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1267	DORIBAX	Doripenem, 10 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q2050	DOXIL	Doxorubicin hydrochloride, liposomal, Doxil, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J1790	DROPERIDOL	Droperidol injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1810	DROPERIDOL/FENTANYL CITRATE	Droperidol/fentanyl injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90723	DTAP-HEP B-IPV VACCINE	Dtap-Hep B-Ipv Vaccine, IM	THERAPEUTIC INJ	IMMUNIZATION
J9130	DTIC-DOME	Dacarbazine 100 mg injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J9130	DTIC-DOME	Dacarbazine 200 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J3590, C9399	DUPIXENT	Dupilumab injection, for subcutaneous use	SELF-INJECTABLE	
J0735	DURACLON	Clonidine hydrochloride	THERAPEUTIC INJ	
J2270	DURAMORPH	Morphine sulfate, up to 10 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2274	DURAMORPH	Morphine sulfate, preservative-free for epidural or intrathecal use, 10mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2275	DURAMORPH	Morphine sulfate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7318	DUROLANE	Sodium hyaluronic, for single intra-articular injection 60mg/3ml	THERAPEUTIC INJ	
J7351	DURYSTA	Injection, bimatoprost, intracameral implant, 1 microgram	THERAPEUTIC INJ	
J1130	DYLOJECT	Diclofenac sodium, 0.5 mg, Injection	THERAPEUTIC INJ	
J0586	DYSPORT	AbobotulinumtoxinA, 5 units	THERAPEUTIC INJ	
J3520	EDETATE DISODIUM	Edetate disodium /150 mg	THERAPEUTIC INJ	
J0270	EDEX	Injection, alprostadil, 1.25 mcg	SELF-INJECTABLE	
J3590, C9399	EGRIFTA SV	Tesamorelin acetate for inj 2 mg	SELF-INJECTABLE	HIV/AIDS
J9063	ELAHERE	Injection, mirvetuximab soravtansine-gynx, 1 mg , for intravenous use	THERAPEUTIC	CHEMOTHERAPY*
J1743	ELAPRASE	Idursulfase,1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J1743	ELAPRASE	Idursulfase,1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1320	ELAVIL	Amitriptyline injection	THERAPEUTIC INJ	
J3060	ELELYSO	Taliglucerase alfa Injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1413	ELEVIDYS	Delandistrogene moxeparvovec-rokl suspension, for intravenous infusion	THERAPEUTIC INJ	
J2508	ELFABRIO	Pegunigalsidase alfa-iwxj injection	THERAPEUTIC INJ	
J9217	ELIGARD	Leuprolide acetate suspension	THERAPEUTIC INJ	CHEMOTHERAPY*
J9217	ELIGARD	Leuprolide acetate suspension	THERAPEUTIC INJ	CHEMOTHERAPY*
J2783	ELITEK	Rasburicase, 0.5 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J9178	ELLENCE	Epirubicin hcl, 2 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9175	ELLIOTTS B	Elliotts b solution per ml	THERAPEUTIC INJ	CHEMOTHERAPY*
J7205	ELOCTATE	Antihemophilic Factor (Recombinant), Fc Fussion Protein], Lyophilized Powder for Solution For Intravenous Injection	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J9263	ELOXATIN	Oxaliplatin	THERAPEUTIC INJ	CHEMOTHERAPY*
J1323	ELREXFIO™	Injection, elranatamab-bcmm, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY
J9020	ELSPAR	Asparaginase injection, 10,000 units	THERAPEUTIC INJ	CHEMOTHERAPY*
J9269	ELZONRIS	Tagraxofusp-erzs injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J1453	EMEND 115 MG SOLR	Fosaprepitant, 1 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J3590	EMGALITY	Galcanezumab-gnlm	SELF-INJECTABLE	
J0350	EMINASE	Anistreplase 30 u	THERAPEUTIC INJ	
J7799	EMPAVELI®	Pegcetacoplan injection, for subcutaneous use NDC 73606-0010-01	SELF-INJECTABLE	
C9151	EMPAVELI™	Pegcetacoplan subcutaneous Solution 1080 mg/20ml	THERAPEUTIC INJ	
J9176	EMPLICITI	Elotuzumab for Intravenous infusion	THERAPEUTIC INJ	CHEMOTHERAPY*
J1438	ENBREL	Etanercept injection	SELF-INJECTABLE	
90740	ENGERIX-B	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3-dose schedule), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90746	ENGERIX-B	Hepatitis B vaccine, adult dosage, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90744	ENGERIX-B 10 MCG/0.5ML INJ	Hepatitis B vaccine, pediatric/adolescent dosage (3-dose schedule), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90747	ENGERIX-B 20 MCG/ML INJ	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4-dose schedule), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J9358	ENHERTU	Fam-trastuzumab deruxtecan-nxki for IV Solution	THERAPEUTIC INJ	CHEMOTHERAPY*
J1302	ENJAYMO™	Sutimlimab-jome) injection, for intravenous use	THERAPEUTIC INJ	
J3590	ENSPRYNG™	Satralizumab-mwge for subcutaneous use	SELF-INJECTABLE	
J3380	ENTYVIO	Vedolizumab for injection, for intravenous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J3380	ENTYVIO® (SubQ)	Vedolizumab soln **pen-injector** 108 MG/0.68ML 64764-0108-20; 64764-0108-21	SELF-INJECTABLE	
J3490	EPHEDRINE	Ephedrine sulfate inj 50 mg/ml	THERAPEUTIC INJ	
J0173	Epinephrine	Injection, epinephrine (belcher) not therapeutically equivalent to j0171, 0.1 mg	THERAPEUTIC INJ	
J0171	EPINEPHRINE HCL	Adrenalin epinephrine inject	THERAPEUTIC INJ	
J3490	EPIPEN	Epinephrine hcl injection device 1:1000	SELF-INJECTABLE	
J3490	EPIPEN JR	Epinephrine hcl injection device 1:1000	SELF-INJECTABLE	
J9231	EPKINLY™	Epcoritamab-bysp injection for subcutaneous (SC) use.	THERAPEUTIC INJ	CHEMOTHERAPY*
J0885	EPOGEN	Epoetin alfa, (for non-ESRD use), 1000 units	SELF-INJECTABLE	CHEMO ADJUNCT*
Q4081	EPOGEN	Epoetin Alfa, 100 Units (For ESRD On Dialysis) (For Renal Dialysis Facilities And Hospital Use)	SELF-INJECTABLE	
J0348	ERAXIS 50 MG	Anadulafungin injection	THERAPEUTIC INJ	
J9055	ERBITUX	Cetuximab injection	THERAPEUTIC INJ	CHEMOTHERAPY*
C9399, J3490	ERELZI	Etanercept-szzs injection, for subcutaneous	SELF-INJECTABLE	
J1330	ERGONOVINE MALEATE	Ergonovine maleate injection	THERAPEUTIC INJ	
J9019	ERWINAZE	Asparaginase Erwinia chrysanthemi Injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J1364	ERYTHROCIN	Erythromycin lactobionate 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1364	ERYTHROMYCIN LACTOBIONATE	Erythromycin lactobionate 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1805	Esmolol	Injection, esmolol HCl, 10 mg	THERAPEUTIC INJ	
J1806	Esmolol	Injection, esmolol HCl (WG Critical Care) not therapeutically equivalent to J1805, 10 mg	THERAPEUTIC INJ	
J7204	ESPEROCT	Antihemophilic factor (recombinant), glycopegylated-exei is a coagulation Factor VIII concentrate indicated for use in adults and children with hemophilia A	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J1380	ESTRADIOL VALERATE 10 MG/ML	Estradiol valerate injection, Up to 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*/ TRANSGENDER HORMONES+
J1430	ETHAMOLIN	Ethanolamine oleate 100 mg	THERAPEUTIC INJ	
J0207	ETHYOL	Amifostine	THERAPEUTIC INJ	CHEMO ADJUNCT*
J9181	ETOPOPHOS	Etoposide 10 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J7323	EUFLEXXA	Sodium Hyaluronate injection	THERAPEUTIC INJ	
J3111	EVENITY	Romosozumab-aqqg injection, for subcutaneous use	THERAPEUTIC INJ	
J1305	EVKEEZA	Evinacumab-dgnb injection, for intravenous	THERAPEUTIC INJ	
J9246	EVOMELA	Melphalan	THERAPEUTIC INJ	CHEMOTHERAPY*
~~J3490~~	~~EVUSHELD™~~	~~Tixagevimab 150 Mg/1.5ml & Cilgavimab 150 Mg/1.5ml IM Soln~~	~~Discontinued~~	
C9399/J3490	EVZIO	Naloxone hydrochloride injection Auto-Injector	SELF-INJECTABLE	
J1428	EXONDYS 51	Eteplirsen IV Soln 100 MG/2ML	THERAPEUTIC INJ	
C9290	EXPAREL	Injection, bupivacaine liposome, 1 mg	THERAPEUTIC INJ	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J1830	EXTAVIA	Interferon beta-1b	SELF-INJECTABLE	
J0178	EYLEA	Aflibercept injection	THERAPEUTIC INJ	
J0177	EYLEA® HD	Aflibercept Injection 8 MG	THERAPEUTIC INJ	
J0180	FABRAZYME	Agalsidase beta injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0517	FASENRA	Benralizumab, for subcutaneous use	THERAPEUTIC INJ	
J0517	FASENRA PEN	Benralizumab subcutaneous soln auto-injector 30 mg/ml	SELF-INJECTABLE	
J9395	FASLODEX	Fulvestrant	THERAPEUTIC INJ	CHEMOTHERAPY*
J7198	FEIBA VH IMMUNO (ANTI-INHIBITOR COAGULANT COMPLEX)	Anti-inhibitor, coagulant complex, per IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J1951	FENSOLVI	Leuprolide acetate for injectable suspension,	THERAPEUTIC INJ	
J3010	FENTANYL CITRATE	Fentanyl citrate injeciton	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1810	FENTANYL-DROPERIDOL	Droperidol/fentanyl injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q0138	FERAHEME INJECTION	Ferumoxytol 1 mg, for iron deefiency anemia, non-ESRD use	THERAPEUTIC INJ	
Q0139	FERAHEME INJECTION	Ferumoxytol 1 mg, for iron deefiency anemia, for ESRD on dialysis	THERAPEUTIC INJ	
J2916	FERRLECIT	Na ferric gluconate complex	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0699	FETROJA®	Injection, cefiderocol, 10 mg	THERAPEUTIC INJ	
J0693	FETROJA®	Injection, cefiderocol, 5 mg	THERAPEUTIC INJ	
J7177	FIBRYGA	Fibrinogen Concentrate (Human) Lyophilized Powder for Reconstitution	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J1744	FIRAZYR	Icatibant	SELF-INJECTABLE	
J9155	FIRMAGON	Degarelix, 1 mg for Injection	THERAPEUTIC INJ	CHEMOTHERAPY*
S0030	FLAGYL	Metronidazole	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1572	FLEBOGAMMA	Immune globulin, intravenous, non-lyophilized (e.g liquid), 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1325	FLOLAN	Epoprostenol injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
S0155	FLOLAN STREILE DILUENT	Sterile diluent for epoprostenol, 50 mL	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
S0034	FLOXIN	Ofloxacin, 400 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9200	FLOXURIDINE	Floxuridine injection, 500 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
90694	FLUAD® Quadrivalent	Influenza virus vaccine, quadrivalent (aIIV4), inactivated, adjuvanted, preservative free, 0.5 mL dosage, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90686	FLUARIX® Quadrivalent	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90682	FLUBLOK® QUAD INJ 2022-23	nfluenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
90674	FLUCELVAX® QUADRIVALENT 2022-2023	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J1450	FLUCONAZOLE IN DEXTROSE	Fluconazole	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1450	FLUCONAZOLE IN SODIUM CHLORIDE	Fluconazole	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9185	FLUDARA	Fludarabine phosphate injection, 50 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9185	FLUDARABINE PHOSPHATE	Fludarabine phosphate injection, 50 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
90686	FLULAVAL® Quadrivalent	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J9190	FLUOROURACIL	Fluorouracil injection, 500 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J2679	FLUPHENAZINE	Injection, fluphenazine HCl, 1.25 mg	THERAPEUTIC INJ	
J2680	FLUPHENAZINE DECANOATE	Fluphenazine decanoate 25 mg	THERAPEUTIC INJ	
Q2037	FLUVIRIN	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90662	FLUZONE® High-Dose Quadrivalent	Influenza virus vaccine (IIV), split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular	THERAPEUTIC INJ	IMMUNIZATION
90685	FLUZONE® Quadrivalent	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.25 mL dosage, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90688	FLUZONE® Quadrivalent	Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.5 mL dosage, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90687	FLUZONE® Quadrivalent	Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.25 mL, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J1434	FOCINVEZ	Injection, fosaprepitant, 1 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
S0128	FOLLISTIM AQ	Follitropin beta, 75 IU	SELF-INJECTABLE	INFERTILITY
J9307	FOLOTYN	Pralatrexate injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J0713	FORTAZ	Ceftazidime per 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0713	FORTAZ IN D5W	Ceftazidime per 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3110	FORTEO	Teriparatide, 10 mcg	SELF-INJECTABLE	
J1456	Fosaprepitant	Injection, fosaprepitant (Teva), not therapeutically equivalent to J1453, 1 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1455	FOSCAVIR	Foscarnet sodium injection	THERAPEUTIC INJ	HIV/AIDS
J1645	FRAGMIN	Dalteparin sodium, per 2,500 IU	SELF-INJECTABLE	
J9200	FUDR	Floxuridine injection, 500 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
Q5108	FULPHILA	Pegfilgrastim-jmdb biosimilar	SELF-INJECTABLE	CHEMO ADJUNCT*
Q5108	FULPHILA	Pegfilgrastim-jmdb, biosimilar, 0.5 mg	THERAPEUTIC INJ	TRANSPLANT DRUGS-IF USED WITH (G-CSF WITH MOZOBIL)

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J9393	FULVESTRANT	Injection, fulvestrant (Teva) not therapeutically equivalent to J9395, 25 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9394	FULVESTRANT	Injection, fulvestrant (Fresenius Kabi) not therapeutically equivalent to J9395, 25 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9395	FULVESTRANT	Fulvestrant inj, 25 MG	THERAPEUTIC INJ	CHEMOTHERAPY*
J0285	FUNGIZONE	Amphotericin B	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1941	FUROSCIX	Injection, furosemide 20 mg	THERAPEUTIC INJ	
J1940	FUROSEMIDE	Furosemide injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0641	FUSILEV	Levoleucovorin calcium, 0.5 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1324	FUZEON	Enfuvirtide, 1 mg	SELF-INJECTABLE	HIV/AIDS
J9331	FYARRO	Sirolimus protein-bound particles for IV	THERAPEUTIC INJ	CHEMOTHERAPY*
Q1530	FYLNETRA	Pegfilgrastim-pbbk injection, for subcutaneous use	THERAPEUTIC INJ	
J0475	GABLOFEN	Baclofen inj	THERAPEUTIC INJ	
J1560	GAMA**STAN** 15-18%	Gamma globulin, intramuscular, over 10 cc (always use for any amount injected over 10cc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1460	GAMA**STAN** 1 cc	Gamma globulin, intramuscular, 1 cc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9210	GAMIFANT	Emapalumab-lzsg injection, for intravenous use	THERAPEUTIC INJ	
J1569	GAMMAGARD LIQUID	Immune globulin, intravenous, non-lyophilized (e.g liquid), 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1566	GAMMAGARD S/D	Immune globulin, intravenous, lyophilized (e.g powder), 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1561	GAMMAKED	Injection, immune globulin, intravenous, non-lyophilized, e.g. liquid	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1557	GAMMAPLEX	Immune Globulin Intravenous (human)	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1561	GAMUNEX-C	Immune globulin, (Gamunex/Gamunex-C/Gammaked	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1561-JB	GAMUNEX-C	Immune Globulin Injection (human) 10% Caprylate/chromatography purified - Subcutaneous	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1574	Ganciclovir	Injection, ganciclovir sodium (Exela) not therapeutically equivalent to J1570, 500 mg	THERAPEUTIC INJ	HIV/AIDS
S0132	GANIRELIX	Ganirelix acetate 250 mcg	SELF-INJECTABLE	INFERTILITY
J1457	GANITE	Gallium nitrate injection	THERAPEUTIC INJ	CHEMOTHERAPY*
90649	GARDASIL	Human Papilloma Virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), 3 dose schedule, for intramuscular use (Gardasil is only indicated in males and females from 9 through 26 years of age)	THERAPEUTIC INJ	IMMUNIZATION
90651	GARDASIL 9	Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (HPV), 3 dose schedule, for intramuscular use (Gardasil 9 is only indicated for females from 9 through 26 years of age and males from 9 through 15 years of age)	THERAPEUTIC INJ	IMMUNIZATION
J3490/C9399	GATTEX 5 MG KIT	Teduglutide [rDNA origin], for Injection, for subcutaneous use	SELF-INJECTABLE	

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J9301	GAZYVA	Obinutuzumab Injection 10 MG	THERAPEUTIC INJ	CHEMOTHERAPY*
J7326	GEL-ONE	Hyaluronan or derivative, Gel-One, for intra-articular injection	THERAPEUTIC INJ	
J7328	GEL-SYN	Hyaluronan or derivative for intra-articular injection, 0.1 mg	THERAPEUTIC INJ	
J9196	Gemcitabine	Injection, gemcitabine hydrochloride (Accord), not therapeutically equivalent to J9201, 200 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9201	GEMZAR	Gemcitabine HCl, 200 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0395	GENESA	Arbutamine hcl injection	THERAPEUTIC INJ	
J2941	GENOTROPIN	Somatropin, 1 mg	SELF-INJECTABLE	GROWTH HORMONE
J1580	GENTAMICIN SULFATE	Gentamicin injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7100	GENTRAN 40 IN D5W	Dextran 40 infusion	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7100	GENTRAN 40 IN NACL	Dextran 40 infusion	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7320	GENVISC 850	Hyaluronan or derivative, for intra-articular injection	THERAPEUTIC INJ	
J3486	GEODON	Ziprasidone mesylate	THERAPEUTIC INJ	
J3490	GIAPREZA	Angiotensin II Injection for Intravenous Infusion	THERAPEUTIC INJ	
J0223	GIVLAARI	Givosiran injection, for Subcutaneous use	THERAPEUTIC INJ	
J0257	GLASSIA	Alpha 1 proteinase inhibitor	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1595	GLATOPA	Glatiramer acetate, 20 mg	SELF-INJECTABLE	
J1610	GLUCAGEN	Glucagon hydrochloride, per 1mg	SELF-INJECTABLE	
J1610	GLUCAGON	Glucagon hydrochloride, per 1mg	SELF-INJECTABLE	
J1611	GLUCAGON	Injection, glucagon HCl (Fresenius Kabi), not therapeutically equivalent to J1610, per 1 mg	SELF-INJECTABLE	
J1610	GLUCAGON EMERGENCY	Glucagon hydrochloride, per 1mg	SELF-INJECTABLE	
J1598	GLYCOPYRROL	Injection, glycopyrrolate (fresenius kabi), not therapeutically equivalent to J1596, 0.1 mg	THERAPEUTIC INJ	
J1596	Glycopyrrolate	Injection, glycopyrrolate, 0.1 mg	THERAPEUTIC INJ	
J1600	GOLD SODIUM THIOMALATE	Gold sodium thiomaleate injection	THERAPEUTIC INJ	
S0126	GONAL-F	Follitropin alfa 75 iu	SELF-INJECTABLE	INFERTILITY
J1447	GRANIX	tbo-filgrastim, 1 microgram	SELF-INJECTABLE	CHEMO ADJUNCT*
J1447	GRANIX	tbo-filgrastim, 1 microgram	THERAPEUTIC INJ	TRANSPLANT DRUGS-IF USED WITH (G-CSF WITH MOZOBIL)
J1610	GVOKE	Glucagon hydrochloride, per 1mg	SELF-INJECTABLE	
J0599	HAEGARDA	C1 esterase inhibitor (human) for subcutaneous inj	SELF-INJECTABLE	
J9179	HALAVEN	Eribulin mesylate Injecton	THERAPEUTIC INJ	CHEMOTHERAPY*
J1630	HALDOL	Haloperidol injection	THERAPEUTIC INJ	
J1631	HALDOL DECANOATE	Haloperidol decanoate injection	THERAPEUTIC INJ	
J1630	HALOPERIDOL LACTATE	Haloperidol injection	THERAPEUTIC INJ	
90632	HAVRIX	Hepatitis A vaccine, adult dosage, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
90633	HAVRIX	Hepatitis A vaccine, pediatric/adolescent dosage (2-dose schedule), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90371	H-BIG	Hepatitis B Immune Globulin (HBIg), human, for intramuscular use (Price is per 1 mL)	THERAPEUTIC INJ	
J1270	HECTOROL	Doxercalciferol	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7192	HELIXATE FS	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J1411	HEMGENIX®	Etranacogene dezaparvovec-drlb) suspension, for intravenous infusion	THERAPEUTIC INJ	
J7170	HEMLIBRA	Emicizumab-kxwh injection, for subcutaneous use	SELF-INJECTABLE	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J7190	HEMOFIL M	Factor VIII (antihemophilic Factor [human]) per IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
90748	HEP B/HIB VACCINE	Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use (Price is per 0.5 mL dose)	THERAPEUTIC INJ	IMMUNIZATION
J1642	HEP FLUSH-10	Heparin sodium per 10 u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1571	HEPAGAM B - IM	Hepatitis B immune globulin (Hepagam B), intramuscular, 0.5 mL (see J1573 for IV use)	THERAPEUTIC INJ	
J1573	HEPAGAM B - IV	Hepatitis B immune globulin (Hepagam B), intravenous, 0.5 mL (see J1571 for IM use)	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1643	HEPARIN	Injection, heparin sodium (Pfizer), not therapeutically equivalent to J1644, per 1000 units	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1644	HEPARIN (PORCINE) IN D5W	Heparin sodium per 1000u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1642	HEPARIN (PORCINE) IN NACL	Heparin sodium per 10 u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1644	HEPARIN (PORCINE) IN NACL	Heparin sodium per 1000u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1642	HEPARIN (PORCINE) LOCK FLUSH	Heparin sodium per 10 u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1642	HEPARIN COMBINATION	Heparin sodium per 10 u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1642	HEPARIN LOCK FLUSH	Heparin sodium per 10 u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1644	HEPARIN SODIUM (BOVINE)	Heparin sodium per 1000u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1644	HEPARIN SODIUM (PORCINE)	Heparin sodium per 1000u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1642	HEPARIN SODIUM FLUSH	Heparin sodium per 10 u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1644	HEPARIN SODIUM IN NACL	Heparin sodium per 1000u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1642	HEPARIN SODIUM LOCK FLUSH	Heparin sodium per 10 u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90739	HEPLISAV-B	Hepatitis B vaccine (HepB), adult dosage, 2 dose schedule, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J1642	HEP-LOCK	Heparin sodium per 10 u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1642	HEP-LOCK FLUSH	Heparin sodium per 10 u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1642	HEP-LOCK PF	Heparin sodium per 10 u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9355	HERCEPTIN	Trastuzumab, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9355	HERCEPTIN HYLECTA™	Trastuzumab, excludes biosimilar, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
Q5113	HERZUMA	Trastuzumab-pkrb, biosimilar, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
90646	HIB VACCINE, PRP-D	Hib Vaccine, Prp-D, IM	THERAPEUTIC INJ	IMMUNIZATION
90648	HIBERIX	Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4-dose schedule), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J1559	HIZENTRA	Immune Globulin Subcutanenous (human)	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90281	HUMAN IG, IM	Immune Globulin (IG), human, for intramuscular use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90283	HUMAN IG, IV	Immune Globulin (IGIV), human, for intravenous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90284	HUMAN IG, SUB Q	Immune globulin (IGIV), human, for use in subcutaneous infusions, 100 mg, each	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7187	HUMATE-P	Von Willebrand Factor complex, human, ristocetin coFactor, per IU, VWF:RCO	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J2941	HUMATROPE	Somatropin, 1 mg	SELF-INJECTABLE	GROWTH HORMONE
J0135	HUMIRA	Adalimumab injection	SELF-INJECTABLE	
J7321	HYALGAN	Hyaluronan or derivative,for intra-articular injection, per dose	THERAPEUTIC INJ	
J9351	HYCAMTIN	Topotecan, 0.1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0360	HYDRALAZINE HCL	Hydralazine hcl injection	THERAPEUTIC INJ	
J1700	HYDROCORTISONE ACETATE	Hydrocortisone acetate injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1710	HYDROCORTONE	Hydrocortisone sodium ph injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1170	HYDROMORPHONE HCL	Hydromorphone injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3425	HYDROXO-COBOLAMINE	Injection, hydroxocobalamin, 10 mcg	THERAPEUTIC INJ	
J1729	HYDROXYprogesterone Caproate	HYDROXYprogesterone Caproate 1.25 GM/5ML SOLN	THERAPEUTIC INJ	
J3410	HYDROXYZINE HCL	Hydroxyzine hcl injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J3473	HYLENEX	Hyaluronidase, recombinant, 1 USP unit	THERAPEUTIC INJ	
J7322	HYMOVIS	Hyaluronan or derivative, Hymovis, for intra-articular injection, 1 mg	THERAPEUTIC INJ	
90375	HYPERRAB	Rabies Immune Globulin (RIg), human, for intramuscular and/or subcutaneous use	THERAPEUTIC INJ	
J1730	HYPERSTAT	Diazoxide injection	THERAPEUTIC INJ	
J1575	HYQVIA 10 GM/100ML KIT	Immune Globulin Infusion 10% [human] with recombinant human hyaluronidase	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q5131	IDACIO®	Adalimumab-aacf	SELF-INJECTABLE	
J9211	IDAMYCIN PFS	Idarubicin hcl injection, 5mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9211	IDARUBICIN	Idarubicin hcl injection, 5mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J7202	IDELVION	Coagulation Factor IX (Recombinant), Albumin Fusion Protein (rIX-FP), a recombinant human blood coagulation factor	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J7355	iDose® TR	Injection, travoprost, intracameral implant, 1 microgram	THERAPEUTIC INJ	
J9208	IFEX	Ifosfomide injection, 1 gram	THERAPEUTIC INJ	CHEMOTHERAPY*
J9208	IFOSFAMIDE	Ifosfomide injection, 1 gram	THERAPEUTIC INJ	CHEMOTHERAPY*
J2403	IHEEZO™	Chloroprocaine Hcl Ophth Gel 3%	THERAPEUTIC INJ	

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J0638	ILARIS INJECTION	Canakinumab 180 mg	THERAPEUTIC INJ	
J3245	ILUMYA	Tildrakizumab-asmn 100 mg/ml injection, for subcutaneous use	THERAPEUTIC INJ	
J7313	ILUVIEN	fluocinolone acetonide, intravitreal implant, 0.01 mg	THERAPEUTIC INJ	
J3490	IMCIVREE	Setmelanotide injection, for subcutaneous use	SELF-INJECTABLE	
J3590	IMDELLTRA™	Tarlatamab-dlle for injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J9173	IMFINZI	Durvalumab soln for IV infusion	THERAPEUTIC INJ	CHEMOTHERAPY*
J3030	IMITREX	Sumatriptan, succinate	SELF-INJECTABLE	
J3030	IMITREX STATDOSE	Sumatriptan, succinate	SELF-INJECTABLE	
J9347	IMJUDO®	Tremelimumab-actl soln for IV infusion 25 mg/1.25ml	THERAPEUTIC INJ	CHEMOTHERAPY*
J9325	IMLYGIC	Talimogene laherparepvec, 1 million plaque forming units (PFU)	THERAPEUTIC INJ	CHEMOTHERAPY*
J2373	IMMPHENTIV	Injection, phenylephrine hydrochloride , 20 micrograms	THERAPEUTIC INJ	
J1460	IMMUNE GLOBULIN (HUMAN)	Gamma Globulin, intramuscular, 2cc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1460	IMMUNE GLOBULIN (HUMAN)	Gamma Globulin, intramuscular, 3cc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1460	IMMUNE GLOBULIN (HUMAN)	Gamma Globulin, intramuscular, 4cc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1460	IMMUNE GLOBULIN (HUMAN)	Gamma Globulin, intramuscular, 5cc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1460	IMMUNE GLOBULIN (HUMAN)	Gamma Globulin, intramuscular, 6cc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1460	IMMUNE GLOBULIN (HUMAN)	Gamma Globulin, intramuscular, 7cc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1460	IMMUNE GLOBULIN (HUMAN)	Gamma Globulin, intramuscular, 8cc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1460	IMMUNE GLOBULIN (HUMAN)	Gamma Globulin, intramuscular, 9cc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1460	IMMUNE GLOBULIN (HUMAN)	Gamma Globulin, intramuscular, 10cc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1560	IMMUNE GLOBULIN (HUMAN)	Gamma Globulin, intramuscular, over 10cc (always use for any amount injected over 10cc and place number of units)(1cc = 1 unit)	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90376	IMOGAM RABIES-HT	Rabies IG, heat treated	THERAPEUTIC INJ	
90675	IMOVAX RABIES	Rabies vaccine, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J7307	IMPLANON	Etonogestrel (Contraceptive) Implant System, Including Implants And Supplies	THERAPEUTIC INJ	
J7501	IMURAN	Azathioprine parenteral	THERAPEUTIC INJ	TRANSPLANT*
J1790	INAPSINE	Droperidol injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2170	INCRELEX	Mecasermin [rDNA origin] Injection	SELF-INJECTABLE	GROWTH HORMONE
J1800	INDERAL	Propranolol injection	THERAPEUTIC INJ	
90700	INFANRIX	Diphtheria and Tetanus Toxoids and Acellular Pertussis Vaccine Adsorbed	THERAPEUTIC INJ	IMMUNIZATION
J1750	INFED	Iron dextran 50 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q5103	INFLECTRA	Infliximab, biosimilar, 10 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90654	INFLUENZA VACCINE	Influenza virus vaccine, split virus, preservative free, for intradermal use	THERAPEUTIC INJ	IMMUNIZATION

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J9198	INFUGEM	Gemcitabine in sodium chloride injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J2270	INFUMORPH 200	Morphine sulfate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2271	INFUMORPH 200	Morphine SO4 injection 100mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2275	INFUMORPH 200	Morphine sulfate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2275	INFUMORPH 500	Morphine sulfate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1439	INJECTAFER	Ferric carboxymaltose Injection	THERAPEUTIC INJ	
J1815	INSULIN	Injection, insulin, per 5 units	PHARMACY BENEFIT	
J1327	INTEGRILIN	Eptifibatide injection	THERAPEUTIC INJ	
J9214	INTRON-A	Interferon alfa-2b, recombinant, 1 million units	SELF-INJECTABLE	CHEMOTHERAPY*
J1335	INVANZ	Ertapenem injection, 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2426	INVEGA HAFYERA™	Paliperidone palmitate inj, 1 MG	THERAPEUTIC INJ	
J2426	INVEGA SUSTENNA	Paliperidone palmitate	THERAPEUTIC INJ	
J3490	INVEGA TRINZA	Paliperidone palmitate extended release injectable	THERAPEUTIC INJ	
90713	IPOL	Poliovirus Vaccine Inactivated	THERAPEUTIC INJ	IMMUNIZATION
J1750	IRON DEXTRAN COMPLEX	Iron dextran, 50 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9315	ISTODAX	Romidepsin, 1mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9207	IXEMPRA KIT	Ixabepilone, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
90738	IXIARO SUSPENSION	Japanese encephalitis virus vaccine, inactivated, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
Q5109	IXIFI	Infliximab-qbtx, biosimilar, 10 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7213	IXINITY	Coagulation factor IX (recombinant)] Lyophilized Powder for Solution for Intravenous Injection	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J2782	IZERVAY	Avacincaptad Pegol Intravitreal Soln 2 MG/0.1ML (20 MG/ML)	THERAPEUTIC INJ	
J9281	JELMYTO	Mitomycin pyelocalyceal instillation, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9272	JEMPERLI	Dostarlimab-gxly	THERAPEUTIC INJ	CHEMOTHERAPY*
J7316	JETREA	Ocriplasmin Intravitreal Injection, 2.5 mg/mL	THERAPEUTIC INJ	
90735	JE-VAX	Japanese Encephalitis Virus Vaccine Inactivated	THERAPEUTIC INJ	IMMUNIZATION
J9043	JEVTANA	Cabazitaxel Injection 60 MG/1.5ML SOLN	THERAPEUTIC INJ	CHEMOTHERAPY*
J7208	JIVI	Antihemophilic factor (recombinant), PEGylated-aucl] lyophilized powder for solution, for intravenous use	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J9354	KADCYLA	Ado-trastuzumab emtansine for iv soln 100 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J1290	KALBITOR	Ecallantide	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1840	KANAMYCIN SULFATE	Kanamycin sulfate 500 MG injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1850	KANAMYCIN SULFATE	Kanamycin sulfate 75 MG injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q5117	KANJINTI	Trastuzumab-anns,10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J2480	KANUMA	Sebelipase alfa injection, for intravenous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J7168	KCENTRA	Prothrombin Complex Concentrate (Human)) for Intravenous Use	THERAPEUTIC INJ	
90399	KEDRAB	Rabies Immune Globulin (RIg), human, for intramuscular use	THERAPEUTIC INJ	
J0690	KEFZOL	Cefazolin sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3301	KENALOG	Triamcinolone acetonide injection, 10 mg	THERAPEUTIC INJ	
C9460	KENGREAL	Cangrelor Injection	THERAPEUTIC INJ	
J2425	KEPIVANCE	Palifermin injectionection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1953	KEPPRA	Levetiracetam, 500 mg/5 mL injection	THERAPEUTIC INJ	
J1953	KEPPRA 500 MG/5ML SOLN	Levetiracetam, 10 mg	THERAPEUTIC INJ	
J3590	KESIMPTA	Ofatumumab soln auto-injector 20 mg/0.4ml	SELF-INJECTABLE	
J3490	KETAMINE	Ketamine hcl Injection	THERAPEUTIC INJ	
J1885	KETOROLAC TROMETHAMINE	Ketorolac tromethamine injection	THERAPEUTIC INJ	
J3590	KEVZARA	Sarilumab subcutaneous soln prefilled syringe	SELF-INJECTABLE	
J9271	KEYTRUDA	Pembrolizumab for injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J0642	KHAPZORY	Levoleucovorin for IV soln	THERAPEUTIC INJ	CHEMO ADJUNCT*
J9274	KIMMTRAK®	Tebentafusp-tebn IV soln 100 mcg/0.5m	THERAPEUTIC INJ	CHEMOTHERAPY*
J2046	KIMYRSA™	Oritavancin Diphosphate For IV Soln 1200 Mg	THERAPEUTIC INJ	
J3590	KINERET	Anakinra subcutaneous injection 100 mg/0.67ml	SELF-INJECTABLE	
90696	KINRIX SUSP	Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (DTaP-IPV), when administered to children 4 years through 6 years of age, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J0175	KISUNLA™	Donanemab-azbt IV SOLN 350 MG/20ML (17.5 MG/ML)	THERAPEUTIC INJ	
J7190	KOATE-DVI	Factor VIII (antihemophilic Factor [human]) per IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J7192	KOGENATE FS	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J0879	KORSUVA™	Difelikefalin injection, for intravenous use	THERAPEUTIC INJ	
J7211	KOVALTRY	Antihemophilic Factor (Recombinant), is a recombinant,human DNA sequence derived, full length Factor VIII concentrate	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J2507	KRYSTEXXA	Pegloticase	THERAPEUTIC INJ	
C9399, J3490	KYBELLA	Deoxycholic Acid injection	THERAPEUTIC INJ	
Q2042	KYMRIAH	Tisagenlecleucel, up to 250 million car-positive viable T cells, including leukapheresis and dose preparation procedures, per infusion	THERAPEUTIC INJ	CHEMOTHERAPY*
J9047	KYPROLIS	Carfilzomib Injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J1626	KYTRIL	Granisetron hcl injection	THERAPEUTIC INJ	CHEMO ADJUNCT*

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
S0091	KYTRIL	Granisetron hcl injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1920	Labetalol	Injection, labetalol HCl, 5 mg	THERAPEUTIC INJ	
J1921	Labetalol	Injection, labetalol HCl (Hikma) not therapeutically equivalent to J1820, 5 mg	THERAPEUTIC INJ	
J7120	LACTATED RINGER'S	Ringers lactate infusion	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0217	LAMZEDE	Velmanase alfa-tycv) for injection, for intravenous use	THERAPEUTIC INJ	
J1160	LANOXIN	Digoxin injection	THERAPEUTIC INJ	
J1932	Lanreotide 1 mg (Cipla)	Lanreotide acetate, 1 mg	THERAPEUTIC INJ	
J9285	LARTRUVO	Injection, olaratumab, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0202	LEMTRADA	Alemtuzumab Injection for Intravenous Infusion	THERAPEUTIC INJ	
J0174	LEQEMBI™	Lecanemab-irmb injection, for intravenous use	THERAPEUTIC INJ	
J1306	LEQVIO®	Inclisiran injection, for subcutaneous use	THERAPEUTIC INJ	
J0640	LEUCOVORIN CALCIUM	Leucovorin calcium injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J2820	LEUKINE	Sargramostim injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J9218	LEUPROLIDE ACETATE	Leuprolide acetate injection	SELF-INJECTABLE	CHEMOTHERAPY*
J9065	LEUSTATIN	Cladribine per 1 MG	THERAPEUTIC INJ	CHEMOTHERAPY*
J1956	LEVAQUIN	Levofloxacin injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1955	LEVOCARNITINE	Levocarnitine per 1 gm	THERAPEUTIC INJ	
J1960	LEVO-DROMORAN	Levorphanol tartrate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3490	Levothyroxine Injection, 200 mcg	Levothyroxine	THERAPEUTIC INJ	
J3490	Levothyroxine Injection, 500 mcg	Levothyroxine	THERAPEUTIC INJ	
J1980	LEVSIN	Hyoscyamine sulfate injection	THERAPEUTIC INJ	
J1990	LIBRIUM	Chlordiazepoxide injection	THERAPEUTIC INJ	
J9119	LIBTAYO	Cemiplimab-Rwlc IV Soln	THERAPEUTIC INJ	CHEMOTHERAPY*
J2001	LIDOCAINE IN D5W	Lidocaine injection	THERAPEUTIC INJ	
J2010	LINCOCIN	Lincomycin injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2021	LINEZOLID	Injection, linezolid (Hospira) not therapeutically equivalent to J2020, 200 mg	THERAPEUTIC INJ	
J0476	LIORESAL	Baclofen intrathecal	THERAPEUTIC INJ	
J7100	LMD IN NACL	Dextran 40 infusion	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3263	LOQTORZI®	Toripalimab-tpzi IV solution	THERAPEUTIC INJ	CHEMOTHERAPY*
J2060	LORAZEPAM	Lorazepam injection	THERAPEUTIC INJ	
J1650	LOVENOX	Enoxaparin sodium, 10 mg	SELF-INJECTABLE	
J2778	LUCENTIS 0.5 MG/0.05ML SOLN	Ranibizumab, 0.5 Mg	THERAPEUTIC INJ	
J2560	LUMINAL	Phenobarbital sodium injection	THERAPEUTIC INJ	
J0221	LUMIZYME	Alglucosidase alfa	THERAPEUTIC INJ	HOME HEALTH / INFUSION**

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J9313	LUMOXITI	Moxetumomab pasudotox-tdfk for injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J9350	LUNSUMIO™	Mosunetuzumab-axgb) injection, for intravenous use	THERAPEUTIC	CHEMOTHERAPY*
C9399, J3490	LUPANETA PACK	Leuprolide acetate for depot suspension; norethindrone acetate tablets	THERAPEUTIC INJ	
J9218	LUPRON	Leuprolide acetate injection Kit 5 mg	SELF-INJECTABLE	CHEMOTHERAPY*
J1950	LUPRON DEPOT	Leuprolide acetate 3.75 MG	THERAPEUTIC INJ	CHEMOTHERAPY*
J9217	LUPRON DEPOT	Leuprolide acetate suspension 7.5mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9217	LUPRON DEPOT-PED	Leuprolide acetate suspension	THERAPEUTIC INJ	CHEMOTHERAPY*
J3490	LUSEDRA	Fospropofol disodium Injection	THERAPEUTIC INJ	
A9513	LUTATHERA	Lutetium Lu 177 dotatate injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J1954	LUTRATE DEPOT®	Injection, leuprolide acetate for depot suspension, 7.5 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J3490	LUVERIS	Lutropin alfa for subcutaneous injection 75 unit	SELF-INJECTABLE	INFERTILITY
J3398	LUXTURNA	Voretigene neparvovec-rzyl	THERAPEUTIC INJ	
J3590	LYFGENIA®	Lovotibeglogene autotemcel suspension for intravenous infusion	THERAPEUTIC INJ	
J3394	LYFGENIA®	Lovotibeglogene autotemcel suspension for intravenous infusion	THERAPEUTIC INJ	
90665	LYME DISEASE VACCINE	Lyme disease vaccine, adult dosage, IM	THERAPEUTIC INJ	IMMUNIZATION
J3590	LYNMELDY™	Atidarsagene autotemcel IV SUSP	THERAPEUTIC INJ	
J2503	MACUGEN	Pegaptanib sodium, 0.3 mg	THERAPEUTIC INJ	
J3475	MAGNESIUM SULFATE	Magnesium sulfate	THERAPEUTIC INJ	
J2150	MANNITOL	Mannitol injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9353	MARGENZA	Injection, margetuximab-cmkb, 5 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0692	MAXIPIME	Cefepime hcl for injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90708	MEASLES-RUBELLA VACCINE	Measles-Rubella Vaccine, SC	THERAPEUTIC INJ	IMMUNIZATION
J1051	MEDROXYPROGESTERONE MICRO	Medroxyprogesterone injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J0694	MEFOXIN IN DEXTROSE	Cefoxitin sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9249	Melphalan Hydrochloride	Injection, melphalan (apotex), 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
90734	MENACTRA	Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, diphtheria toxoid carrier (MenACWY-D) or CRM197 carrier (MenACWY-CRM), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90644	MENHIBRIX	Meningococcal conjugate vaccine, serogroups C & Y and Hemophilus influenza b vaccine (Hib-MenCY), 4 dose schedule, when administered to children 2-15 months of age, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90733	MENOMUNE	Meningococcal Polysaccharide Vaccine, Groups A, C, Y and W-135 Combined	THERAPEUTIC INJ	IMMUNIZATION

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
S0122	MENOPUR	Menotropins 75 iu	SELF-INJECTABLE	INFERTILITY
90619	MENQUADFI™	Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, tetanus toxoid carrier (MenACWY-TT), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90734	MENVEO	Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, diphtheria toxoid carrier (MenACWY-D) or CRM197 carrier (MenACWY-CRM), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J2180	MEPERGAN	Meperidine/promethazine injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2175	MEPERIDINE HCL	Meperidine hydrochl /100 MG	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3397	MEPSEVII™	Vestronidase alpha-vjbk	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2184	MEROPENEM	Injection, meropenem (B. Braun) not therapeutically equivalent to J2185, 100 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2185	MERREM	Meropenem 100MG	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2183	MERREM	injection, meropenem (wg critical care), not therapeutically equivalent to J2185, 100 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90706	MERUVAX II	Rubella vaccine, SC	THERAPEUTIC INJ	IMMUNIZATION
J9209	MESNA	Mesna injection, 200mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9209	MESNEX	Mesna injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J1230	METHADONE HCL	Methadone HCl, up to 10 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2210	METHERGINE	Methylergonovin maleate injection	THERAPEUTIC INJ	
J2800	METHOCARBAMOL	Methocarbamol injection	THERAPEUTIC INJ	
J9255	METHOTREXATE	Injection, methotrexate (Accord), not therapeutically equivalent to J9250 and J9260, 50 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9260	METHOTREXATE POWDER 1GM IN 50ML SD VIAL (P.F.)	Methotrexate sodium injection, 25mg/ml	THERAPEUTIC INJ	CHEMOTHERAPY*
J9260	METHOTREXATE POWDER 1GM IN 50ML SD VIAL (P.F.)	Methotrexate sodium injection, 25mg/ml (Not for Chemotherapy)	SELF-INJECTABLE	
J9250	METHOTREXATE SODIUM	Methotrexate sodium injection, 5mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9260	METHOTREXATE SODIUM	Methotrexate sodium injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J9250	METHOTREXATE SODIUM LPF	Methotrexate sodium injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J0210	METHYLDOPATE HCL	Methyldopate hcl injection	THERAPEUTIC INJ	
J1020	METHYLPRED 20	Methylprednisolone 20 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J1030	METHYLPRED 40	Methylprednisolone 40 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J1040	METHYLPREDNISOLONE ACETATE	Methylprednisolone 80 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J1030	METHYLPREDNISOLONE ACETATE USP	Methylprednisolone 40 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J2920	METHYLPREDNISOLONE SODIUM SUCC	Methylprednisolone injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J2930	METHYLPREDNISOLONE SODIUM SUCC	Methylprednisolone injection	THERAPEUTIC INJ	CHEMO ADJUNCT*

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J2765	METOCLOPRAMIDE HCL	Metoclopramide hcl injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1836	Metronidazole	Injection, metronidazole, 10 mg	THERAPEUTIC INJ	
J0630	MIACALCIN	Calcitonin salmon injection	SELF-INJECTABLE	
J2247	MICAFUNGIN	Injection, micafungin sodium (Par Pharm) not therapeutically equivalent to J2248, 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2246	MICAFUNGIN	Injection, micafungin in sodium (Baxter), not therapeutically equivalent to J2248, 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90385	MICRHOGAM	Rh IG, minidose, IM	THERAPEUTIC INJ	
J2788	MICRHOGAM	Rho d immune globulin, human, minidose, 50 mcg (250 IU)	THERAPEUTIC INJ	
J2251	MIDAZOLAM	Injection, midazolam HCl (WG Critical Care) not therapeutically equivalent to J2250, per 1 mg	THERAPEUTIC INJ	
J2250	MIDAZOLAM HCL	Midazolam hydrochloride	THERAPEUTIC INJ	
J2260	MILRINONE IN DEXTROSE	Milrinone lactate Per 5 MG	THERAPEUTIC INJ	
J2260	MILRINONE LACTATE	Milrinone lactate Per 5 MG	THERAPEUTIC INJ	
J2265	MINOCIN	Minocycline hydrochloride Injection 1 mg	THERAPEUTIC INJ	
J0887	MIRCERA	Injection, epoetin beta, 1 microgram, (for ESRD on dialysis)	SELF-INJECTABLE	
J0888	MIRCERA	Injection, epoetin beta, 1 microgram, (for non-ESRD use)	SELF-INJECTABLE	CHEMO ADJUNCT*
J9270	MITHRACIN	Plicamycin, 2.5mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9280	MITOMYCIN	Mitomycin 5 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J9291	MITOMYCIN	Mitomycin 40 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
90707	M-M-R II	MMR vaccine, SC	THERAPEUTIC INJ	IMMUNIZATION
J9349	MONJUVI	Tafasitamab-cxix For IV Soln 200 MG	THERAPEUTIC INJ	CHEMOTHERAPY*
J7190	MONOCLATE-P	Factor VIII (antihemophilic Factor [human]) per IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J1437	MONOFERRIC	Injection ferric derisomaltose 10 mg	THERAPEUTIC INJ	
J7193	MONONINE	Factor IX (antihemophilic Factor, purified, non-recombinant) per IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J7327	MONOVISC	High Molecular Weight Hyaluronan	THERAPEUTIC INJ	
J2270	MORPHINE SULFATE	Morphine sulfate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2271	MORPHINE SULFATE	Morphine SO4 injection 100mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2274	MORPHINE SULFATE	Morphine sulfate, preservative-free for epidural or intrathecal use, 10 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2272	MORPHINE SULFATE	Injection, morphine sulfate (Fresenius Kabi) not therapeutically equivalent to J2270, up to 10 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2275	MORPHINE SULFATE (PF)	Morphine sulfate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3590	MOUNJARO™	Tirzepatide Injection, for subcutaneous use	SELF-INJECTABLE	
J2281	MOXIFLOXACIN	Injection, moxifloxacin (Fresenius Kabi) not therapeutically equivalent to J2280, 100 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J2562	MOZOBIL 24 MG/1.2ML SOLN	Plerixafor injection	THERAPEUTIC INJ	
90683	MRESVIA™	RSV mRNA Pre-F Vaccine IM Susp Pref Syr 50 MCG/0.5ML	THERAPEUTIC INJ	IMMUNIZATION
90704	MUMPSVAX	Mumps vaccine, SC	THERAPEUTIC INJ	IMMUNIZATION
J9230	MUSTARGEN	Mechlorethamine hydrochloride, (nitrogen mustard), 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9280	MUTAMYCIN	Mitomycin 20 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J9280	MUTAMYCIN	Mitomycin 40 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
Q5107	MVASI	Bevacizumab-awwb	THERAPEUTIC INJ	CHEMOTHERAPY*
J3590	MYALEPT	Metreleptin for injection	SELF-INJECTABLE	
J2248	MYCAMINE	Micafungin sodium for Injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9203	MYLOTARG	Gemtuzumab ozogamicin, 0.1 mg 4.5 MG SOLR	THERAPEUTIC INJ	CHEMOTHERAPY*
J0587	MYOBLOC	RimabotulinumtoxinB, 100 units	THERAPEUTIC INJ	
J1600	MYOCHRYSINE	Gold sodium thiomaleate injection	THERAPEUTIC INJ	
J0220	MYOZYME 10 MG	Alglucosidase Alfa, 10 Mg	THERAPEUTIC INJ	
90371	NABI-HB	Hepatitis B Immune Globulin (HBIg), human, for intramuscular use (Price is per 1 mL)	THERAPEUTIC INJ	
S0032	NAFCILLIN	Nafcillin sodium	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1458	NAGLAZYME 1MG/ML	Galsulfase injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2300	NALBUPHINE HCL	Nalbuphine hydrochloride	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3490	NALMEFENE	Nalmefene hcl inj 1 mg/ml	THERAPEUTIC INJ	
J2322	NANDROLONE DECANOATE	Nandrolone decanoate 200 MG	THERAPEUTIC INJ	CHEMO ADJUNCT*
J2795	NAROPIN	Ropivacaine hcl injection	THERAPEUTIC INJ	
C9399, J3590	NATPARA	Parathyroid Hormone	SELF-INJECTABLE	
J9390	NAVELBINE	Vinorelbine tartrate, per 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J2515	NEMBUTAL	Pentobarbital sodium inj, 50 mg	THERAPEUTIC INJ	
J2710	NEOSTIGMINE METHYLSULFATE	Neostigmine methylslate injection	THERAPEUTIC INJ	
J2370	NEO-SYNEPHRINE	Phenylephrine hcl injection	THERAPEUTIC INJ	
J2506	NEULASTA ONPRO KIT	6 mg/0.6 mL Pegfilgrastim in a single-dose prefilled syringe co-packaged with the on-body injector (OBI)	THERAPEUTIC INJ	CHEMO ADJUNCT*
J2506	NEULASTA®	Injection, pegfilgrastim, excludes biosimilar, 0.5 mg (Self-Injectable)	SELF-INJECTABLE	CHEMO ADJUNCT*
J2506	NEULASTA®	Injection, pegfilgrastim, excludes biosimilar, 0.5 mg (Therapeutic Inj)	THERAPEUTIC INJ	TRANSPLANT DRUGS-IF USED WITH (G-CSF WITH MOZOBIL)
J1442	NEUPOGEN	Filgrastim 300 mcg injection	SELF-INJECTABLE	CHEMO ADJUNCT*
J1442	NEUPOGEN	Filgrastim 480 mcg injection	SELF-INJECTABLE	CHEMO ADJUNCT*
J1442	NEUPOGEN	Filgrastim (G-CSF), excludes biosimilars, 1 microgram	THERAPEUTIC INJ	TRANSPLANT DRUGS-IF USED WITH (G-CSF WITH MOZOBIL)
J3420	NEURO B-12 FORTE S	Vitamin B-12 cyanocobalamin, up to 1,000mcg	THERAPEUTIC INJ	

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J3420	NEURO B-12 S	Vitamin B-12 cyanocobalamin, up to 1,000mcg	THERAPEUTIC INJ	
J3305	NEUTREXIN	Trimetrexate glucoronate	THERAPEUTIC INJ	
J3490	NEXIUM I.V. 20 MG SOLR	Esomeprazole injection	THERAPEUTIC INJ	
J7307	NEXPLANON	Etonogestrel (contraceptive) implant system, including implant and supplies	THERAPEUTIC INJ	
J0283	NEXTERONE®	Injection, amiodarone hydrochloride, 30 mg	THERAPEUTIC INJ	
J0219	NEXVIAZYME™	Avalglucosidase alfa-ngpt	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3490	NGENLA™	Somatrogon-ghla injection, for subcutaneous use	SELF-INJECTABLE	
J2404	Nicardipine	Injection, nicardipine, 0.1 mg	THERAPEUTIC INJ	
J9268	NIPENT	Pentostatin, per 10mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0211	NITHIODOTE™	Injection, sodium nitrite 3 mg and sodium thiosulfate 125 mg	THERAPEUTIC INJ	
J2305	Nitroglycerin	Injection, nitroglycerin, 5 mg	THERAPEUTIC INJ	
Q5110	NIVESTYM	Filgrastim-aafi soln prefilled syringe 300 mcg or 480mcg	SELF-INJECTABLE	CHEMO ADJUNCT*
Q5110	NIVESTYM	Filgrastim-aafi, biosimilar, 1 microgram	THERAPEUTIC INJ	TRANSPLANT DRUGS-IF USED WITH (G-CSF WITH MOZOBIL)
J2941	NORDITROPIN	Somatropin, 1 mg	SELF-INJECTABLE	GROWTH HORMONE
J2360	NORFLEX	Orphenadrine injection	THERAPEUTIC INJ	
90371	NOVAPLUS NABI-HB	Hepatitis B Immune Globulin (HBIg), human, for intramuscular use (Price is per 1 mL)	THERAPEUTIC INJ	
J0725	NOVAREL	Chorionic gonadotropin/1000u	SELF-INJECTABLE	INFERTILITY
J7182	NOVOEIGHT	Factor VIII, antihemophilic factor, recombinant per IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J7189	NOVOSEVEN	Factor VIIa (antihemophilic Factor, recombinant), per 1 microgram	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
C9399, J3490	NOXAFIL	Posaconazole Injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2796	NPLATE	Romiplostim, 10 micrograms	THERAPEUTIC INJ	
J2300	NUBAIN	Nalbuphine hydrochloride	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2182	NUCALA	Mepolizumab for injection	THERAPEUTIC INJ	
J2182	NUCALA AUT0-INJECTOR	Injection, mepolizumab, 1 mg Auto-injector 00173-0892-01	SELF-INJECTABLE	
J3490	NULIBRY	Fosdenopterin	THERAPEUTIC INJ	
J0485	NULOJIX	Belatacept, 1 mg injection	THERAPEUTIC INJ	TRANSPLANT*
C9143	NUMBRINO™	Cocaine hydrochloride nasal solution , 1 mg		
J2410	NUMORPHAN	Oxymorphone hcl injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2941	NUTROPIN	Somatropin, 1 mg	SELF-INJECTABLE	GROWTH HORMONE
J2941	NUTROPIN AQ	Somatropin, 1 mg	SELF-INJECTABLE	GROWTH HORMONE
J2941	NUTROPIN DEPOT	Somatropin, 1 mg	SELF-INJECTABLE	GROWTH HORMONE

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J7209	NUWIQ	Factor VIII (antihemophilic factor, recombinant) 1 I.U.	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J0121	NUZYRA	Omadacycline for injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q5122	NYVEPRIA	Pegfilgrastim-apgf	THERAPEUTIC INJ	TRANSPLANT DRUGS-IF USED WITH (G-CSF WITH MOZOBIL)
Q5122	NYVEPRIA™	Pegfilgrastim-apgf	SELF-INJECTABLE	CHEMO ADJUNCT*
J7188	OBIZUR	Antihemophilic Factor (Recombinant), Porcine Sequence IV Injection	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J2350	OCREVUS	Ocrelizumab injection, for intravenous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1568	OCTAGAM	Immune Globulin, intravenous, non-lyophilized (e.g liquid), 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0131	OFIRMEV	Acetaminophen Injection	THERAPEUTIC INJ	
Q5114	OGIVRI	Trastuzumab-dkst, biosimilar, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
C9101	OLINVYK	Oliceridine injection, for intravenous use	THERAPEUTIC INJ	
J3490	OMIDRIA	Phenylephrine and ketorolac injection 1% / 0.3%	THERAPEUTIC INJ	
J3590	OMISIRGE®	Omidubicel-onlv Suspension for IV Infusion	THERAPEUTIC INJ	CHEMOTHERAPY*
J2941	OMNITROPE	Somatropin, 1 mg	SELF-INJECTABLE	GROWTH HORMONE
J2267	OMVOH™	Mirikizumab-mrkz I**ntravenous** injection 00002-7575-01	THERAPEUTIC INJ	
J3590	OMVOH™ SubQ	Mirikizumab-mrkz **subcutaneous** injection 00002-8011-01; 00002-8011-27	SELF-INJECTABLE	
J9266	ONCASPAR	Pegaspargase, per single dose vial	THERAPEUTIC INJ	CHEMOTHERAPY*
J9205	ONIVYDE	Irinotecan liposome injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J0222	ONPATTRO	Patisiran lipid complex injection, for intravenous use	THERAPEUTIC INJ	
J9160	ONTAK	Denileukin diftitox, 300 mcg	THERAPEUTIC INJ	CHEMOTHERAPY*
Q5112	ONTRUZANT	Trastuzumab-dttb, biosimilar, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9299	OPDIVO	Nivolumab, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9298	OPDUALAG™	Nivolumab and relatlimab-rmbw) injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J2407	ORBACTIV	Oritavancin diphosphate for IV soln 400 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0129	ORENCIA 125mg/ml Sb-Q (00003-2188-11)	Abatacept subcutaneous inj 125 mg/1ml	SELF-INJECTABLE	
J0129	ORENCIA IV	Abatacept, 10 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2360	ORPHENADRINE CITRATE	Orphenadrine injection	THERAPEUTIC INJ	
J7505	ORTHOCLONE OKT3	Monoclonal antibodies	THERAPEUTIC INJ	TRANSPLANT*
J7324	ORTHOVISC	Hyaluronan or derivative, Orthovisc, for intra-articular injection, per dose (30 mg/2 mL)	THERAPEUTIC INJ	
C9399, J3490	OTREXUP	Methotrexate Injection	SELF-INJECTABLE	
J3490	OVIDREL	Chorionic gonadotropin 250 MCG/0.5ML INJ	SELF-INJECTABLE	INFERTILITY
J2700	OXACILLIN SODIUM	Oxacillin sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J0224	OXLUMO	Injection, lumasiran, 0.5 mg	THERAPEUTIC INJ	
J2590	OXYTOCIN	Oxytocin injection	THERAPEUTIC INJ	
C9399, J3490	OZEMPIC	SemaglutIde Soln, injection, for subcutaneous use	SELF-INJECTABLE	
J1096	OZURDEX	Dexamethasone intravitreal Implant	THERAPEUTIC INJ	
J9264	PACLITAXEL	Paclitaxel protein-bound particles, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9267	PACLitaxel	Paclitaxel, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9259	Paclitaxel	Injection, paclitaxel protein-bound particles (American Regent) not therapeutically equivalent to J9264, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9258	Paclitaxel protein-bound particles	Injection, paclitaxel protein-bound particles (Teva), not therapeutically equivalent to J9264, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9177	PADCEV®	Enfortumab vedotin-ejfv) for injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J2468	Palonosetron	Injection, palonosetron hydrochloride (avyxa), not therapeutically equivalent to J2469, 25 micrograms	THERAPEUTIC INJ	CHEMO ADJUNCT*
J3590, C9399	PALYNZIQ	Pegvaliase-pqpz injection, for subcutaneous use	SELF-INJECTABLE	
J2430	PAMIDRONATE DISODIUM	Pamidronate disodium /30 MG	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1566	PANGLOBULIN NF	Immune Globulin, intravenous, lyophilized (e.g powder), 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1640	PANHEMATIN	Hemin, 1 mg	THERAPEUTIC INJ	
J1576	PANZYGA	Immune globulin intravenous, human - ifas 10% Liquid Preparation	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2440	PAPAVERINE HCL	Papaverine hcl injection	THERAPEUTIC INJ	
J9045	PARAPLATIN	Carboplatin injection, 50 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0606	PARSABIV	Injection, etelcalcetide, 0.1 mg for intravenous use	THERAPEUTIC INJ	
90647	PEDVAX HIB	Hib vaccine, prp-omp, IM	THERAPEUTIC INJ	IMMUNIZATION
S0145	PEGASYS	Pegylated interferon alfa-2a, 180 mcg per mL	SELF-INJECTABLE	
J9314	PEMETREXED	Injection, pemetrexed (Teva) not therapeutically equivalent to J9305, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9294	Pemetrexed	Injection, pemetrexed (Hospira), not therapeutically equivalent to J9305, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9296	Pemetrexed	Injection, pemetrexed (Accord), not therapeutically equivalent to J9305, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9297	Pemetrexed	Injection, pemetrexed (Sandoz), not therapeutically equivalent to J9305, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9304	PEMFEXY®	Pemetrexed IV soln 500 mg/20ml	THERAPEUTIC INJ	CHEMOTHERAPY*
Q0224	PEMGARDA™	Pemivibart IV soln 500 mg/4ml (125 mg/ml)	THERAPEUTIC INJ	
J9324	PEMRYDI RTU®	Injection, pemetrexed, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
90623	PENBRAYA™	Meningococcal ACYW (Tet Conj)-Mening B (Rcmb) Vacc For Inj	THERAPEUTIC INJ	IMMUNIZATION
J2540	PENICILLIN G POT IN DEXTROSE	Penicillin G potassium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2540	PENICILLIN G POTASSIUM	Penicillin G potassium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J2510	PENICILLIN G PROCAINE	Penicillin g procaine injection	THERAPEUTIC INJ	
90698	PENTACEL	Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine, inactivated (DTaP - Hib - IPV), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
S0080	PENTAM 300 MG SOLUTION	Pentamidine isethionateper 300 mg	THERAPEUTIC INJ	
J2513	PENTASPAN 10%	Pentastarch 10% solution	THERAPEUTIC INJ	
S0028	PEPCID	Famotidine, 20 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9306	PERJETA	Pertuzumab Solution	THERAPEUTIC INJ	CHEMOTHERAPY*
J2798	PERSERIS	Risperidone for extended-release injectable suspension	THERAPEUTIC INJ	
91319	PFIZER-BIONTECH COVID-19 VACCINE/5-11Y	Covid-19 mRNA Vaccine Tris-S Ages 5-11-Pfizer IM Susp 2024-25 Formula	THERAPEUTIC INJ	IMMUNIZATION
91318	PFIZER-BIONTECH COVID-19 VACCINE/6 months to 4 Years of age	Covid-19 mRNA Vaccine Tris-S Ages 6 months-4 years of age Pfizer IM Susp 2024-25 Formula	THERAPEUTIC INJ	IMMUNIZATION
J2540	PFIZERPEN-G	Penicillin g potassium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2550	PHENERGAN	Promethazine hcl injection	THERAPEUTIC INJ	
J2560	PHENOBARBITAL SODIUM	Phenobarbital sodium injection	THERAPEUTIC INJ	
J2760	PHENTOLAMINE MESYLATE	Phentolamine mesylate injection	THERAPEUTIC INJ	
J2372	Phenylephrine	Injection, phenylephrine HCl (Biorphen), 20 mcg	THERAPEUTIC INJ	
J2370	PHENYLEPHRINE HCL	Phenylephrine hcl injection	THERAPEUTIC INJ	
J1165	PHENYTOIN SODIUM	Phenytoin sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
C9399	PHESGO	Pertuzumab-trastuz-hyaluron-zzxf inj	THERAPEUTIC INJ	CHEMOTHERAPY*
J9600	PHOTOFRIN	Porfimer sodium, 75 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J3430	PHYTONADIONE	Vitamin K phytonadione injection	THERAPEUTIC INJ	
S0081	PIPERACILLIN	Piperacillin sodium	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2590	PITOCIN	Oxytocin injection	THERAPEUTIC INJ	
90727	PLAGUE VACCINE	Plague Vaccine, IM	THERAPEUTIC INJ	IMMUNIZATION
J9060	PLATINOL AQ	Cisplatin 10 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J9062	PLATINOL AQ	Cisplatin 50 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
C9399, J3490	PLEGRIDY	Peginterferon beta-1a soln pen-inj	SELF-INJECTABLE	
90732	PNEUMOVAX 23	Pneumococcal polysaccharide vaccine, 23-valent (PPSV23), adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use (	THERAPEUTIC INJ	IMMUNIZATION
J9309	POLIVY	Polatuzumab vedotin-piiq for Intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J0670	POLOCAINE	Mepivacaine HCL 10 ml	THERAPEUTIC INJ	
J0670	POLOCAINE-MPF	Mepivacaine HCL/10 ml	THERAPEUTIC INJ	
J1566	POLYGAM S/D	Immune Globulin, intravenous, lyophilized (e.g powder), 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1203	POMBILITI™	Cipaglucosidase alfa-atga for IV solution	THERAPEUTIC INJ	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J9295	PORTRAZZA	Necitumumab	THERAPEUTIC INJ	CHEMOTHERAPY*
C9144	POSIMIR®	Bupivacaine infiltration soln 660 mg/5ml (132 mg/ml)	THERAPEUTIC INJ	
J3480	POTASSIUM CHLORIDE	Potassium chloride	THERAPEUTIC INJ	
S5012	POTASSIUM CHLORIDE in DEXTROSE SOLUTION	5% dextrose with potassium chloride, 1000 mL	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9204	POTELIGEO	Mogamulizumab-kpkc injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J3590	PRALUENT	Alirocumab Injection, for subcutaneous use	SELF-INJECTABLE	
C9399	PRAXBIND	Idarucizumab injection, for intravenous use	THERAPEUTIC INJ	
J3490	PRECEDEX	Dexmedetomidine hcl inj 200 mcg/2ml	THERAPEUTIC INJ	
J2650	PREDACORT 50	Prednisolone acetate injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J2650	PRED-JECT-50	Prednisolone acetate injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J2650	PREDNISOLONE ACETATE	Prednisolone acetate injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J0725	PREGNYL	Chorionic gonadotropin/1000u	SELF-INJECTABLE	INFERTILITY
J1410	PREMARIN	Estrogen conjugate 25 MG	THERAPEUTIC INJ	CHEMO ADJUNCT*
S0195	PREVNAR 16 MCG/0.5ML SUSP	Pneumococcal conjugate vaccine, polyvalent, intramuscular, for children from five years to nine years of age who have not previously received the vaccine	THERAPEUTIC INJ	IMMUNIZATION
90677	PREVNAR 20™	Pneumococcal conjugate vaccine, 20 valent (PCV20), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J3490	PREVYMIS	Letermovir injection, for intravenous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2278	PRIALT	Ziconotide injection	THERAPEUTIC INJ	
J2260	PRIMACOR	Milrinone lactate / 5 MG	THERAPEUTIC INJ	
J2260	PRIMACOR IN DEXTROSE	Milrinone lactate / 5 MG	THERAPEUTIC INJ	
J0743	PRIMAXIN IV	Cilastatin sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2670	PRISCOLINE	Totazoline hcl injection	THERAPEUTIC INJ	
J1459	PRIVIGEN	Immune globulin (Privigen), intravenous, non-lyophilized (e.g., liquid), 500 mg (Privigen)	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0570	PROBUPHINE IMPLANT KIT	Buprenorphine hcl subdermal implant 74.2 mg	THERAPEUTIC INJ	
J2690	PROCAINAMIDE HCL	Procainamide hcl injection	THERAPEUTIC INJ	
J0780	PROCHLORPERAZINE EDISYLATE	Prochlorperazine, up to 10 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J0885	PROCRIT	Epoetin alfa, (for non-ESRD use), 1000 units	SELF-INJECTABLE	CHEMO ADJUNCT*
Q4081	PROCRIT	Epoetin Alfa, 100 Units (For ESRD On Dialysis) (For Renal Dialysis Facilities And Hospital Use)	SELF-INJECTABLE	
J0725	PROFASI	Chorionic gonadotropin/1000u	SELF-INJECTABLE	INFERTILITY
J0725	PROFASI HP	Chorionic gonadotropin/1000u	SELF-INJECTABLE	INFERTILITY
J7194	PROFILNINE SD	Factor IX, complex, per IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J2675	PROGESTERONE	Progesterone per 50 MG	THERAPEUTIC INJ	CHEMO ADJUNCT*
J7525	PROGRAF	Tacrolimus injection	THERAPEUTIC INJ	TRANSPLANT*

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J0256	PROLASTIN	Alpha 1 proteinase inhibitor	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9015	PROLEUKIN	Aldesleukin, per single use vial	THERAPEUTIC INJ	CHEMOTHERAPY*
J0897	PROLIA	Denosumab 60MG/ML	THERAPEUTIC INJ	
J2950	PROMAZINE HCL	Promazine hcl injection	THERAPEUTIC INJ	
J2550	PROMETH-50	Promethazine hcl injection	THERAPEUTIC INJ	
J2550	PROMETHAZINE HCL	Promethazine hcl injection	THERAPEUTIC INJ	
J7401	PROPEL	Mometasone furoate sinus implant, 10 micrograms	THERAPEUTIC INJ	
J1800	PROPRANOLOL HCL	Propranolol injection	THERAPEUTIC INJ	
90710	PROQUAD	Measles, Mumps, Rubella and Varicella (Oka/Merck) Virus Vaccine Live	THERAPEUTIC INJ	IMMUNIZATION
J0270	PROSTIN VR 500 MCG	Injection, alprostadil, 1.25 mcg (code may be used for Medicare when drug administered under direct physician supervision, not for use when drug is self-administered)	SELF-INJECTABLE	
J2720	PROTAMINE SULFATE	Protamine sulfate/10 MG	THERAPEUTIC INJ	
J3490	PROTONIX	Pantoprazole sodium, 40 mg	THERAPEUTIC INJ	
J2730	PROTOPAM CHLORIDE	Pralidoxime chloride injection	THERAPEUTIC INJ	
Q2043	PROVENGE	Sipuleucel-T, minimum of 50 million autologous CD54+ cells activated with PAP-GM-CSF, including leukapheresis and all other preparatory procedures, per infusion	THERAPEUTIC INJ	CHEMOTHERAPY*
J3415	PYRIDOXINE HCL	Pyridoxine hcl 100 mg	THERAPEUTIC INJ	
J3590	PYZCHIVA®	Ustekinumab-ttwe is biosimilar* to STELARA (ustekinumab)	SELF-INJECTABLE	
J1304	QALSODY	Tofersen Intrathecal Soln 100 MG/15ML (6.7 MG/ML)	THERAPEUTIC INJ	
90696	QUADRACEL	Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (DTaP-IPV)	THERAPEUTIC INJ	IMMUNIZATION
J0330	QUELICIN	Succinycholine chloride injection	THERAPEUTIC INJ	
J1201	QUZYTTIR	Cetirizine hydrochloride injection, for intravenous use	THERAPEUTIC INJ	
90675	RABAVERT	Rabies vaccine, for intramuscular use (Price is per 1 mL)	THERAPEUTIC INJ	IMMUNIZATION
J1301	RADICAVA	Edaravone injection, for intravenous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q2026	RADIESSE	Calcium hydroxylapatite Implant	THERAPEUTIC INJ	
J2780	RANITIDINE	Ranitidine hydrochloride injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2547	RAPIVAB	Peramivir Injection	THERAPEUTIC INJ	
C9399, J3490	RASUVO	Methotrexate Injection	SELF-INJECTABLE	
Q3028	REBIF	Interferon beta-1a injection	SELF-INJECTABLE	
J7203	REBINYN	Coagulation Factor IX (Recombinant), GlycoPEGylated lyophilized powder for solution for intravenous injection	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J0896	REBLOZYL	Luspatercept-aamt for Subcutaneous inj	THERAPEUTIC INJ	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J0742	RECARBRIO	Imipenem, cilastatin, and relebactam for injection, for intravenous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3489	RECLAST	Zoledronic acid 1 mg Injection (Reclast)	THERAPEUTIC INJ	CHEMO ADJUNCT*
J7192	RECOMBINATE	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
90743	RECOMBIVAX HB 10MCG/0.5ML	Hepatitis B vaccine, adolescent dosage (2-dose schedule), for intramuscular use (Price is per dose) (Recombivax HB 10mcg = one dose)	THERAPEUTIC INJ	IMMUNIZATION
90746	RECOMBIVAX HB 10MCG/ML	Hepatitis B vaccine, adult dosage, for intramuscular use 3 dose schedule	THERAPEUTIC INJ	IMMUNIZATION
90740	RECOMBIVAX HB 40MCG/ML	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3-dose schedule), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90743	RECOMBIVAX HB 5MCG/0.5ML	Hepatitis B vaccine, adolescent dosage (2-dose schedule), for intramuscular use (Price is per dose) (Recombivax HB 10mcg = one dose)	THERAPEUTIC INJ	IMMUNIZATION
90746	RECOMBIVAX HB 5MCG/0.5ML	Hepatitis B vaccine, adult dosage, for intramuscular use 3 dose schedule	THERAPEUTIC INJ	IMMUNIZATION
J7192	REFACTO	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J1945	REFLUDAN	Lepirudin	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q0243	REGEN-COV	Injection, casirivimab and imdevimab, 2400 mg	THERAPEUTIC INJ	
J2765	REGLAN	Metoclopramide hcl injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
Q5125	RELEUKO™	Filgrastim-ayow inj soln 300 mcg/ml	SELF-INJECTABLE	CHEMO ADJUNCT*
J2212	RELISTOR	Methylnaltrexone bromide injection	SELF-INJECTABLE	
J1745	REMICADE	Infliximab, 10mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3285	REMODULIN	Treprostinil injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q2004	RENACIDIN	Bladder calculi irrig sol	THERAPEUTIC INJ	
Q5104	RENFLEXIS	Infliximab-abda for Injection, for Intravenous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0130	REOPRO	Abciximab injection	THERAPEUTIC INJ	
C9399, J3590	REPATHA	Evolocumab subcutaneous soln	SELF-INJECTABLE	
S0122	REPRONEX	Menotropins 75 iu	SELF-INJECTABLE	INFERTILITY
Q5105	RETACRIT	Epoetin alfa-epbx, biosimilar, (retacrit) (for esrd on dialysis), 100 units	SELF-INJECTABLE	
Q5106	RETACRIT	Epoetin alfa-epbx, biosimilar, (retacrit) (for non-esrd use), 1000 units	SELF-INJECTABLE	CHEMO ADJUNCT*
J2993	RETAVASE	Injection, reteplase, 18.1 mg	THERAPEUTIC INJ	
J7311	RETISERT IMPLANT	Fluocinolone acetonide invitreal implant	THERAPEUTIC INJ	
J3485	RETROVIR	Zidovudine	THERAPEUTIC INJ	HIV/AIDS
J3490	REVATIO	Sildenafil Inj	THERAPEUTIC INJ	
C9399, J3590	REVCOVI	Elapegademase-lvlr injection, for intramuscular use	THERAPEUTIC INJ	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J3490	REZIPRES®	Ephedrine hydrochloride injection for intravenous use	THERAPEUTIC INJ	
J0349	REZZAYO™	Rezafungin for injection, for intravenous use	THERAPEUTIC INJ	
90386	RH Ig, IV	Rho(D) Immune Gobulin (RhIgIV), human, for intravenous use (Effective 3/30/06 Price is per 100 IU - previously Price was per 1500 IU) (see also J2790, Q4089	THERAPEUTIC INJ	
J7100	RHEOMACRODEX IN NACL	Dextran 40 infusion	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90384	RHO(D) Ig (RHIG)	Rho(D) Immune Globulin (RhIg), human, full dose, for intramuscular use	THERAPEUTIC INJ	
J2790	RHOGAM (HUMAN)	Injection, Rho d immune globulin, human, full dose, 300 mcg (see also Q4089, 90384, 90386)	THERAPEUTIC INJ	
J2791	RHOPHYLAC	Rho d immune globulin injection	THERAPEUTIC INJ	
Q5123	RIABNI™	RITUXIMAB-ARRX IV SOLN 100 MG/10ML (10 MG/ML)	THERAPEUTIC INJ	CHEMOTHERAPY*
J7178	RIASTAP	Injection, human fibrinogen concentrate, 1 mg	THERAPEUTIC INJ	
J1212	RIMSO-50	Dimethyl sulfoxide 50% 50 ML	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2794	RISPERDAL CONSTA	Risperidone 0.5 mg, Injection	THERAPEUTIC INJ	
J9312	RITUXAN	Rituximab,100 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9311	RITUXAN HYCELA	Rituximab and hyaluronidase human injection, for subcutaneous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J3490	RIVFLOZA™	Nedosiran Sodium Subcutaneous Soln 80 MG/0.5ML	SELF-INJECTABLE	
J7200	RIXUBIS	Factor ix (antihemophilic factor, recombinant)	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J2800	ROBAXIN	Methocarbamol injection	THERAPEUTIC INJ	
J3490	ROBINUL	Glycopyrrolate 0.2MG/ML	THERAPEUTIC INJ	
J0696	ROCEPHIN	Ceftriaxone sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0696	ROCEPHIN IN DEXTROSE	Ceftriaxone sodium injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1412	ROCKTAVIAN	Valoctocogene roxaparvovec-rvox	THERAPEUTIC INJ	
J1449	ROLVEDON	Eflapegrastim-xnst injection, for subcutaneous use	THERAPEUTIC INJ	CHEMO ADJUNCT*
J3490	ROMAZICON	Flumazenil IV soln 0.5 mg/5ml	THERAPEUTIC INJ	
J9314	ROMIDEPSIN	Injection romidepsin non-lypohilized 1mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9318	ROMIDEPSIN	Romidepsin, non-lyophilized, 0.1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9319	ROMIDEPSIN	Romidepsin, lyophilized, 0.1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0596	RUCONEST	C1 esterase inhibitor (recombinant) for Intravenous Injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q5119	RUXIENCE	Rituximab-pvvr (Rituxan biosimilar)	THERAPEUTIC INJ	CHEMOTHERAPY*
C9399, J3490	RYANODEX	Dantrolene sodium for injectable suspension, for intravenous use	THERAPEUTIC INJ	
J9061	RYBREVANT	Amivantamab-vmjw	THERAPEUTIC INJ	CHEMOTHERAPY*

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J2801	RYKINDO	Risperidone for extended-release injectable suspension, for intramuscular use	THERAPEUTIC INJ	
J9021	RYLAZE	Asparaginase erwinia chrysanthemi (recombinant)- rywn) injection, for intramuscular use	THERAPEUTIC INJ	CHEMO ADJUNCT*
J2998	RYPLAZIM	Plasminogen, human-tvmh)	THERAPEUTIC INJ	
J9333	RYSTIGGO	Rozanolixizumab-noli injection, for subcutaneous use	THERAPEUTIC INJ	
J9999	RYTELO™	Imetelstat sodium for IV soln	THERAPEUTIC INJ	CHEMOTHERAPY*
J3590	RYZNEUTA®	Injection, efbemalenograstim alfa-vuxw, 0.5 mg	THERAPEUTIC INJ	
J2941	SAIZEN	Somatropin, 1 mg	SELF-INJECTABLE	GROWTH HORMONE
J1744	SAJAZIR™	Icatibant acetate subcutaneous soln pref syr	SELF-INJECTABLE	
J7131	SALINE BACTERIOSTATIC	Hypertonic Saline solution	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7130	SALINE FLUSH	Hypertonic Saline solution	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7516	SANDIMMUNE	Cyclosporine, parenteral, 250mg	THERAPEUTIC INJ	TRANSPLANT*
J2354	SANDOSTATIN	Octreotide injection, non-depot	SELF-INJECTABLE	CHEMO ADJUNCT*
J2353	SANDOSTATIN LAR DEPOT	Octreotide, depot form for intramuscular injection, 1 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J0491	SAPHNELO™	Anifrolumab-fnia) injection, for intravenous use	THERAPEUTIC INJ	
J9227	SARCLISA	Isatuximab-irfc iv soln 100 mg/5ml	THERAPEUTIC INJ	CHEMOTHERAPY*
J3490	SAXENDA	Liraglutide (weight management) soln pen-injector 6 mg/ml	SELF-INJECTABLE	
J3490	SCENESSE	Afamelanotide implant, 1 mg	THERAPEUTIC INJ	
Q2027	SCULPTRA	Poly-L-lactic acid Implant	THERAPEUTIC INJ	
J2850	SECRETIN SYNTHETIC HUMAN INJ	Secretin synthetic human	THERAPEUTIC INJ	
J3590	SELARSDI™	ustekinumab-aekn is biosimilar* to STELARA®	SELF-INJECTABLE	
J2941	SEROSTIM	Somatropin, 1 mg	SELF-INJECTABLE	GROWTH HORMONE
J7189	SEVENFACT	Factor VIIa (antihemophilic factor, recombinant)-jncw, 1 mcg	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J2561	SEZABY™	Phenobarbital injection, for intravenous use	THERAPEUTIC	
90750	SHINGRIX	Zoster Vaccine Recombinant Adjuvanted for IM Inj	THERAPEUTIC INJ	IMMUNIZATION
J3490/C9399	SIGNIFOR	Pasireotide injection, for subcutaneous use	SELF-INJECTABLE	
J2502	SIGNIFOR LAR	Pasireotide Injection	THERAPEUTIC INJ	
C9399, J3490	SILIQ	Brodalumab Injection	SELF-INJECTABLE	
J3590	SIMLANDI®	Adalimumab-ryvk auto-injector kit 40 mg/0.4ml	SELF-INJECTABLE	
C9399/J3590	SIMPONI	Golimumab 50 mg / 0.5ml Solution	SELF-INJECTABLE	
J1602	SIMPONI ARIA	Golimumab Injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0480	SIMULECT	Basiliximab	THERAPEUTIC INJ	TRANSPLANT*
J2805	SINCALIDE	Sincalide injection	THERAPEUTIC INJ	
J7402	SINUVA	Mometasone furoate sinus implant, 10 micrograms	THERAPEUTIC INJ	
J3090	SIVEXTRO	Tedizolid phosphate Injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J3590	SKYRIZI®	Rosankizumab-rzaa injection, for subcutaneous use	SELF-INJECTABLE	
J2327	SKYRIZI®	Injection, risankizumab-rzaa, intravenous, 600 mg/10 mL (60 mg/mL) in each single-dose vial.. NDC 00074-5015-01	THERAPEUTIC INJ	
J3590	SKYSONA	Elivaldogene autotemcel IV suspension	THERAPEUTIC INJ	
J3590	SKYTROFA	lonapegsomatropin-tcgd) for injection, for subcutaneous use	SELF-INJECTABLE	GROWTH HORMONE
J7030	SODIUM CHLORIDE	Infusion, normal saline solution, 1000 cc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7040	SODIUM CHLORIDE	Infusion, normal saline solution, sterile (500ml = 1 unit	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7042	SODIUM CHLORIDE	5% dextrose/normal saline	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7050	SODIUM CHLORIDE	Normal saline solution infus	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7130	SODIUM CHLORIDE BACTERIOSTATIC	Hypertonic saline solution	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7331	SODIUM HYALURONATE 1%	Sodium Hyaluronate 1% for Intra-articular injection	THERAPEUTIC INJ	
J2590	SODIUM PHOSPHATE	Oxytocin injection	THERAPEUTIC INJ	
J3490	SOGROYA®	Somapacitan-beco injection, for subcutaneous use	SELF-INJECTABLE	GROWTH HORMONE
J3490	SOLESTA	Dextranomer-sodium hyaluronate injection	THERAPEUTIC INJ	
J2910	SOLGANAL	Aurothioglucose injeciton	THERAPEUTIC INJ	
C9399, J3490	SOLIQUA	Insulin Glargine-Lixisenatide Solution	SELF-INJECTABLE	
J1300	SOLIRIS	Eculizumab 10 mg/ml Soln	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1720	SOLU-CORTEF	Hydrocortisone sodium succinate	THERAPEUTIC INJ	CHEMO ADJUNCT*
J2920	SOLU-MEDROL	Methylprednisolone sodium succinate, up to 40 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J2930	SOLU-MEDROL	Methlprednisolone sodium succinate, up to 125 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J2919	SOLU-MEDROL®	METHYLPREDNISOLONE SOD SUCC FOR INJ PF 500		
J1094	SOLUREX LA	Dexamethasone acetate	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1930	SOMATULINE DEPOT	Lanreotide acetate, 1 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J3590	SOMAVERT	Pegvisomant for injection	SELF-INJECTABLE	
J3490	Sotalol	Sotalol inj	THERAPEUTIC INJ	
J3490	SOTRADECOL	Sodium Tetradecyl Sulfate Injection	THERAPEUTIC INJ	
Q0247	SOTROVIMAB	Sotrovimab 500MG/8ML Solution	THERAPEUTIC INJ	
J1747	SPEVIGO®	Injection, spesolimab-sbzo, 1 mg , for intravenous use	THERAPEUTIC INJ	
J2326	SPINRAZA	Nusinersen injection, for intrathecal use -	THERAPEUTIC INJ	
J1835	SPORANOX	Itraconazole injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0595	STADOL NS	Butorphanol tartrate 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90717	STAMARIL	Yellow Fever Vaccine [Live])	THERAPEUTIC INJ	IMMUNIZATION
J3357	STELARA	Usetekinumab	SELF-INJECTABLE	
J3358	STELARA IV	Ustekinumab, for intravenous injection, 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J9165	STILPHOSTROL	Diethylstilbestrol injection, 250 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
Q5127	STIMUFEND®	Injection, pegfilgrastim-fpgk , biosimilar, 0.5 mg	SELF-INJECTABLE	
C9399, J3590	STRENSIQ	Asfotase alfa subcutaneous injection	SELF-INJECTABLE	
J2995	STREPTASE	Streptokinase /250000 IU	THERAPEUTIC INJ	
J3000	STREPTOMYCIN SULFATE	Streptomycin injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3010	SUBLIMAZE	Fentanyl citrate injeciton	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q9991	SUBLOCADE	Buprenorphine extended-release less than or equal to 100	THERAPEUTIC INJ	
Q9992	SUBLOCADE	Buprenorphine extended-release over 100 mg	THERAPEUTIC INJ	
J0330	SUCCINYLCHOLINE CHLORIDE	Succinycholine chloride injection	THERAPEUTIC INJ	
S0039	SULFAMETHOXAZOLE	Sulfamethoxazole	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1961	SUNLENCA®	Lenacapavir injection, for subcutaneous use	THERAPEUTIC	HIV/AIDS
J7321	SUPARTZ	Sodium hyaluronate injection	THERAPEUTIC INJ	
J9226	SUPPRELIN LA, 50 MG	Histrelin implant	THERAPEUTIC INJ	
J1627	SUSTOL	Granisetron extended-release, 0.1 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J2779	SUSVIMO	Ranibizumab injection) for intravitreal use (Ocular Implant)	THERAPEUTIC INJ	
J2781	SYFOVRE™	Pegcetacoplan injection, for intravitreal use	THERAPEUTIC	
J2860	SYLVANT	Siltuximab for Intravenous infusion	THERAPEUTIC INJ	
J3490	SYMLIN	Pramlintide acetate Injection	SELF-INJECTABLE	
90378	SYNAGIS	Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg	THERAPEUTIC INJ	
J2770	SYNERCID	Quinupristin/dalfopristin	THERAPEUTIC INJ	
J9262	SYNRIBO	Omacetaxine mepesuccinate for Injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J7325	SYNVISC INJ	Hyaluronan or derivative, Synvisc or Synvisc-One, for intra-articular injection, 1 mg	THERAPEUTIC INJ	
J7325	SYNVISC-ONE INJ	Hyaluronan or derivative, Synvisc or Synvisc-One, for intra-articular injection, 1 mg	THERAPEUTIC INJ	
S0023	TAGAMET	Cimetidine hydroc	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0593	TAKHZYRO	Landelumab-flyo	SELF-INJECTABLE	
C9399, J3590	TALTZ	Ixekizumab	SELF-INJECTABLE	
J3055	TALVEY	Talquetamab-tgvs injection, for subcutaneous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J3070	TALWIN	Pentazocine injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9265	TAXOL	Paclitaxel injection, 30 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9171	TAXOTERE	Docetaxel, 20 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0713	TAZICEF	Ceftazidime per 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q2053	TECARTUS	Brexucabtagene Autoleucel Suspension for IV Infusion	THERAPEUTIC INJ	CHEMOTHERAPY*
J9022	TECENTRIQ	Atezolizumab injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J9380	TECVAYLI™	Teclistamab-cqyv injection, for subcutaneous use	THERAPEUTIC INJ	CHEMOTHERAPY*

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J0712	TEFLARO	Ceftaroline fosamil	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3490	TEGSEDI	Inotersen injection, for subcutaneous use	SELF-INJECTABLE	
J9328	TEMODAR 100 MG SOLR	Temozolomide, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
90714	TENIVAC	Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, when administered to individuals 7 years or older, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J3241	TEPEZZA	Teprotumumab-trbw for IV Infusion	THERAPEUTIC INJ	
J1590	TEQUIN	Gatifloxacin injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3105	TERBUTALINE SULFATE INJECTION USP	Terbutaline sulfate injection	THERAPEUTIC INJ	
J3490	TERLIVAZ	Terlipressin for injection, for intravenous use	THERAPEUTIC INJ	
J2460	TERRAMYCIN	Oxytetracycline injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
S0189	TESTOPEL 75MG PELLET	Testosterone pellet, 75 mg	THERAPEUTIC INJ	
J1080	TESTOSTERONE CYPIONATE	Testosterone cypionate 200 MG	THERAPEUTIC INJ	TRANSGENDER HORMONES
J3121	TESTOSTERONE ENANTHATE	Testosterone enanthate injection, Up to 100mg	THERAPEUTIC INJ	CHEMOTHERAPY*/ TRANSGENDER HORMONES+
90389	Tetanus Immune Globulin (TIg), human, IM	Tetanus IG (Tig), human, IM	THERAPEUTIC INJ	
90703	TETANUS TOXOID	Tetanus Toxoid Adsorbed USP	THERAPEUTIC INJ	IMMUNIZATION
90718	TETANUS-DIPHTHERIA TOXOIDS TD	Tetanus and diphtheria toxoids (Td) adsorbed	THERAPEUTIC INJ	IMMUNIZATION
J0120	TETRACYCLINE	Tetracycline	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3590	TEVIMBRA®	Tislelizumab-jsgr injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J2356	TEZSPIRE®	Tezepelumab-ekko injection, subcutaneous Solution **AUTO-INJECTOR** 210 MG/1.91ML 55513-0123-01	SELF-INJECTABLE	
J2356	TEZSPIRE™	Tezepelumab-ekko injection, for **SYRINGE** subcutaneous use 55513-0112-01- intended for administration by a healthcare provider.	THERAPEUTIC INJ	
J2810	THEOPHYLLINE IN D5W	Theophylline per 40 MG	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
90586	TheraCys 81 MG/VIAL SUSR	Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer, live, for intravesical use	THERAPEUTIC INJ	CHEMOTHERAPY*
J3411	THIAMINE HCL	Thiamine hcl 100 mg	THERAPEUTIC INJ	
J9340	THIOTEPA	Thiotepa, 15 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J3230	THORAZINE	Chlorpromazine hcl injection	THERAPEUTIC INJ	
J7197	THROMBATE III	Antithrombin III (human), per IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J7511	THYMOGLOBULIN	Antithymocyte globuln rabbit	THERAPEUTIC INJ	
J2725	THYREL TRH	Protirelin per 250 mcg	THERAPEUTIC INJ	
J3240	THYROGEN	Injection,thyrotropin alpha, 0.9 mg, provided in 1.1 mg	THERAPEUTIC INJ	
S0040	TICARCILLIN	Ticarcillin disod	THERAPEUTIC INJ	HOME HEALTH / INFUSION**

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
90585	Tice BCG 50 MG SUSR	Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis, live, for percutaneous use (Price is per 50 mg)	THERAPEUTIC INJ	
90586	Tice BCG 50 MG SUSR	Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer, live, for intravesical use	THERAPEUTIC INJ	CHEMOTHERAPY*
J9031	Tice BCG 50 MG SUSR	BCG (intravesical), per installation	THERAPEUTIC INJ	CHEMOTHERAPY*
J3250	TIGAN	Trimethobenzamide hcl injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J3244	TIGCYCLINE	Injection, tigecycline (Accord) not therapeutically equivalent to J3243, 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9273	TIVDAK®	Tisotumab vedotin-tftv for injection 40 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J3101	TNKASE	Tenecteplase injection	THERAPEUTIC INJ	
J3260	TOBRAMYCIN SULFATE	Tobramycin sulfate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3260	TOBRAMYCIN SULFATE IN SALINE	Tobramycin sulfate injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q5133	TOFIDENCE™	Tocilizumab-bavi, biosimilar, 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9181	TOPSAR	Etoposide 10 MG injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J1885	TORADOL IM	Ketorolac tromethamine injection	THERAPEUTIC INJ	
J3280	TORECAN	Thiethylperazine maleate injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J9330	TORISEL	Temsirolimus, 1mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J1190	TOTECT 500 MG SOLR	Dexrazoxane hydrochloride, per 250 mg	THERAPEUTIC INJ	CHEMO ADJUNCT*
J0365	TRASYLOL	Aprotonin, 10,000 kiu	THERAPEUTIC INJ	
Q5116	TRAZIMERA	Trastuzumab-qyyp,C1220 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9033	TREANDA 100 MG SOLR	Bendamustine HCl, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J3315	TRELSTAR®	Triptorelin Pamoate For IM Susp 3.75mg, 11.25mg, 22.5mg	THERAPEUTIC INJ	
J1628	TREMFYA	Guselkumab injection, for subcutaneous use	SELF-INJECTABLE	
J7181	TRETTEN	Factor XIII (antihemophilic factor, recombinant)	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J3301	TRIAMCINOLONE ACETONIDE USP	Triamcinolone acetonide injection	THERAPEUTIC INJ	
J3300	TRIESENCE 40 MG/ML SUSP	Triamcinolone acetonide injectable suspension	THERAPEUTIC INJ	
J1443	TRIFERIC	Ferric pyrophosphate citrate solution, 0.1 mg of iron	THERAPEUTIC INJ	
J1444	TRIFERIC (For use in dialasate)	Ferric pyrophosphate citrate powder, 0.1 mg of iron	THERAPEUTIC INJ	
J1445	TRIFERIC® AVNU	Ferric pyrophosphate citrate solution 0.1 mg of iron	THERAPEUTIC INJ	
90721	TRIHIBIT PRESERVATIVE FREE	Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DTP-Hib), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
J3310	TRILAFON	Perphenazine injeciton	THERAPEUTIC INJ	
J3250	TRIMETHOBENZAMIDE HCL	Trimethobenzamide hcl injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J3316	TRIPTODUR	Triptorelin pamoate for IM ER susp 22.5 mg	THERAPEUTIC INJ	
J9017	TRISENOX	Arsenic trioxide, 1mg	THERAPEUTIC INJ	CHEMOTHERAPY*

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J7329	TRIVISC	Sodium hyaluronate for intra-articular injection	THERAPEUTIC INJ	
J3320	TROBICIN	Spectinomycn di-hcl injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9317	TRODELVY	Sacituzumab govitecan-hziy for injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J1746	TROGARZO	Ibalizumab-uiyk injection, for intravenous use	THERAPEUTIC INJ	
J0200	TROVAN	Alatrofloxacin mesylate	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
C9399, J3490	TRULICITY	Dulaglutide injection, for subcutaneous use	SELF-INJECTABLE	
90621	TRUMENBA	Meningococcal recombinant lipoprotein vaccine, serogroup B, 3 dose schedule, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
Q5115	TRUXIMA	Rituximab-abbs	THERAPEUTIC INJ	CHEMOTHERAPY*
90636	TWINRIX	Hep a/hep b vacc, adult IM	THERAPEUTIC INJ	IMMUNIZATION
J3243	TYGACIL 50MG	Tigecycline injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3490	TYMLOS	Abaloparatide injection, for subcutaneous use	SELF-INJECTABLE	
90691	TYPHIM VI	Typhoid Vi Polysaccharide Vaccine	THERAPEUTIC INJ	IMMUNIZATION
90692	TYPHOID VACCINE, H-P	Typhoid Vaccine, H-P, sc/id	THERAPEUTIC INJ	IMMUNIZATION
Q5134	TYRUKO®	Injection, natalizumab-sztn , biosimilar, 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2323	TYSABRI	Natalizumab 1 mg injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9381	TZIELD™	Teplizumab-mzwv IV Soln 2 MG/2ML (1 MG/ML)	THERAPEUTIC INJ	
Q5111	UDENYCA	Pegfilgrastim-CBQV	SELF-INJECTABLE	CHEMO ADJUNCT*
Q5111	UDENYCA	Pegfilgrastim-cbqv, biosimilar, 0.5 mg	THERAPEUTIC INJ	TRANSPLANT DRUGS-IF USED WITH (G-CSF WITH MOZOBIL)
Q5111	UDENYCA ONBODY™	Pegfilgrastim-cbqv On Body Injector	THERAPEUTIC INJ	CHEMO ADJUNCT*
J1303	ULTOMIRIS	Ravulizumab-cwvz injection, for intravenous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0295	UNASYN 1.5GM	Ampicillin sodium per 1.5 gm	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1246	UNITUXIN®	Injection, Dinutuximab, 0.1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J1823	UPLIZNA	Inebilizumab-cdon injection, for intravenous use	THERAPEUTIC INJ	
J3350	UREAPHIL	Urea injection	THERAPEUTIC INJ	
J0520	URECHOLINE	Bethanechol chloride inject	THERAPEUTIC INJ	
J2679	UZEDY	Risperidone Subcutaneous ER Susp Prefilled Syr 200 MG/0.56ML	THERAPEUTIC INJ	
J2185	VABOMERE	Meropenem and vaborbactam for injection, for intravenous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2777	VABYSMO	Faricimab-svoa intravitreal inj 6 mg/0.05ml	THERAPEUTIC INJ	
90393	VACCINIA	Vaccinia IG, human, IM	THERAPEUTIC INJ	
J0900	VALERTEST #1	Testosterone enanthate and estradiol valerate	THERAPEUTIC INJ	CHEMOTHERAPY*
J3360	VALIUM	Diazepam, up to 5 mg	THERAPEUTIC INJ	
J9357	VALSTAR	Valrubicin, intravesical, 200 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J3370	VANCOCIN HCL	Vancomycin hcl injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J3371	VANCOMYCIN	Injection, vancomycin HCl (Mylan) not therapeutically equivalent to J3370, 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3370	VANCOMYCIN HCL	Vancomycin hcl injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9225	VANTAS IMPLANT	Histrelin implant	THERAPEUTIC INJ	CHEMOTHERAPY*
C9488	VAPRISOL	Conivaptan hydrochloride Injection	THERAPEUTIC INJ	
90632	VAQTA	Hepatitis A vaccine, adult dosage, for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90633	VAQTA	Hepatitis A vaccine, pediatric/adolescent dosage (2-dose schedule), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90396	VARICELLA-ZOSTER IMMUNE GLOB	Varicella-zoster IG, IM	THERAPEUTIC INJ	
C9399, J3490	VARITHENA	Polidocanol injectable foam	THERAPEUTIC INJ	
90716	VARIVAX	Chicken pox vaccine, SC	THERAPEUTIC INJ	IMMUNIZATION
J3490 / 90396	VARIZIG	Varicella-zoster Immune Globulin (VZIG), human, for intramuscular use	THERAPEUTIC INJ	
J1642	VASCEZE	Heparin sodium injection per 10 u	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2599	Vasopressin	Injection, vasopressin (American Regent) not therapeutically equivalent to J2598, 1 unit	THERAPEUTIC INJ	
J2598	Vasopressin	Injection, vasopressin, 1 unit	THERAPEUTIC INJ	
90697	VAXELIS™	Diphtheria, tetanus toxoids, acellular pertussis vaccine, inactivated poliovirus vaccine,Haemophilus influenzae type b PRP-OMP conjugate vaccine, and hepatitis B vaccine (DTaP-IPV-Hib-HepB), for intramuscular use	THERAPEUTIC INJ	IMMUNIZATION
90671	VAXNEUVANCE™	Pneumococcal 15-valent Conjugate Vaccine) Suspension for Intramuscular Injection	THERAPEUTIC INJ	IMMUNIZATION
J2370	VAZCULEP	Phenylephrine hydrochloride Injection for intravenous use	THERAPEUTIC INJ	
J9303	VECTIBIX	Panitumumab, 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
Q5129	VEGZELMA®	Injection, bevacizumab-adcd biosimilar, 10 mg	THERAPEUTIC	CHEMOTHERAPY*
J0248	VEKLURY	Remdesivir, 1 mg	THERAPEUTIC INJ	
J9041	VELCADE	Bortezomib, 0.1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J1756	VENOFER	Iron sucrose injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9376	VEOPOZ™	Pozelimab-bbfg inj soln	THERAPEUTIC INJ	
J2250	VERSED	Midazolam hydrochloride	THERAPEUTIC INJ	
J3400	VESPRIN	Triflupromazine hcl injection	THERAPEUTIC INJ	
J3465	VFEND IV	Voriconazole 10 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J9219	VIADUR	Leuprolide acetate implant	THERAPEUTIC INJ	CHEMOTHERAPY*
J3095	VIBATIV	Telavancin injection	THERAPEUTIC INJ	
J3490/C9399	VICTOZA 18 MG/3ML SOLN	Liraglutide [rDNAorigin] Injection	SELF-INJECTABLE	
J9025	VIDAZA	Azacitidine injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J1427	VILTEPSO	Viltolarsen	THERAPEUTIC INJ	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J1322	VIMIZIM	Elosulfase alfa	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
C9254	VIMPAT INJECTION	lacosamide, 1 mg	THERAPEUTIC INJ	
J9360	VINBLASTINE SULFATE	Vinblastine sulfate inj 1 mg/ml	THERAPEUTIC INJ	CHEMOTHERAPY*
J9370	VINCRISTINE SULFATE	Vincristine sulfate, 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J9390	VINORELBINE TARTRATE	Vinorelbine tartrate, per 10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J7333	VISCO-3	Hyaluronan or derivative for intra-articular injection, per dose	THERAPEUTIC INJ	
J3410	VISTARIL	Hydroxyzine hcl injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J0740	VISTIDE	Cidofovir 375 mg injection	THERAPEUTIC INJ	HIV/AIDS
J3396	VISUDYNE	Verteporfin 0.1 mg injection	THERAPEUTIC INJ	
J3420	VITAMIN B-12	Vitamin B-12 cyanocobalamin, up to 1,000mcg	THERAPEUTIC INJ	
J3430	VITAMIN K	Vitamin K phytonadione injection	THERAPEUTIC INJ	
J3470	VITRASE 200 UNIT/ML SOLN	Hyaluronidase, up to 150 units	THERAPEUTIC INJ	
J3471	VITRASE 200 UNIT/ML SOLN	Hyaluronidase, ovine, preservative free, per 1 USP unit (up to 999 USP units)	THERAPEUTIC INJ	
J3472	VITRASE 6200 UNIT SOLR	Hyaluronidase, ovine, preservative free, per 1000 USP units	THERAPEUTIC INJ	
J9056	VIVIMUSTA™	Injection, bendamustine HCl , 1 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J2315	VIVITROL	Naltrexone, Depot Form, 1 Mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J7179	VONVENDI	Von Willebrand factor Recombinant	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
C9293	VORAXAZE	Glucarpidase Injection	THERAPEUTIC INJ	
J3490	VOXZOGO	Vosoritide for injection, for subcutaneous	SELF-INJECTABLE	
J3385	VPRIV	Velaglucerase alfa, 100 units	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3032	VYEPTI	Eptinezumab-jjmr	THERAPEUTIC INJ	
J3490	VYLEESI	Bremelanotide for subcutaneous use	SELF-INJECTABLE	
J1429	VYONDYS 53	Golodirsen IV Solution	THERAPEUTIC INJ	
J9332	VYVGART®	Efgartigimod alfa-fcab injection, for intravenous use	THERAPEUTIC INJ	
J9334	VYVGART® HYTRULO	Efgartigimod alfa and hyaluronidase-qvfc injection, for subcutaneous use	THERAPEUTIC INJ	
J9153	VYXEOS	Daunorubicin-cytarabine liposome for IV inj	THERAPEUTIC INJ	CHEMOTHERAPY*
J3490	WAINUA™	Eplontersen Sodium Subcutaneous Soln Auto-Inj 45 Mg/0.8ml	SELF-INJECTABLE	
J3490	WEGOVY®	Semaglutide (weight mngmt) solution	SELF-INJECTABLE	
Q5137	WEZLANA™	Injection, ustekinumab-auub, biosimilar, subcutaneous, 1 mg	SELF-INJECTABLE	
Q5138	WEZLANA™	Injection, ustekinumab-auub , biosimilar, intravenous, 1 mg	THERAPEUTIC INJ	
J7183	WILATE SOLUTION	Injection, von Willebrand factor /Coagulation Factor VIII Complex, human	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA

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** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J3590	WINREVAIR™	Sotatercept-csrk for subcutaneous soln kit	THERAPEUTIC INJ	
J2792	WINRHO	Injection, rho D immune globulin, intravenous, human, solvent detergent, 100 IU	THERAPEUTIC INJ	
J2510	WYCILLIN	Penicillin G procaine injection	THERAPEUTIC INJ	
J3490	XACDURO®	Sulbactam Sodium & Durlobactam Sodium co-packaged For IV Soln 1-1 GM	THERAPEUTIC INJ	
J3372	XELLIA	Injection, vancomycin HCl (Xellia) not therapeutically equivalent to J3370, 500 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1558	XEMBIFY	Immune Globulin Subcutaneous, human-klhw 20%	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0691	XENLETA	Lefamulin injection, for intravenous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0218	XENPOZYME™	Injection, olipudase alfa-rpcp, 1 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J0588	XEOMIN	IncobotulinumtoxinA	THERAPEUTIC INJ	
J0122	XERAVA	Eravacycline	THERAPEUTIC INJ	
J0897	XGEVA	Denosumab 120mg/ 1.7ml	THERAPEUTIC INJ	CHEMO ADJUNCT*
J0775	XIAFLEX	Collagenase Clostridium Histolyticum Injection	THERAPEUTIC INJ	
J3299	XIPERE	triamcinolone acetonide injectable suspension), for suprachoroidal use	THERAPEUTIC INJ	
J2357	XOLAIR	Omalizumab, 5 mg	THERAPEUTIC INJ	DOFR Class change effective 2/14/08 as a result of FDA and Manufacturers recommendation due to black box warnings Re-reviwed Jan 11, 2022 no change
J3490	XULTOPHY	Insulin Degludec-Liraglutide Solution	SELF-INJECTABLE	
J2001	XYLOCAINE (CARDIAC)	Lidocaine injection	THERAPEUTIC INJ	
J7185	XYNTHA KIT	Factor VIII (antihemophilic Factor, recombinant), per IU	THERAPEUTIC INJ	BLOOD/BLOOD PRODUCTS FOR HEMOPHILIA
J3490	XYOSTED	Testosterone enanthate solution auto-injector	SELF-INJECTABLE	
J9228	YERVOY	Ipilimumab Injection, for intravenous infusion	THERAPEUTIC INJ	CHEMOTHERAPY*
Q2041	YESCARTA	Axicabtagene ciloleucal, up to 200 Million autologous Anti-CD 19 Car T Cells, including leukapheresis and dose preparation	THERAPEUTIC INJ	CHEMOTHERAPY*
90717	YF-VAX	Yellow Fever vaccine, SC	THERAPEUTIC INJ	IMMUNIZATION
J9352	YONDELIS	Trabectedin for injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J7314	YUTIQ	Fluocinolone acetonide, intravitreal implant, 0.01 mg	THERAPEUTIC INJ	
J9400	ZALTRAP	Ziv-aflibercept Injection	THERAPEUTIC INJ	CHEMOTHERAPY*
J9320	ZANOSAR	Streptozocin injection, 1 gm	THERAPEUTIC INJ	CHEMOTHERAPY*
J2780	ZANTAC	Ranitidine hydrochloride injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2780	ZANTAC IN NACL	Ranitidine hydrochloride injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q5101	ZARXIO	Filgrastim-sndz injection, biosimilar. 1 microgram	SELF-INJECTABLE	CHEMO ADJUNCT*

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
Q5101	ZARXIO	Filgrastim-sndz injection, biosimilar. 1 microgram	THERAPEUTIC INJ	TRANSPLANT DRUGS-IF USED WITH (G-CSF WITH MOZOBIL)
J0256	ZEMAIRA	Alpha 1-proteinase inhibitor, human, 10 mg	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J3030	ZEMBRACE	Sumatriptan Succinate	SELF-INJECTABLE	
J0291	ZEMDRI	Plazomicin injection, for intravenous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2501	ZEMPLAR	Paricalcitol 1 mcg	THERAPEUTIC INJ	
J7513	ZENAPAX	Daclizumab 25 mg, parenteral	THERAPEUTIC INJ	TRANSPLANT*
J3490	ZEPBOUND™	Tirzepatide (weight mngmt) solution	SELF-INJECTABLE	
J9223	ZEPZELCA	Lurbinectedin for injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J0695	ZERBAXA	Ceftolozane/tazobactam Injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
A9543	ZEVALIN Y-90 3.2 MG/2ML KIT	Ibritumomab Tiuxetan	THERAPEUTIC INJ	CHEMOTHERAPY*
Q5120	ZIEXTENZO	Pegfilgrastim-bmez injection, for Subcutaneous use	SELF-INJECTABLE	CHEMO ADJUNCT*
Q5120	ZIEXTENZO	Pegfilgrastim-bmez injection, for Subcutaneous use	THERAPEUTIC INJ	TRANSPLANT DRUGS-IF USED WITH (G-CSF WITH MOZOBIL)
J3490	ZILBRYSQ®	Zilucoplan Sodium Subcutaneous Soln Pref Syr 16.6 MG/0.416ML	SELF-INJECTABLE	
J3304	ZILRETTA	Triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg	THERAPEUTIC INJ	
J2310	ZIMHI™	Injection, naloxone HCl, 1 mg	SELF-INJECTABLE	
J0697	ZINACEF	Cefuroxime injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1190	ZINECARD	Dexrazoxane hcl injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J0565	ZINPLAVA	Bezlotoxumab injection, for intravenous use	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
Q5118	ZIRABEV	Bevacizumab-bvzr,10 mg	THERAPEUTIC INJ	CHEMOTHERAPY*
J0456	ZITHROMAX	Azithromycin injection	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J2405	ZOFRAN	Ondansetron hcl injection	THERAPEUTIC INJ	CHEMO ADJUNCT*
J9202	ZOLADEX	Goserelin acetate implant	THERAPEUTIC INJ	CHEMOTHERAPY*
J3399	ZOLGENSMA	Onasemnogene abeparvovec-xioi	THERAPEUTIC INJ	
J3489	ZOMETA	Zoledronic acid 1 mg Injection (Zometa)	THERAPEUTIC INJ	CHEMO ADJUNCT*
J2941	ZORBTIVE	Somatropin, 1 mg	SELF-INJECTABLE	GROWTH HORMONE
90736	ZOSTAVAX	Zoster (shingles) vaccine, live, for subcutaneous injection	THERAPEUTIC INJ	IMMUNIZATION
J2543	ZOSYN	Piperacillin/tazobactam	THERAPEUTIC INJ	HOME HEALTH / INFUSION**
J1632	ZULRESSO	Brexanolone injection, for intravenous use	THERAPEUTIC INJ	
J1748	ZYMFENTRA®	Infliximab-dyyb) injection, for subcutaneous use-CELLTRION USA	SELF-INJECTABLE	
J9359	ZYNLONTA	Loncastuximab tesirine-lpyl) for injection, for intravenous use	THERAPEUTIC INJ	CHEMOTHERAPY*
J3393	ZYNTEGLO™	Betibeglogene autotemcel	THERAPEUTIC INJ	
J9345	ZYNYZ™	Retifanlimab-dlwr IV Soln 500 MG/20ML (25 MG/ML)	THERAPEUTIC INJ	CHEMOTHERAPY*

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

HCPCS	DRUG NAME	GENERIC NAME	PRIMARY CATEGORY	SECONDARY CATEGORY
J3490	ZYPREXA	Olanzapine, 2.5 mg	THERAPEUTIC INJ	
J2358	ZYPREXA RELPREV	Olanzapine Extended Release Injection	THERAPEUTIC INJ	
J2020	ZYVOX	Linezolid 200 mg injection	THERAPEUTIC INJ	

* If associated with a cancer diagnosis- ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9

** When administered by a nurse in a home setting

INPATIENT CALIFORNIA HEALTHNET COMMERCIAL PRIOR AUTHORIZATION

Complete and **Fax** to: 1-844-694-9165

HMO

POS

PPO

Standard requests - Determination within 5 business days of receiving all necessary information.

Urgent requests - I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 72 hours to avoid complications and unnecessary suffering or severe pain.

X

URGENT REQUESTS MUST BE SIGNED BY THE PHYSICIAN TO RECEIVE PRIORITY

***Indicates Required Field**

MEMBER INFORMATION

Last Name, First

*Date of Birth

*Member ID

(MMDDYYYY)

REQUESTING PROVIDER INFORMATION

Requesting Provider Contact Name

*Requesting NPI

*Requesting TIN

Phone

Requesting Provider *Address*

*Fax

City, State, Zip

SERVICING PROVIDER / FACILITY INFORMATION

Same as Requesting Provider

Servicing Provider Contact Name

*Servicing NPI

*Servicing TIN

Phone

Servicing Provider/Facility Name Address

Fax

City, State, Zip

AUTHORIZATION REQUEST

***Primary** Procedure Code

(CPT/HCPCS) (Modifier)

Additional Procedure Code

(CPT/HCPCS) (Modifier)

***Start Date** OR Admission Date

(MMDDYYYY)

*Diagnosis Code

(ICD-10)

Additional Procedure Code

(CPT/HCPCS) (Modifier)

Additional Procedure Code

(CPT/HCPCS) (Modifier)

Discharge Date (if applicable) otherwise Length of Stay will be based on Medical Necessity

(MMDDYYYY)

Additional Diagnosis Code

(ICD-10)

*INPATIENT SERVICE TYPE

(Enter the Service type number in the boxes)

Delivery
779 C-Section Delivery
720 Vaginal Delivery

Inpatient Rehab
427 Rehab

Transplant
992 Transplant

Miscellaneous
121 Long Term Acute Care
970 Medical
414 Premature/False Labor
402 Skilled Nursing Facility
411 Surgical
490 Boarder Baby
300 Neonate

Miscellaneous
121 Hospice Inpatient
492 Sub Acute

Behavioral Health
528 BH Chemical Substance Abuse
529 BH Psychiatric Admission

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Rev. 02242021
XD-PAF-1653

No-Cost Interpreter Services Available 24/7 for Your Patients

Your patients can access no-cost interpreter services.

Phone interpreters are available in over 150 languages for immediate needs.

Request in-person or video interpreters a minimum of five business days before the appointment during regular business hours. Allow 10 business days for in-person sign language interpreter requests.

When asking for an interpreter, tell us:

- The member's Health Net identification (ID) number
- The appointment date, time and place
- Language needed

Please allow for a phone interpreter if that is the only interpreter available for the language, date and time of the appointment.

Ask for no-cost interpreter services to help you effectively communicate with your patients.

Line of business	Phone number	Hours of availability
Individual & Family Plans (Ambetter PPO)	844-463-8188	Monday through Friday, 8 a.m. to 5 p.m., Pacific time (see below for after hours)
Individual & Family Plans (Ambetter HMO)	888-926-2164	
Employer Group HMO, POS and PPO	800-641-7761	
After-hours language assistance line	800-546-4570	Monday through Friday, 5 p.m. to 8 a.m., Pacific time; weekends and holidays
Medi-Cal	800-675-6110	Monday through Friday, 8 a.m. to 6 p.m., Pacific time. For after hours select member option
Behavioral Health	800-647-7526	Monday through Friday, 8 a.m. to 5 p.m., Pacific time (not available for after hours)

For office use only. Do NOT post in a patient area.

Phone numbers listed here are for provider use only. Members may contact the number listed on the back of their ID card for member services.

24-1158 (11/24)

wellcare By health net

Akorbi
PEOPLE ■ TECHNOLOGY ■ LANGUAGE

Access interpretation services 24/7 at no cost. This chart includes languages commonly spoken in your community; additional languages are available.

English
Do you speak [language]? We will provide an interpreter at no personal cost to you.

Amharic (አማርኛ)
አማሪኛ ይናገራሉ? እርሶ በግልዎ ምንም ወጪ ሳያወጡ አስተርጓሚ እናቀርባለን።

Arabic (اللغة العربية)
هل تتحدث اللغة العربية؟ سوف نوفر لك مترجماً فورياً من دون أي تكلفة عليك.

Armenian (հայերէն)
Դուք հայերեն եք խոսում: Մենք Ձեզ անվճար թարգմանիչ կտրամադրենք:

Bengali (বাংলা)
আপনি কি বাংলায় কথা বলেন? আমরা আপনাকে একজন দোভাষী দেবো যার জন্য আপনার ব্যক্তিগতভাবে অর্থ ব্যয় করতে হবে না।

Burmese (မြန်မာ)
သင် မြန်မာစကား ပြောပါသလား။ သင့်အတွက် ကုန်ကျစရိတ် မရှိစေဘဲ စကားပြန်တစ်ဦး ကျွန်ုပ်တို့ ပေးပါမည်။

Cambodian (ភាសាខ្មែរ)
តើអ្នកនិយាយភាសាខ្មែរដែរទេ? យើងខ្ញុំនឹងផ្តល់ជូនអ្នកបកប្រែភាសាដោយឥតគិតថ្លៃផ្ទាល់ខ្លួនដល់អ្នក។

Cantonese (粵語)
您講粵語嗎？我們將免費為您提供翻譯 。

Farsi (فارسی)
فارسی صحبت می‌کنید؟ یک مترجم شفاهی رایگان در اختیار شما قرار خواهیم داد.

French (Français)
Vous parlez français ? Nous vous fournirons gratuitement un interprète.

Greek (Ελληνικά)
Μιλάτε ελληνικά; Θα σας παρέχουμε ένα διερμηνέα χωρίς καμία οικονομική επιβάρυνση για εσάς.

Hindi (हिन्दी)
क्या आप हिंदी बोलते हैं? हम आपके लिए बिना किसी लागत के एक दुभाषिया उपलब्ध कराएंगे।

Hmong (Hmoob)
Koj puas yog ib tus neeg uas hais tau lus Hmoob? Peb yuav nrhiav kom muaj ib tug kws txhais lus rau koj uas yeej tsis muaj nqi dab tsi rau koj them li.

Japanese (日本語)
日本語を話せますか？ 通訳が必要な場合、
こちらで無料で手配させていただきます。

Korean (한국어)
한국어를 사용하십니까? 무료로 통역 서비스를 제공해 드리겠습니다.

Lao (ພາສາລາວ)
ທ່ານເວົ້າພາສາບໍ? ພວກເຮົາຈະຈັດກຽມນາຍແປພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ.

Mandarin (中文)
您講中文嗎? 我們將免費為您提供翻譯。

Mixteco
¿Ka'an ndávi ni? Ná ke'eí un ña'a noo meni ta koo ya'avian.

Navajo (Diné bizaad)
Diné k'ehjíísh yánílti'? Ata' halne'ígíí náhóló t'áájíík'eh.

Portuguese (Português)
Você fala português? Nós lhe forneceremos um intérprete, sem qualquer custo adicional.

Punjabi (ਪੰਜਾਬੀ)
ਕੀ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ? ਅਸੀਂ ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਨਿੱਜੀ ਲਾਗਤ ਦੇ ਇੱਕ ਦੁਭਾਸ਼ੀਆ ਉਪਲਬਧ ਕਰਾਂਗੇ।

Russian (Русский)
Вы говорите по-русски? Мы предоставим вам переводчика бесплатно.

Spanish (Español)
¿Habla español? Le proporcionaremos un intérprete sin costo alguno para usted.

Tagalog
Nakapagsasalita ka ba ng Tagalog? Magbibigay kami ng interpreter nang wala kang babayaran.

Thai (ภาษาไทย)
คุณพูดภาษาไทยใช่หรือไม่
เราจะจัดหาล่ามให้คุณโดยไม่มีค่าใช้จ่ายส่วนตัว

Vietnamese (Tiếng Việt)
Quý vị có nói tiếng Việt không? Chúng tôi sẽ cung cấp một thông dịch viên miễn phí cho quý vị.

American Sign Language (ASL)

Please call Provider Services using the number on the member's ID card or contact 800-929-9224.

For office use only. Do NOT post in a patient area.

ADULT HEALTH MAINTENANCE CHECKLIST

Name: _____ D.O.B. _____

Age: _____ Sex: Male Female MR# _____

Immunizations current: Yes No
(See Immunization list below)

TB Risk: Yes No
(Every Periodic Physical Examination)

Advanced Directive discussed: Yes No

Date Discussed: _____

Examination & Tests	Age Range	Frequency	DATE DONE	DATE DONE	DATE DONE
INITIAL HEALTH ASSESSMENT	18 yrs. and older	Within 120 days of effective date with Plan or effective date with the PCP. May be requested from Previous PCP if done within last year.			
IHEBA/"Staying Healthy"	18 yrs and Older	Within 120 days of effective date with Plan or effective date with the PCP. Reviewed at every Periodic Health Evaluation and re-administered every 3-5 years.	Record on Staying Healthy Form.		
Check-Up Visit	18 yrs. and older	Every 1-3 years			
	Age > 65	Annually			
Cholesterol	Male, 35 yrs. and older	Every 5 years			
	Female, 45 yrs. and older	Every 5 years			
Diabetes Mellitus Screening	As risk factors indicate	PRN			
Urinalysis	65 yrs. and older	PRN			
Breast Exam	Age > 40 yrs.	Annually			
Mammography	50-74 yrs.	Every 2 years			
Pelvic Exam	19-39 yrs.	Every 1-3 yrs.			
	40 and older	Annually			
Pap Smear	Onset of sexual activity or 21-65 yrs.	Every 1 to 3 yrs. At 65 discontinue routine screening if previous screenings negative. Discontinue at age 70 unless clinically indicated.			
Chlamydia	< age 25, all sexually active non-pregnant women > age 25, as risk factors indicate				
Bone Density	65 yrs. and older	At least once			
Vitamin D Deficiency	65 yrs. and older	At clinician's discretion			
TSH Screening	40 yrs. and older	Every 5 years			
Fecal Occult Blood	50-75 yrs., then at clinician's discretion	Annually			
Sigmoidoscopy	50 and older	3-5 yrs.			
	High Risk	PRN			
Colonoscopy	50 and older	Every 10 years			
Prostate Exam	Physician discretion and as clinically indicated	PRN			
PSA	50 and older or as clinically indicated	PRN			
Adult Immunizations					
Tetanus-Diptheria-Pertussis(Tdap) Tetanus-Diphtheria (Td)	18 yrs. and older 18 yrs. and older	1 dose only Every 10 yrs.			
HPV	Females, 18-26 yrs. (HPV2 or HPV4) Males, 18-26 yrs (HPV 4)	3 doses			
Varicella	18 yrs. and older	2 doses if no evidence of immunity			
Zoster	60 yrs. and older	1 dose			
MMR	Born 1957 or after Born before 1957	1-2 doses unless immunity documented Considered immune, unless documentation of immunity required			
Influenza	18 yrs. and older	Annually			
Pneumococcal	18 yrs. and older	1-2 doses, when clinically indicated			
Hepatitis A	18 yrs. and older	2 doses			
Hepatitis B	18 yrs. and older	3 doses			
Meningococcal	18 yrs. and older	1 dose, 2nd dose if high risk			

Advanced Directive Education: Date_________
Refused______ Yes_______ Initials:_______

Advanced Directive Education: Date_________
Refused______ Yes_______ Initials:_______

Advanced Directive Education: Date_________
Refused______ Yes_______ Initials:_______

Advanced Directive Education: Date_________
Refused______ Yes_______ Initials:_______

Advanced Directive Education: Date_________
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Advanced Directive Education: Date_________
Refused______ Yes_______ Initials:_______

Advanced Directive Education: Date_________
Refused______ Yes_______ Initials:_______

Advanced Directive Education: Date_________
Refused______ Yes_______ Initials:_______

LAST NAME: **FIRST NAME:** **MRN#**

PLACE OF SCREENING: **CIRCLE ONE:** ANSI - #____ ISO - #____

AUDIOMETER: **SCORING:** Child responds at 25 dB: Child does not respond at 25 dB: ☐

DATE OF LAST CALIBRATION: **AGE:**

1st Screen Date:_____	RIGHT Ear	1000	2000	3000	4000	LEFT Ear	1000	2000	3000	4000
2nd Screen Date:_____		1000	2000	3000	4000		1000	2000	3000	4000

Vision Test Date:_____		Right Eye	Left Eye
	Without Glasses	20/	20/
	With Glasses	20/	20/

Comments: _____

Referred To: _____

Signature & Title of Person Performing Test

DATE OF LAST CALIBRATION: **AGE:**

1st Screen Date:_____	RIGHT Ear	1000	2000	3000	4000	LEFT Ear	1000	2000	3000	4000
2nd Screen Date:_____		1000	2000	3000	4000		1000	2000	3000	4000

Vision Test Date:_____		Right Eye	Left Eye
	Without Glasses	20/	20/
	With Glasses	20/	20/

Comments: _____

Referred To: _____

Signature & Title of Person Performing Test

DATE OF LAST CALIBRATION: **AGE:**

1st Screen Date:_____	RIGHT Ear	1000	2000	3000	4000	LEFT Ear	1000	2000	3000	4000
2nd Screen Date:_____		1000	2000	3000	4000		1000	2000	3000	4000

Vision Test Date:_____		Right Eye	Left Eye
	Without Glasses	20/	20/
	With Glasses	20/	20/

Comments: _____

Referred To:

Signature & Title of Person Performing Test

HISTORIA MEDICA Y EXAMEN FISICO

MRN # _____

NOMBRE:	ESTADO CIVIL: ❑· S ❑ C ❑ V ❑ D ❑ SEP.	FECHA:
FECHA DE NACIMIENTO:	TEL (CASA):	TEL (TRABAJO):
OCUPACION/EMPLEADOR	Nº del Seg. Soc.:	Nº del SEGURO:

HISTORIA MEDICA FAMILIAR

SI ALGUN PARIENTE SANGUINEO HA TENIDO CUALQUIERA DE LAS SIGUIENTES ENFERMEDADES, PONGA UN CIRCULO ALREDEDOR DEL NUMERO E INDIQUE QUE PARIENTE.

1) ALCOHOLISMO
2) ANEMIA
3) ASMA
4) ARTRITIS
5) SANGRA FACILMENTE
6) CANCER
7) DIABETES
8) EPILEPSIA
9) GLAUCOMA
10) ASMA DEL HENO
11) ENFERMEDAD CARDIACA
12) HIPERTENSION
13) ENFERMEDAD RENAL
14) ENFERMEDAD MENTAL
15) MIGRAÑA
16) OSTEOPOROSIS
17) APOPLEJIA
18) TIROIDES
19)
20)

INTERNACIONES EN HOSPITALES

(sin incluir embarazos)

AÑO — ENFERMEDAD U OPERACION

ALERGIAS

Pasado:

Presente:

ANOTE TODOS LOS MEDICAMENTOS QUE TOMA AHORA: (incluso los que se venden sin receta médica)

1) _____ 7) _____
2) _____ 8) _____
3) _____ 9) _____
4) _____ 10) _____
5) _____ 11) _____
6) _____ 12) _____

VACUNA (Fecha de la última)	PRUEBA / EXAMEN (Fecha del último)
Tétano / Difteria	Colesterol
Influenza	Dental
Neumocócica	Vista
Hepatitis	Oído
	Rectal / Excremento
	Sigmoidoscopía
	Prueba cutánea de tuberculosis

HISTORIA MEDICA

Marque con una palomita (✓) e indique la edad en la que tuvo cualquiera de los siguientes síntomas o enfermedades. MARQUE con una equis (X) los problemas actuales.

PROBLEMAS PRINCIPALES 1) _____ 2) _____ 3) _____

❑ Oído disminuido
❑ Zumbido en el oído
❑ Infecciones de oído - *frecuentes*
❑ Mareos
❑ Falla de la vista ❑ Dolor del ojo
❑ Visión doble o borrosa
❑ Infecciones del ojo - *frecuentes*
❑ Sangrado de la nariz - *recurrentes*
❑ Problema del seno
❑ Dolores de garganta - *frecuentes*
❑ Asma del heno / Alergias
❑ Ronquera - *prolongada*
❑ Neumonía / Pleuresía
❑ Bronquitis / Tos crónica
❑ Asma / Jadeo
Falta de aliento:
❑ Haciendo esfuerzo
❑ Estando acostado
❑ Dolor del pecho
❑ Presión sanguínea alta
❑ Soplo cardíaco
❑ Pulso irregular
❑ Palpitaciones
❑ Tobillos hinchados
❑ Desmayos
❑ Dolor de pierna - *caminando*
❑ Venas varicosas / Flebitis
❑ Pérdida del apetito - *reciente*
❑ Dificultad para tragar

❑ Indigestión o acidez estomacal
❑ Ulceras pépticas
❑ Dolor abdominal - *crónico*
❑ Problema de vesícula biliar
❑ Ictericia / Hepatitis
❑ Cambio de hábitos de evacuación intestinal
❑ Diarrea ❑ Estreñimiento
❑ Diverticulosis
❑ Enfermedad de Crohn / Colitis
❑ Excrementos sanguinolentos o alquitranados
❑ Hemorroides
❑ Hernia
❑ Infecciones urinarias - frecuentes
❑ Sangre en la orina
❑ Emisión de orina ❑ Durante la noche más de dos veces
❑ Dolorosa
❑ Pérdida del control
❑ Disminución de la Fuerza/Flujo
❑ Cálculos renales
❑ Enfermedad venérea
❑ Derrame uretral
❑ Fatiga crónica
❑ Pérdida de peso - *reciente*
❑ Anemia
❑ Se magulla fácilmente

❑ Cancer
❑ Diabetes
❑ Enfermedad de tiroides
❑ Convulsiones / Ataques epilépticos
❑ Apoplejía
❑ Temblor / Manos temblantes
❑ Debilidad muscular
❑ Adormecimiento / Sensaciones de hormigueo
❑ Dolores de cabeza - *frecuentes*
❑ Artritis / Reumatismo
❑ Dolor de Espalda - *recurrente*
❑ Fracturas óseas / Lesión de articulaciones
❑ Gota
❑ Osteoporosis
❑ Dolor de pie
❑ Pies fríos y adormecidos
❑ Sarpullido
❑ Ronchas
❑ Psoriasis
❑ Eczema
❑ Sueño - *dificultad*
❑ Nerviosismo
❑ Depresión
❑ Pérdida de la memoria
❑ Mal humor - *excesivo*
❑ Fobias

❑ Enfermedad mental
❑ Varicela
❑ Poliomielitis
❑ Paperas
❑ Sarampión
❑ Rubéola
❑ Fiebre reumática
❑ Escarlatina
❑ Tuberculosis
❑ Herpes
❑ Contacto con sangre o fluidos corporales
❑ Alcohol _____ onzas por semana
❑ Fuma _____ cig. por día
Número de años_____
❑ Café / Té
Nº de tazas por día _____
❑ Directivas con adelanto

HOMBRES - Favor de completar
Fecha del último examen de próstata

❑ Normal ❑ Anormal
Fecha de la última PSA _____

MUJERES - Favor de completar
Flujo Menstrual:
❑ Reg. ❑ Irreg.
❑ Dolor / Cólico
Días de flujo _____
Duraciones del ciclo _____
Fecha del último período _____
❑ Dolor / Sangramiento durante o después del coito
Número de:
Embarazos _____
Abortos provocados _____
Abortos espontáneos _____
Nacimientos con vida _____
Método de control de la natalidad _____
Píldora de control de la natalidad (nombre) _____
❑ Calores súbitos / Menopausia
Fecha del último examen pélvico _____
Fecha de la última prueba de Papanicolaou _____
❑ Normal ❑ Anormal

Fecha del último examen de senos _____
Fecha del último mamograma ____
❑ Normal ❑ Anormal

SINOPSIS **PARA USO DE OFICINA SOLAMENTE:**

Directivas Anticipadas: ❑ Si ❑ No Educativo de Directivas Anticipadas: ❑ Cuestionario "Mantengase Saludable" Fecha:_____

Firma: Dr./Dra.

MEDICATION AND SUMMARY CHART MRN

NAME: **DATE OF BIRTH:** **HT:** **WT:**

ALLERGIES

Pharmacy Name & Telephone #

Patient's (home) Telephone #s: (work)

PROBLEM # START DATE	MEDICATION DOSAGE/FREQ.	REFILL DATES *(record any changes in dosage or frequency)*				STOP DATE OR CONTINUED

CHRONIC PROBLEM LIST

	Date Resolved
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	

Signature Page

(Please post on left-hand side of each Medical Record)

Please Write Signature as Entries are Typically Signed	Print Name in Full (First Name, Last Name, Title)

Nondiscrimination Notice

In addition to the State of California nondiscrimination requirements (as described in benefit coverage documents), Health Net of California, Inc. and Health Net Life Insurance Company (Health Net) comply with applicable federal civil rights laws and do not discriminate, exclude people or treat them differently on the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, sexual orientation, age, disability, or sex.

Health Net:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net's Customer Contact Center at:
Individual & Family Plan (IFP) Members On Exchange/Covered California 1-888-926-4988 (TTY: 711)
Individual & Family Plan (IFP) Members Off Exchange 1-800-839-2172 (TTY: 711)
Individual & Family Plan (IFP) Applicants 1-877-609-8711 (TTY: 711)
Group Plans through Health Net 1-800-522-0088 (TTY: 711)

If you believe that Health Net has failed to provide these services or discriminated in another way based on one of the characteristics listed above, you can file a grievance by calling Health Net's Customer Contact Center at the number above and telling them you need help filing a grievance. Health Net's Customer Contact Center is available to help you file a grievance. You can also file a grievance by mail, fax or email at:

Health Net of California, Inc./Health Net Life Insurance Company Appeals & Grievances
PO Box 10348, Van Nuys, CA 91410-0348

Fax: 1-877-831-6019
Email: Member.Discrimination.Complaints@healthnet.com (Members) or
Non-Member.Discrimination.Complaints@healthnet.com (Applicants)

For HMO, HSP, EOA, and POS plans offered through Health Net of California, Inc.: If your health problem is urgent, if you already filed a complaint with Health Net of California, Inc. and are not satisfied with the decision or it has been more than 30 days since you filed a complaint with Health Net of California, Inc., you may submit an Independent Medical Review/Complaint Form with the Department of Managed Health Care (DMHC). You may submit a complaint form by calling the DMHC Help Desk at 1-888-466-2219 (TDD: 1-877-688-9891) or online at www.dmhc.ca.gov/FileaComplaint.

For PPO and EPO plans underwritten by Health Net Life Insurance Company: You may submit a complaint by calling the California Department of Insurance at 1-800-927-4357 or online at https://www.insurance.ca.gov/01-consumers/101-help/index.cfm.

If you believe you have been discriminated against because of race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights (OCR), electronically through the OCR Complaint Portal, at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

FLY018690EP00 (6/18)

English
No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call the Customer Contact Center at the number on your ID card or call Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). For California marketplace, call IFP On Exchange 1-888-926-4988 (TTY: 711) or Small Business 1-888-926-5133 (TTY: 711). For Group Plans through Health Net, call 1-800-522-0088 (TTY: 711).

Arabic
خدمات لغوية مجانية. يمكننا أن نوفر لك مترجم فوري. ويمكننا أن نقرأ لك الوثائق بلغتك. للحصول على المساعدة اللازمة، يرجى التواصل مع مركز خدمة العملاء عبر الرقم المبين على بطاقتك أو الاتصال بالرقم الفرعي لخطة الأفراد والعائلة: 1-800-839-2172 (TTY: 711). للتواصل في كاليفورنيا، يرجى الاتصال بالرقم الفرعي لخطة الأفراد والعائلة عبر الرقم: 1-888-926-4988 (TTY: 711) أو المشروعات الصغيرة 1-888-926-5133 (TTY: 711). لخطط المجموعة عبر Health Net، يرجى الاتصال بالرقم 1-800-522-0088 (TTY: 711).

Armenian
Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են կարդալ ձեր լեզվով: Օգնության համար զանգահարեք Հաճախորդների սպասարկման կենտրոն ձեր ID քարտի վրա նշված հեռախոսահամարով կամ զանգահարեք Individual & Family Plan (IFP) Off Exchange՝ 1-800-839-2172 հեռախոսահամարով (TTY՝ 711): Կալիֆորնիայի համար զանգահարեք IFP On Exchange՝ 1-888-926-4988 հեռախոսահամարով (TTY՝ 711) կամ Փոքր բիզնեսի համար՝ 1-888-926-5133 հեռախոսահամարով (TTY՝ 711): Health Net-ի Խմբային ծրագրերի համար զանգահարեք 1-800-522-0088 հեռախոսահամարով (TTY՝ 711):

Chinese
免費語言服務。您可使用口譯員服務。您可請人將文件唸給您聽並請我們將某些文件翻譯成您的語言寄給您。如需協助，請撥打您會員卡上的電話號碼與客戶聯絡中心聯絡或者撥打健康保險交易市場外的 Individual & Family Plan (IFP) 專線：1-800-839-2172（聽障專線：711）。如為加州保險交易市場，請撥打健康保險交易市場的 IFP 專線 1-888-926-4988（聽障專線：711），小型企業則請撥打 1-888-926-5133（聽障專線：711）。如為透過 Health Net 取得的團保計畫，請撥打 1-800-522-0088（聽障專線：711）。

Hindi
बिना शुल्क भाषा सेवाएं। आप एक दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेजों को अपनी भाषा में पढ़वा सकते हैं। मदद के लिए, अपने आईडी कार्ड में दिए गए नंबर पर ग्राहक सेवा केंद्र को कॉल करें या व्यक्तिगत और फैमिली प्लान (आईएफपी) ऑफ एक्सचेंज: 1-800-839-2172 (TTY: 711) पर कॉल करें। कैलिफोर्निया बाजारों के लिए, आईएफपी ऑन एक्सचेंज 1-888-926-4988 (TTY: 711) या स्मॉल बिजनेस 1-888-926-5133 (TTY: 711) पर कॉल करें। हेल्थ नेट के माध्यम से ग्रुप प्लान के लिए 1-800-522-0088 (TTY: 711) पर कॉल करें।

Hmong
Tsis Muaj Tus Nqi Pab Txhais Lus. Koj tuaj yeem tau txais ib tus kws pab txhais lus. Koj tuaj yeem muaj ib tus neeg nyeem cov ntaub ntawv rau koj ua koj hom lus hais. Txhawm rau pab, hu xovtooj rau Neeg Qhua Lub Chaw Tiv Toj ntawm tus npawb nyob ntawm koj daim npav ID lossis hu rau Tus Neeg thiab Tsev Neeg Qhov Kev Npaj (IFP) Ntawm Kev Sib Hloov Pauv: 1-800-839-2172 (TTY: 711). Rau California qhov chaw kiab khw, hu rau IFP Ntawm Qhov Sib Hloov Pauv 1-888-926-4988 (TTY: 711) lossis Lag Luam Me 1-888-926-5133 (TTY: 711). Rau Cov Pab Pawg Chaw Npaj Kho Mob hla Health Net, hu rau 1-800-522-0088 (TTY: 711).

Japanese
無料の言語サービスを提供しております。通訳者もご利用いただけます。日本語で文書をお読みすることも可能です。ヘルプが必要な場合は、IDカードに記載されている番号で顧客連絡センターまでお問い合わせいただくか、Individual & Family Plan（IFP）（個人・家族向けプラン）Off Exchange：1-800-839-2172（TTY：711）までお電話ください。カリフォルニア州のマーケットプレイスについては、IFP On Exchange 1-888-926-4988（TTY：711）または Small Business 1-888-926-5133（TTY：711）までお電話ください。Health Netによるグループプランについては、1-800-522-0088（TTY：711）までお電話ください。

Khmer
សេវាភាសាដោយឥតគិតថ្លៃ។ លោកអ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ លោកអ្នកអាចស្តាប់គេអានឯកសារឱ្យលោកអ្នកជាភាសារបស់លោកអ្នក។ សម្រាប់ជំនួយ សូមហៅទូរស័ព្ទទៅកាន់មជ្ឈមណ្ឌលទំនាក់ទំនងអតិថិជនតាមលេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក ឬហៅទូរស័ព្ទទៅកាន់កម្មវិធី Off Exchange របស់គម្រោងជាលក្ខណៈបុគ្គល និងក្រុមគ្រួសារ (IFP) តាមរយៈលេខ៖ 1-800-839-2172 (TTY: 711)។ សម្រាប់ទីផ្សាររដ្ឋ California សូមហៅទូរស័ព្ទទៅកាន់កម្មវិធី On Exchange របស់គម្រោង IFP តាមរយៈលេខ 1-888-926-4988 (TTY: 711) ឬក្រុមហ៊ុនអាជីវកម្មខ្នាតតូចតាមរយៈលេខ 1-888-926-5133 (TTY: 711)។ សម្រាប់គម្រោងជាក្រុមតាមរយៈ Health Net សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-800-522-0088 (TTY: 711)។

Korean
무료 언어 서비스입니다. 통역 서비스를 받으실 수 있습니다. 문서 낭독 서비스를 받으실 수 있으며 일부 서비스는 귀하가 구사하는 언어로 제공됩니다. 도움이 필요하시면 ID 카드에 수록된 번호로 고객서비스 센터에 연락하시거나 개인 및 가족 플랜(IFP)의 경우 Off Exchange: 1-800-839-2172(TTY: 711)번으로 전화해 주십시오. 캘리포니아 주 마켓플레이스의 경우 IFP On Exchange 1-888-926-4988(TTY: 711), 소규모 비즈니스의 경우 1-888-926-5133(TTY: 711)번으로 전화해 주십시오. Health Net을 통한 그룹 플랜의 경우 1-800-522-0088(TTY: 711)번으로 전화해 주십시오.

Navajo
Doo bą́ąh ílínígóó saad bee háká ada'iiyeed. Ata' halne'ígíí da ła' ná hádídóot'įįł. Naaltsoos da t'áá shí shizaad k'ehjí shichį' yídooltah nínízingo t'áá ná ákódoolníił. Ákót'éego shíká a'doowoł nínízingo Customer Contact Center hoolyéhíjį' hodíílnih ninaaltsoos nanitingo bee néého'dolzinígíí hodoonihjį' bikáá' éí doodago kojį' hólne' Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). California marketplace báhígíí kojį' hólne' IFP On Exchange 1-888- 926-4988 (TTY: 711) éí doodago Small Business báhígíí kojį' hólne' 1-888-926-5133 (TTY: 711). Group Plans through Health Net báhígíí éí kojį' hólne' 1-800-522-0088 (TTY: 711).

Persian (Farsi)
خدمات زبان بدون هزینه. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید اسناد به زبان شما برایتان خوانده شوند. برای دریافت کمک، با مرکز تماس مشتریان به شماره روی کارت شناسایی یا طرح فردی و خانوادگی (IFP) Off Exchange به شماره: 1-800-839-2172 (TTY:711) تماس بگیرید. برای بازار کالیفرنیا، با IFP On Exchange شماره 1-888-926-4988 (TTY:711) یا کسب و کار کوچک 1-888-926-5133 (TTY:711) تماس بگیرید. برای طرح های گروهی از طریق Health Net، با 1-800-522-0088 (TTY:711) تماس بگیرید.

Panjabi (Punjabi)
ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਦੀ ਸੇਵਾ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਗਾਹਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ ਕਾਲ ਕਰੋ ਜਾਂ ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਯੋਜਨਾ (IFP) ਔਫ਼ ਐਕਸਚੇਂਜ 'ਤੇ ਕਾਲ ਕਰੋ: 1-800-839-2172 (TTY: 711)। ਕੈਲੀਫੋਰਨੀਆ ਮਾਰਕਿਟਪਲੇਸ ਲਈ, IFP ਔਨ ਐਕਸਚੇਂਜ ਨੂੰ 1-888-926-4988 (TTY: 711) ਜਾਂ ਸਮੌਲ ਬਿਜ਼ਨੇਸ ਨੂੰ 1-888-926-5133 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਹੈਲਥ ਨੈੱਟ ਰਾਹੀਂ ਸਾਮੂਹਿਕ ਪਲੈਨਾਂ ਲਈ, 1-800-522-0088 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Russian
Бесплатная помощь переводчиков. Вы можете получить помощь переводчика. Вам могут прочитать документы на Вашем родном языке. Если Вам нужна помощь, звоните по телефону Центра помощи клиентам, указанному на вашей карте участника плана. Вы также можете позвонить в отдел помощи участникам не представленных на федеральном рынке планов для частных лиц и семей (IFP) Off Exchange 1-800-839-2172 (TTY: 711). Участники планов от California marketplace: звоните в отдел помощи участникам представленных на федеральном рынке планов IFP (On Exchange) по телефону 1-888-926-4988 (TTY: 711) или в отдел планов для малого бизнеса (Small Business) по телефону 1-888-926-5133 (TTY: 711). Участники коллективных планов, предоставляемых через Health Net: звоните по телефону 1-800-522-0088 (TTY: 711).

Spanish
Servicios de idiomas sin costo. Puede solicitar un intérprete, obtener el servicio de lectura de documentos y recibir algunos en su idioma. Para obtener ayuda, comuníquese con el Centro de Comunicación con el Cliente al número que figura en su tarjeta de identificación o llame al plan individual y familiar que no pertenece al Mercado de Seguros de Salud al 1-800-839-2172 (TTY: 711). Para planes del mercado de seguros de salud de California, llame al plan individual y familiar que pertenece al Mercado de Seguros de Salud al 1-888-926-4988 (TTY: 711); para los planes de pequeñas empresas, llame al 1-888-926-5133 (TTY: 711). Para planes grupales a través de Health Net, llame al 1-800-522-0088 (TTY: 711).

Tagalog
Walang Bayad na Mga Serbisyo sa Wika. Makakakuha kayo ng interpreter. Makakakuha kayo ng mga dokumento na babasahin sa inyo sa inyong wika. Para sa tulong, tumawag sa Customer Contact Center sa numerong nasa ID card ninyo o tumawag sa Off Exchange ng Planong Pang-indibidwal at Pampamilya (Individual & Family Plan, IFP): 1-800-839-2172 (TTY: 711). Para sa California marketplace, tumawag sa IFP On Exchange 1-888-926-4988 (TTY: 711) o Maliliit na Negosyo 1-888-926-5133 (TTY: 711). Para sa mga Planong Pang-grupo sa pamamagitan ng Health Net, tumawag sa 1-800-522-0088 (TTY: 711).

Thai
ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังเป็นภาษาของคุณได้ หากต้องการความช่วยเหลือ โทรหาศูนย์ลูกค้าสัมพันธ์ได้ที่หมายเลขบนบัตรประจำตัวของคุณ หรือโทรหาฝ่ายแผนบุคคลและครอบครัวของเอกชน (Individual & Family Plan (IFP) Off Exchange) ที่ 1-800-839-2172 (โหมด TTY: 711) สำหรับเขตแคลิฟอร์เนีย โทรหาฝ่ายแผนบุคคลและครอบครัวของรัฐ (IFP On Exchange) ได้ที่ 1-888-926-4988 (โหมด TTY: 711) หรือ ฝ่ายธุรกิจขนาดเล็ก (Small Business) ที่ 1-888-926-5133 (โหมด TTY: 711) สำหรับแผนแบบกลุ่มผ่านทาง Health Net โทร 1-800-522-0088 (โหมด TTY: 711)

Vietnamese
Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu c ầu được đọc cho nghe tài liệu bằng ngôn ngữ của quý vị. Để được giúp đỡ, vui lòng gọi Trung Tâm Liên Lạc Khách Hàng theo số điện thoại ghi trên thẻ ID của quý vị hoặc gọi Chương Trình Bảo Hiểm Cá Nhân & Gia Đình (IFP) Phi Tập Trung: 1-800-839-2172 (TTY: 711). Đối với thị trường California, vui lòng gọi IFP Tập Trung 1-888-926-4988 (TTY: 711) hoặc Doanh Nghiệp Nhỏ 1-888-926-5133 (TTY: 711). Đối với các Chương Trình Bảo Hiểm Nhóm qua Health Net, vui lòng gọi 1-800-522-0088 (TTY: 711).

CA Commercial On and Off-Exchange Member Notice of Language Assistance

FLY017549EH00 (12/17)

Offshore Subcontracting Attestation: Participating Provider

If you are a Health Net of California, Inc., Health Net Community Solutions, Inc. and/or Health Net Life Insurance Company (Health Net) participating provider (also referred to as first-tier, downstream or related entities) using offshore subcontractors, indicate your business name and tax identification (ID) number below.
Name of participating provider (if applicable): **Tax ID:**
If you manage multiple participating providers, list the name(s) and tax IDs for whom you are completing this attestation or attach a separate sheet.
Enter your name, title, phone number, signature, and date that you completed this attestation.
Name: **Title:** **Phone number:** **Signature:** **Date:**

Do you utilize offshore subcontractors? The Centers for Medicare & Medicaid Services (CMS) defines *offshore subcontractor* as follows: "The term subcontractor refers to any organization that a Medicare Advantage Organization or Part D sponsor contracts with to fulfill or help fulfill requirements in their Part C and/or Part D contracts. Subcontractors include all first-tier, downstream and/or related entities. The term offshore refers to any country that is not within the United States or one of the United States territories (American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands). Examples of countries that meet the definition of 'offshore' include Mexico, Canada, India, Germany, and Japan. Subcontractors that are considered offshore can be either American-owned companies with certain portions of their operations performed outside the United States or foreign-owned companies with their operations performed outside the United States. Offshore subcontractors provide services that are performed by workers located in offshore countries, regardless of whether the workers are employees of American or foreign companies." Health Net policy prohibits the transfer or storage of data outside the United States.	**Response:** **Yes** **No**
Do you engage in offshore subcontracting that involves processing, handling or accessing protected health information (PHI)? If "No," the survey is complete and you do not need to complete or submit the attestation. If "Yes," continue completing the form and submit a copy via mail or fax to: Health Net Kristina Rodriguez Director, Provider Network Management Operations Email: Kristina.M.Rodriguez@healthnet.com This form must be completed in full for each new offshore subcontractor, and sent to Health Net within 20 calendar days from the date the contract is signed with the offshore subcontractor to the address or fax number provided above.	**Response:** **Yes** **No**

Offshore Subcontracting Attestation: Participating Provider

Part I. Offshore subcontractor information	
Offshore subcontractor name:	
Offshore subcontractor country:	
Offshore subcontractor address:	
Describe offshore subcontractor functions:	
State proposed or actual effective date for offshore subcontractor (Month, day, year):	

Part II. Precautions for PHI	
Describe the PHI that will be provided to the offshore subcontractor:	
Discuss why providing PHI is necessary to accomplish the offshore subcontractor objectives:	
Describe alternatives considered to avoid providing PHI and why each alternative was rejected:	

Offshore Subcontracting Attestation: Participating Provider

Part III. Attestation of safeguards to protect beneficiary information in the offshore subcontract		
Item	**Attestation**	**Response: Yes No**
III.1	Offshore subcontracting arrangement has policies and procedures in place to ensure that beneficiary PHI and other personal information remain secure.	
	Participating provider to provide a copy of the policies and procedures that document the process used to ensure the security of beneficiary PHI and other personal information. Copies are provided to Health Net along with this completed attestation.	
III.2	Offshore subcontracting arrangement prohibits subcontractor's access to data not associated with the sponsor's contract with the offshore subcontractor.	
III.3	Offshore subcontracting arrangement has policies and procedures in place that allow for immediate termination of the subcontract upon discovery of a significant security breach.	
	Participating provider to provide a copy of the policies and procedures that document the process used for the immediate termination of the subcontract upon discovery of a significant security breach. Copies are provided to Health Net along with this completed attestation.	
III.4	Offshore subcontracting arrangement includes all required Medicare Part C and Part D language, such as record retention requirements, compliance with all Medicare Part C and Part D requirements, etc.	
	Applicable to participating providers contracting with Health Net for the Medicare Advantage line of business – Participating provider to provide a copy of the provider's agreement (proprietary information removed) with the offshore subcontractor. A copy is provided to Health Net along with this completed attestation.	

Part IV. Attestation of audit requirements to ensure protection of PHI		
Item	**Attestation**	**Response: Yes No**
IV.1	Participating provider will conduct an annual audit of the offshore subcontractor.	
	Participating provider to provide a copy of the policies and procedures documenting the process used for conducting annual audits, for monitoring and tracking results, and resolving any identified deficiencies. Copies are provided to Health Net along with this completed attestation.	
IV.2	Audit results are used by the participating provider to evaluate the continuation of its relationship with the offshore subcontractor.	
IV.3	Participating provider agrees to share offshore subcontractors' audit results with Health Net or CMS upon request.	

OUTPATIENT CALIFORNIA HEALTHNET COMMERCIAL AUTHORIZATION FORM

Complete and **Fax** to: 1-844-694-9165
Transplant **Fax** to: 1-833-769-1142

HMO

POS

PPO

Request for additional units. Existing Authorization Units

Standard requests - Determination within 5 business days of receiving all necessary information.

Urgent requests - I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 72 hours to avoid complications and unnecessary suffering or severe pain.

X URGENT REQUESTS MUST BE SIGNED BY THE REQUESTING PHYSICIAN TO RECEIVE PRIORITY.

*** INDICATES REQUIRED FIELD**

MEMBER INFORMATION

Last Name, First *Date of Birth (MMDDYYYY)

*Member ID

REQUESTING PROVIDER INFORMATION

Requesting Provider Contact Name

*Requesting NPI *Requesting TIN Phone

Requesting Provider *Address* *Fax

City, State, Zip

SERVICING PROVIDER / FACILITY INFORMATION

Same as Requesting Provider Servicing Provider Contact Name -

*Servicing NPI *Servicing TIN - Phone

Servicing Provider/Facility Name *Address* Fax

City, State, Zip

AUTHORIZATION REQUEST

***Primary** Procedure Code (CPT/HCPCS) (Modifier

Additional Procedure Code (CPT/HCPCS) (Modifier

***Start Date** OR Admission Date (MMDDYYYY)

*Diagnosis Code (ICD-10)

Additional Procedure Code (CPT/HCPCS) (Modifier

Additional Procedure Code (CPT/HCPCS) (Modifier

End Date OR Discharge Date (MMDDYYYY)

Total Units/Visits/Days

(Enter the Service type number in the boxes)

*OUTPATIENT SERVICE TYPE

412 Auditory
422 Biopharmacy
712 Cochlear Implants & Surgery
299 Drug Testing
922 Experimental and Investigational Services
205 Genetic Testing & Counseling
249 Home Health
390 Hospice Services
290 Hyberbaric Oxygen Therapy
395 Infertility Diagnosis or Treatment
211 OB Ultrasound
410 Observation
997 Office Visit/Consult
210 Orthotics
794 Outpatient Services
171 Outpatient Surgery
202 Pain Management
147 Prosthetics
428 Second Opinion
201 Sleep Study
993 Transplant Evaluation
209 Transplant Surgery
724 Transportation

Behavioral Health

533 BH Applied Behavioral Analysis
512 BH Community Based Services
515 BH Electroconvulsive Therapy
516 BH Intensive Outpatient Therapy
510 BH Medical Management
518 BH Mental Health /Chemical Dependency Observation
519 BH Outpatient Therapy
530 BH PHP
520 BH Professional Fees
522 BH Psychiatric Evaluation
521 BH Psychological Testing

DME

417 Rental
120 Purchase (Purchase Price)

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Rev.02242021
XD-PAF-1654

health net

Request for Necessary Medical Information for Prior Authorization

URGENT REQUEST FOR CONTINUING OCCUPATIONAL, PHYSICAL or SPEECH THERAPY

WARNING: THIS FAX CONTAINS PRIVATE AND CONFIDENTIAL INFORMATION

Patient Information

Patient Name	Subscriber ID #
Date of Birth	Today's Date

Provider Information

Facility Name	Facility Tax ID #
Telephone #	Fax
Requesting Physician Name	ICD-9 Code
Facility Contact Person	Telephone # of Contact Person

In order to process the prior authorization request for occupational, physical or speech therapy regarding the above patient, complete the information requested below and return this form to the Health Net Prior Authorization Department by fax at (800) 672-2135.

Please ensure that all information is legible and that only standard abbreviations are used. The information regarding dates of visits is very important in order to calculate benefits and availability of additional visits.

Occupational and Physical Therapy
1. What is the patient's diagnosis (describe in detail)?
2. What is the patient's dominant hand? Right or left?
3. What was the exact date of surgery and the exact type of surgery?
4. How many physical or occupational therapy visits has the patient had since original date of injury or surgery through last December 31?
5. How many physical or occupational therapy visits has the patient had since January 1 of this year and when was the last visit?
6. How many additional visits are being requested at this time and what will be the start date of the requested additional visits?

7. What are the exact physical or occupational therapy modalities being utilized at this time?	
8. What was the patient's range of motion at the onset of physical or occupational therapy?	
9. What was the patient's range of motion four weeks ago?	Date:
10. What was the patient's range of motion two weeks ago?	Date:
11. What is the patient's range of motion now?	Date:
12. What exercises has the patient been performing?	
13. How many repetitions and at what weight was the patient able to perform at the start of therapy?	Date:
14. How many repetitions and at what weight was the patient able to perform four weeks ago?	Date:
15. How many repetitions and at what weight was the patient able to perform two weeks ago?	Date:
16. How many repetitions and at what weight is the patient able to perform now?	Date:
17. What is the goal range of motion and goal strength?	
18. When do you anticipate the member will reach this goal?	
19. When do you anticipate the member will be transitioned to a home exercise program?	

Speech Therapy
1. Please provide the plan of care addressing the following: a. The date of onset or exacerbation of the disorder/diagnosis: b. Specific statements of long-term and short-term goals: c. Quantitative objectives measuring current age-adjusted level of functioning: d. A reasonable estimate of when the goals will be reached: e. The specific treatment techniques or exercises to be used in treatment: f. The frequency and duration of treatment:
2. How many speech therapy sessions have been provided this calendar year prior to this request?
3. Is there progress or improvement with the therapy?

Please attach any additional documentation supporting this request to the back of this form.

Fax the requested information to:

Health Net Prior Authorization Department
(**800) 672-2135**

Potential Quality Issue (PQI) Referral Form

(Includes HACs/HCACs, OPPCs and SRAEs)

Do not photocopy this form. The information contained is confidential and peer-review protected.

Check one:

☐ Medical/physical medicine PQIs (Complete all fields and forward immediately **via secure fax: 877-808-7024**)
☐ Behavioral health PQIs (Complete all fields and forward immediately **via secure email: pqi@healthnet.com**)

The Potential Quality Issue (PQI) Referral Form is to be used to report any potential or suspected deviation from the standard of care that cannot be determined to be justified without additional review. It should also be used for hospital-acquired conditions (HACs), health care-acquired conditions (HCACs), other provider preventable conditions (OPPCs), and serious reportable adverse events (SRAEs).

Important

The PQI Referral Form is a confidential document used by the Quality Management Program to aid in the evaluation and improvement of the overall quality of care delivered to Health Net enrollees. PQI referral forms are reviewed and evaluated confidentially in a separate and secure manner.

Refer issues identified as *member appeals* or *member grievances* to the Member Appeals and Grievances Department for appropriate case handling and resolution.

To protect the confidentiality and privilege of this PQI referral, follow the guidelines outlined below:

1. Never discuss the details of this referral reporting with anyone (including the enrollee) other than those to whom you have been specifically directed to communicate with by your supervisor or a representative of the PQI review entity.
2. Although you must never refer to the referral reporting itself within the member's medical records, you should objectively record pertinent facts of the incident (for example, injury or medication reaction) within the record whenever appropriate.
3. Never make or retain photocopies of this PQI referral reporting under any circumstances.
4. Never use or refer to this report in associate disciplinary action of any kind or any time.

Referral Content

1. All the fields on the PQI form are **required** fields.
2. Use the fillable PDF form to complete the PQI referral. Do not fax a handwritten PQI referral form. Handwritten PQI forms will be returned to originator for proper re-submission.
3. All sections of the PQI referral must be completed.
4. The form should be completed as follows:
    a) Referral source - Include referral date, first and last name of the associate completing the referral, contact information (telephone number, fax number) and the name of the associate who identified the PQI. If same as the referred by, enter *same as referred by* in this section.
    b) Member demographics – Include member first and last name, member ID, member's current primary care physician (PCP) and the associated participating physician group (PPG).
    c) PQI Event Dates / Filed Against Details – Include date of event, first and last name of practitioner that PQI is filed against (if same as PCP, re-enter PCP and PPG name here) and practitioner's office location. If hospital, please include name of hospital and location. Provide an admission date. Indicate the type of PQI using the check box items provided on the PQI referral. In the description of event field, describe event(s) chronologically, including dates, provider or practitioner names, specify any equipment or medication involved, quote relevant statements made by the provider or others and provide a complete explanation describing the potential deviation in the standard of care.
5. Complete and submit this report directly within one business day of the event/occurrence. The case will be forwarded for clinical evaluation and/or review.
6. Incomplete referral forms are returned to the associate, such as the registered nurse (RN), who initiated the referral and/or his or her supervisor via email.

Referral Source

Referral date:_____

Referred by *(First, Last Name)*: _____

Identified by *(First, Last Name)*: _____

Phone number: _____

Fax number: _____

Member Demographics

Member name *(Last, First, MI)*: _____

ID#: _____

Current primary care physician (PCP): _____

Current participating physician group (PPG): _____

PQI Event Dates

Date(s) of PQI event:_____

Admission date:_____

Prior admission dates (if applicable): _____

_____

Filed Against Details:

Provider/Practitioner name: *(First, Last or name of facility)*: _____

Associated Provider/Practitioner PPG: _____

Provider/Practitioner location: _____

Provider/Practitioner NPI#:_____

HAC/HCAC, OPPC, SRAE, & and other PQI Indicators

Surgical events:

- ☐ **Surgery on wrong body part**
- ☐ **Surgery on wrong patient**
- ☐ **Wrong surgical procedures on a patient**
- ☐ **Foreign object retained after surgery**
- ☐ Anesthesia adverse event
- ☐ **Surgery with post-operative/intra-operative death in a normal healthy patient**
- ☐ Acute MI or CVA within 48 hours after elective surgery
- ☐ Cardiac or respiratory arrest in the operating room (OR)
- ☐ Unplanned return to OR, unplanned removal, injury or repair of an organ
- ☐ Other (explain) _____

Surgical site/post-operative infections:

- ☐ **Mediastinitis after coronary artery bypass graft (CABG)**
- ☐ **Bariatric surgery for obesity (laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery)**
- ☐ **Orthopedic procedures on spine, neck, shoulder, elbow, knee or hip**
- ☐ Other (explain) _____

Bolded text indicates HAC/HCAC, OPPC or SRAE

Patient death/disability:

- ☐ Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a health care facility
- ☐ Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics
- ☐ Patient death or serious disability associated with use or function of a device in patient care in which the device is used or functions other than as intended
- ☐ Patient death or serious disability associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration)
- ☐ Unexpected death (Please explain) _____

Patient issue:

- ☐ Member leaves against medical advice (AMA) when there is a potential for serious adverse event(s)
- ☐ Patient suicide attempt or serious injury to self while in treatment
- ☐ Other (explain)_____

HAC/HCAC, OPPC, SRAE, & AND OTHER PQI INDICATORS

Hospital-acquired (nosocomial) infections:

- ☐ **Catheter-associated urinary tract infection (UTI)**
- ☐ **Vascular catheter-associated Infection**
- ☐ Other (explain) _____

Deep vein thrombosis or pulmonary embolism following orthopedic procedures:

- ☐ **Total knee replacement**
- ☐ **Total hip replacement**
- ☐ Other (explain) _____

Falls (with trauma):

- ☐ **Fractures**
- ☐ **Dislocations**
- ☐ **Intracranial injuries**
- ☐ Other (explain) _____

Injury:

- ☐ **Crushing injuries**
- ☐ **Burns**
- ☐ **Electric shock**
- ☐ Other (explain) _____

Manifestations of poor glycemic control:

- ☐ **Diabetic ketoacidosis**
- ☐ **Nonketotic hyperosmolar coma**
- ☐ **Hypoglycemic coma**
- ☐ **Secondary diabetes with ketoacidosis**
- ☐ **Secondary diabetes with hyperosmolarity**

Obstetrics:

- ☐ Nonmedically indicated (elective) delivery less than 39 weeks gestational age
- ☐ Newborn Apgar < 4 at 1 minute or < 6 at 5 minutes

BOLDED TEXT INDICATES HAC/HCAC, OPPC OR SRAE

Admission/readmission/discharge:

- ☐ Unexpected / unanticipated readmission within 30 days to acute level of care with same or similar diagnosis or as a complication of the previous admission
- ☐ Unplanned admission following diagnostic test or outpatient procedure
- ☐ Neurological deficit present at discharge not present on admit
- ☐ Delay in transfer/treatment or discharge – which results in a poor outcome to the member or additional costs to the plan
- ☐ Delayed diagnosis or missed diagnosis – resulting in adverse member outcome or extended hospital stay
- ☐ **Infant discharged to the wrong person**

Outpatient/ambulatory care:

- ☐ Breach of member confidentiality or ethics concern/violation
- ☐ Abnormal diagnostic study not followed up appropriately where the potential for adverse outcome exists
- ☐ Inattention to or lack of appropriate follow-up of consultant's major recommendations without appropriate rationale
- ☐ Practitioner's failure to follow-up on any member's significant complaint or physical finding within a reasonable period of time
- ☐ Members with a disease process requiring follow-up with no evidence of follow-up and no documentation in the medical records of member contact for follow-up
- ☐ Hospitalization resulting from inappropriate drug therapy

Other:

- ☐ Pressure ulcer stages III & IV occurring after hospital admission
- ☐ Air embolism
- ☐ Blood transfusion incompatibility
- ☐ Any substandard care with the potential for harm to the member (please explain fully) _____
- ☐ Member refused to file a grievance
- ☐ Grievance withdrawal
- ☐ Other (select only when no other selection is applicable and explain fully) _____

HAC/HCAC, OPPC, SRAE, & AND OTHER PQI INDICATORS	BOLDED TEXT INDICATES HAC/HCAC, OPPC OR SRAE

Behavioral health:

- ☐ Inadequate assessment
- ☐ Inadequate treatment strategy or intervention
- ☐ Quality of patient relationship with provider appears very poor
- ☐ Inadequate discharge planning or follow-up
- ☐ Failure to utilize appropriate collateral contacts and/or coordinate care
- ☐ Lack of timely intervention that doesn't involve medication
- ☐ Patient's condition requires medication evaluation, but no referral was made
- ☐ Incident of drug/alcohol use in a facility
- ☐ Incident of possession of a weapon in a facility
- ☐ Situation where provider/facility acted in such a way as to create potential safety concerns
- ☐ Patient assaulting or causing serious injury to other or other criminal activity
- ☐ Use of restrictive interventions (seclusion, restraints, isolation) inconsistent with accepted standards and regulations
- ☐ Clinical risk inadequately assessed or managed
- ☐ Medication error, incident or concern
- ☐ Alleged abuse of child, adolescent or elder not reported to appropriate authorities

Description of event:
Based on my judgment, I believe there was a deviation in the standard of care resulting in a potential quality of care issue for the following reasons (please provide complete and detailed summary – must be typed, not handwritten):

Provider Dispute Resolution Request

Commercial and Medi-Cal

INSTRUCTIONS

- Please complete the form fields below. Fields with an asterisk (*) are required. Forms with incomplete fields may be returned and delay processing.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- For routine follow-up status, please call the appropriate telephone number below.
- Mail the completed form to the following address. Please note the specific address for all Medi-Cal appeals.

Health Net Commercial Provider Appeals Unit
PO Box 9040 Farmington, MO 63640-9040
Commercial Provider Services Center 1-800-641-7761

Health Net Medi-Cal Provider Appeals Unit
PO Box 989881 West Sacramento, CA 95798-9881
Medi-Cal Provider Services Center 1-800-675-6110

*Provider name:	*Provider tax ID #:
*Provider address	Contracted? ☐ Yes ☐ No

Provider type: ☐ Physician ☐ Mental health ☐ Hospital ☐ ASC/outpatient services ☐ SNF ☐ DME ☐ Rehab
☐ Home health ☐ Ambulance ☐ Other professional (please specify type of other) _____

***Claim information:** ☐ Single ☐ Multiple **"LIKE"** claims (complete attached spreadsheet) Number of claims _____

*Patient name:	Date of birth:

*Health Plan ID number:	*Subscriber ID/CIN number:	*Original claim ID/Submission ID number: (If multiple claims, use attached spreadsheet)
*Service from/to date:	Original claim amount billed:	Original claim amount paid:

Dispute type: ☐ Claim ☐ Appeal of medical necessity/utilization management decision ☐ Contract dispute
☐ Seeking resolution of a billing determination ☐ Disputing a request for reimbursement of overpayment ☐ Other

***Description of dispute:** Indicate reason for dispute, provider's position and reasoning: (Additional paper can be attached if necessary)

***Expected outcome:** (Please provide by claim if multiple.)

_____ Contact name (please print)

_____ Title

(____) _____ Area code and phone number

_____ Signature and date

_____ Email address

(____) _____ Area code and fax number

☐ **Check here if additional information is attached: (Please do not staple information.)**

For Health Plan Use Only
Case# _____
Provider# _____

Page ___ of ___

21-225a/FRM047551EC00 (3/21)

Commercial and Medi-Cal Provider Dispute Resolution Request, *continued*

INSTRUCTIONS (for use with multiple like claims only)

- Please complete the form fields below. Fields with an asterisk (*) are required. Forms with incomplete fields may be returned and delay processing.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
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PO Box 989881 West Sacramento, CA 95798-9881
Medi-Cal Provider Services Center 1-800-675-6110

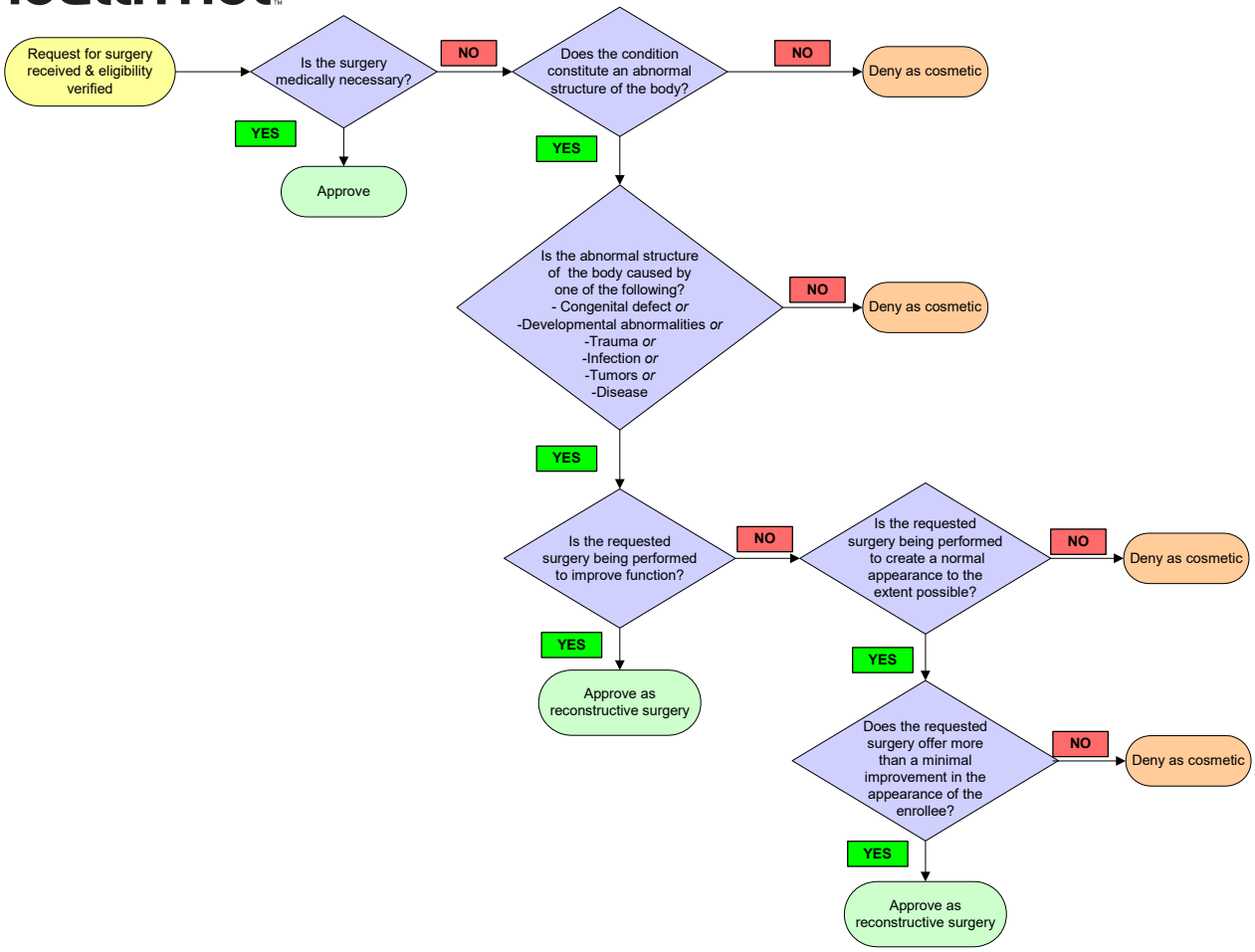
Number	*Patient name		Date of birth	*Subscriber ID/CIN number	*Original claim ID/Submission ID number	*Service from/to date	Original claim amount billed	Original claim amount paid	*Expected outcome
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									

☐ **Check here if additional information is attached:**
(Please do not staple information.)

For Health Plan Use Only
Case# _____
Provider# _____

21-225a/FRM047551EC00 (3/21)

Reconstructive Surgery Decision Tree



Health Net Transplant Performance Centers

			Line of Business				
Center	**Transplant**	**Type**	**HMO**	**Medicare**	**PPO/EPO**	**MEDI-CAL**	**EC PPO**
California Pacific Medical Center - San Francisco	**Kidney**	Adult	X	X	X	X*	Enhanced Care PPO utilizes OptumHealth Transplant Network
	Kidney-Pancreas	Adult	X	X	X	X	
	Liver	Adult	X	X	X	X	
	Pancreas	Adult	X	X	X	X	
	Liver-Kidney	Adult	X	X	X	X	
	Heart	Adult	X	X	X	X	
Cedars-Sinai Medical Center - Los Angeles	**Heart**	Adult	X		X		
	Kidney	Adult	X		X		
	Liver	Adult	X		X		
	Stem Cell	Adult	X		X		
		Autologous	X		X		
		Allogeneic Related & Unrelated	X		X		
Children's Hospital and Research Ctr at Oakland "Publicly know as UCSF Benioff Children's Hospital Oakland"	**Stem Cell**	Pediatric	X		X		
		Autologous	X		X		
		Allogeneic Related	X		X		
Children's Hospital of Los Angeles	**Heart**	Pediatric	X		X		
	Liver	Pediatric	X		X		
	Kidney	Pediatric	X		X		
	Stem Cell	Pediatric	X		X		
		Autologous	X		X		
		Allogeneic Related & Unrelated	X		X		
Children's Hospital of Orange County - Orange	**Stem Cell**	Pediatric	X		X		
		Autologous	X		X		
		Allogeneic Related & Unrelated	X		X		
Loma Linda University Medical Center - Loma Linda	**Heart**	Pediatric	X	X	X		
	Kidney	Adult	X	X	X		
		Pediatric	X	X	X		
	Kidney-Pancreas	Adult	X	X	X		
		Pediatric	X	X	X		
	Liver	Adult	X	X	X		
		Pediatric	X	X	X		
	Pancreas	Adult	X	X	X		
		Pediatric	X	X	X		
Lucile Packard Children's Hospital	**Heart**	Pediatric	X		X	X	
	Heart-Lung	Pediatric	X		X	X	
	Kidney	Pediatric	X		X	X	
	Kidney-Pancreas	Pediatric				X	
	Liver	Pediatric	X		X	X	
	Lung	Pediatric	X		X	X	
	Pancreas	Pediatric				X	
	Stem Cell	Pediatric	X		X	X	
		Autologus Allogeneic Related & Unrelated	X		X	X	
		Allogeneic Related & Unrelated	X		X	X	
Rady Childrens Hospital	**Kidney**	Pediatric	X		X		
	Stem Cell	Pediatric	X		X		
		Autologous	X		X		
		Allogeneic Related & Unrelated	X		X		
Scripps Health - San Diego	**Kidney**	Adult	X	X	X		
	Liver	Adult	X	X	X		
	Stem Cell	Adult	X	X	X		
		Autologous	X	X	X		
		Allogeneic Related & Unrelated	X	X	X		

Updated 1/27/2022

Health Net Transplant Performance Centers

			Line of Business				
Center	**Transplant**	**Type**	**HMO**	**Medicare**	**PPO/EPO**	**MEDI-CAL**	**EC PPO**
Sharp Healthcare System	**Heart**	Adult	X	X	X	X	Enhanced Care PPO utilizes OptumHealth Transplant Network
	Kidney	Adult	X		X	X	
Stanford University Hospital - Palo Alto	**Heart**	Adult	X	X	X	X	
	Heart-Lung	Adult	X	X	X	X	
	Kidney	Adult	X	X	X	X	
	Kidney-Pancreas	Adult	X	X	X	X	
	Liver	Adult	X	X	X	X	
	Lung	Adult	X	X	X	X	
	Pancreas after Kidney TP	Adult	X	X	X	X	
	Stem Cell	Adult	X	X	X	X	
		Autologous	X	X	X	X	
		Allogeneic Related & Unrelated	X	X	X	X	
Sutter Medical Center Sacramento	**Heart**	Adult	X	X	X	X	
	Stem Cell	Adult Allogeneic	X	X	X	X	
		Adult Autologous	X	X	X	X	
UC Davis - Sacramento	**Kidney**	Adult Cadaveric & Adult	X	X	X	X	
	Stem Cell	Adult	X	X	X		
		Autologous	X	X	X		
		Allogeneic Related & Unrelated	X	X	X		
UC San Diego - San Diego	**Kidney**	Adult	X	X	X	X	
	Heart	Adult	X	X	X		
	Liver	Adult	X	X	X		
	Lung	Adult	X	X	X		
	Stem Cell	Adult	X	X	X		
		Autologous	X	X	X		
		Allogeneic Related & Unrelated	X	X	X		
UCSF - SAN FRANCISCO	**Heart**	Adult	X	X	X		
		Pediatric	X		X		
	***Heart-Lung**	Adult	*	**	*		
		Pediatric	*		*		
	Kidney	Adult	X	X	X		
		Pediatric	X		X		
	Kidney-Pancreas	Adult	X	X	X		
	Liver	Pediatric	X		X		
		Adult	X	X	X		
	Lung	Adult	X	X	X		
	Pancreas	Adult	X	X	X		
	***Pancreas Autologous Islet Cell**	Adult	*	**	*		
	Stem Cell	Adult	X	X	X		
		Pediatric	X		X		
		Autologous	X	X	X		
		Allogeneic Related & Unrelated	X	X	X		

Health Net Transplant Performance Centers

			Line of Business				
Center	**Transplant**	**Type**	**HMO**	**Medicare**	**PPO/EPO**	**MEDI-CAL**	**EC PPO**
Ronald Reagan UCLA Medical Center.	**Heart**	Adult	X		X		Enhanced Care PPO utilizes OptumHealth Transplant Network
		Pediatric	X		X		
	Kidney	Adult	X		X		
		Pediatric	X		X		
	Kidney-Pancreas	Adult	X		X		
	Liver	Adult	X		X		
		Pediatric	X		X		
	Lung	Adult	X		X		
	Pancreas	Adult	X		X		
	Small Bowel	Adult	X		X		
		Pediatric	X		X		
	Stem Cell	Adult	X		X		
		Pediatric	X		X		
		Autologous	X		X		
		Allogeneic Related & Unrelated	X		X		
	Liver-Kidney	Adult	X		X		
		Pediatric	X		X		
Keck Hospital of USC.	**Heart**	Adult	X		X		
	Heart-Lung	Adult	X		X		
	Kidney	Adult	X		X		
	Liver	Adult	X		X		
	Lung	Adult	X		X		
	Kidney-Pancreas	Adult	X		X		
	Stem Cell	Adult	X		X		

Updated 1.27.22

X = Participating and Blank = Non Par

*	Transplant is individually negotiated by Letter of Agreement
**	Medicare LOB- Transplant is individually negotiated by Letter of Agreement
***	Medi-Cal LOB- Transplant is individually negotiated by Letter of Agreement

health net

Request for Necessary Medical Information for Prior Authorization

URGENT REQUEST FOR CONTINUING HOME HEALTH SERVICES

WARNING: THIS FAX CONTAINS PRIVATE AND CONFIDENTIAL INFORMATION

Patient Information

Patient Name	Subscriber ID #
Date of Birth	Today's Date

Provider Information

Facility Name	Facility Tax ID #
Telephone #	Fax
Requesting Physician Name	ICD-9 Code
Facility Contact Person	Telephone # of Contact Person

In order to process the prior authorization request for home health services regarding the above patient, complete the information requested below and return this form to the Health Net Prior Authorization Department by fax at (800) 672-2135.

Please ensure that all information is legible and that only standard abbreviations are used.

SERVICES TO BE PROVIDED
1. Type of services (for example, wound care, teaching, infusion):
2. Frequency of services:
3. How many visits are being requested?
4. How many visits have already been performed?
5. a. Start date of service: b. Anticipated completion date of services:

WOUND CARE
6. Current size of wound: Length_____Width_____Depth _____ Type_____ Amount of drainage_____

7. Type of wound care being performed:
8. Date and type of surgery or description of etiology of wound (for example, diabetic ulcer):

HOME INFUSION
9. Type of medication:
10. Frequency of services:
11. Is medication also being requested or is this request just for nursing? If medication is also being requested, please attach documentation describing patient's clinical diagnosis and medical records supporting the diagnosis, including applicable lab data.

HOME IV THERAPY
12. Type of medication:
13. Frequency of dosing:
14. Describe family/patient's ability/inability to self administer:
15. Diagnosis:

HOME HEALTH TEACHING
16. Document teaching needs, date teaching has been performed, and patient/family response to teaching:

ADDITIONAL QUESTIONS
17. Other services, please describe:
18. When will patient be independent in care? What steps are being taken to discharge from service and when is discharge anticipated?

Please attach physician’s order and documentation confirming homebound status and any additional documentation supporting this request to the back of this form.

Fax the requested information to:

Health Net Prior Authorization Department
(**800) 672-2135**

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Request for Necessary Medical Information for Prior Authorization

URGENT REQUEST FOR CONTINUING OCCUPATIONAL, PHYSICAL or SPEECH THERAPY

WARNING: THIS FAX CONTAINS PRIVATE AND CONFIDENTIAL INFORMATION

Patient Information

Patient Name	Subscriber ID #
Date of Birth	Today's Date

Provider Information

Facility Name	Facility Tax ID #
Telephone #	Fax
Requesting Physician Name	ICD-9 Code
Facility Contact Person	Telephone # of Contact Person

In order to process the prior authorization request for occupational, physical or speech therapy regarding the above patient, complete the information requested below and return this form to the Health Net Prior Authorization Department by fax at (800) 672-2135.

Please ensure that all information is legible and that only standard abbreviations are used. The information regarding dates of visits is very important in order to calculate benefits and availability of additional visits.

Occupational and Physical Therapy
1. What is the patient's diagnosis (describe in detail)?
2. What is the patient's dominant hand? Right or left?
3. What was the exact date of surgery and the exact type of surgery?
4. How many physical or occupational therapy visits has the patient had since original date of injury or surgery through last December 31?
5. How many physical or occupational therapy visits has the patient had since January 1 of this year and when was the last visit?
6. How many additional visits are being requested at this time and what will be the start date of the requested additional visits?

7. What are the exact physical or occupational therapy modalities being utilized at this time?	
8. What was the patient's range of motion at the onset of physical or occupational therapy?	
9. What was the patient's range of motion four weeks ago?	Date:
10. What was the patient's range of motion two weeks ago?	Date:
11. What is the patient's range of motion now?	Date:
12. What exercises has the patient been performing?	
13. How many repetitions and at what weight was the patient able to perform at the start of therapy?	Date:
14. How many repetitions and at what weight was the patient able to perform four weeks ago?	Date:
15. How many repetitions and at what weight was the patient able to perform two weeks ago?	Date:
16. How many repetitions and at what weight is the patient able to perform now?	Date:
17. What is the goal range of motion and goal strength?	
18. When do you anticipate the member will reach this goal?	
19. When do you anticipate the member will be transitioned to a home exercise program?	

Speech Therapy
1. Please provide the plan of care addressing the following: a. The date of onset or exacerbation of the disorder/diagnosis: b. Specific statements of long-term and short-term goals: c. Quantitative objectives measuring current age-adjusted level of functioning: d. A reasonable estimate of when the goals will be reached: e. The specific treatment techniques or exercises to be used in treatment: f. The frequency and duration of treatment:
2. How many speech therapy sessions have been provided this calendar year prior to this request?
3. Is there progress or improvement with the therapy?

Please attach any additional documentation supporting this request to the back of this form.

Fax the requested information to:

Health Net Prior Authorization Department
(**800) 672-2135**