Provider Manual - Combined

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Provider Manual

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

The HMO Operations Manual offers Health Net providers access to important plan benefits, limitations and administration processes to make sure members enrolled in the HMO plan receive covered services when needed. The Health Net HMO plan is underwritten by Health Net of California, Inc. and is regulated by the California Department of Managed Health Care (DMHC).

Benefits and policies listed in the HMO Operations Manual apply to all HMO plans, unless specified otherwise in the *Provider Participation Agreement* (*PPA*), *Schedule of Benefits* or member's *Evidence of Coverage* (*EOC*). Information on the tier one (HMO) of the Point of Service (POS) line of business is also included in the HMO Operations Manual.

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
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 | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section describes initial organization determinations, member and provider appeals and dispute resolution processes, and peer-to-peer review requests.

Select any subject below:

- Member Appeals
- Provider Appeals and Dispute Resolution
- Grievances

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
- DMHC Consumer Assistance
- Investigational or Experimental Treatment
- Request for Information

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

All participating providers have five calendar days from receipt of a Health Net request for information 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 Managed Health Care (DMHC). This includes sending members an application form and addressed envelope so members can request an independent medical review (IMR) through the DMHC 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 DMHC, the 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.

DMHC Consumer Assistance

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

The Department of Managed Health Care (DMHC) maintains a program that assists consumers with resolution of problems and complaints involving HMOs. Members are advised of the DMHC requirements in 12-point bold type in their Evidence of Coverage (EOC), on the Health Net Member Grievance Form (PDF), on the appeal form, and on all correspondence and notices relating to complaints.

If the grievance involves an immediate and serious threat to the member's health, the member may seek immediate assistance from DMHC. Participating providers may assist the member in submitting a complaint to the department for resolution and may advocate the member's cause before the department. No participating provider may be sanctioned by Health Net or by a participating physician group (PPG) for giving such assistance to a member.

Online Complaint and Independent Medical Review Application Form

In addition to submitting required paperwork and forms via mail or fax, DMHC launched a secure online form to allow members to file complaints regarding their health plan electronically. The portal is available in both English and Spanish and enables consumers to request an external review of Health Net's denial of medical services, through Independent Medical Review (IMR). The Online Complaint and Independent Medical Review Application Form, can be accessed through the DMHC website. To obtain additional information regarding IMR, refer to Dispute Resolutions and Appeals > Member Appeals > Appeals Process.

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 Managed Health Care (DMHC).

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.

Request for Information

Provider Type: Participating Physician Groups (PPG)

A participating physician group (PPG) has five calendar days after receiving a request for information from Health Net regarding a member appeal to submit the necessary case file information to Health Net. The case file information includes the medical records, rationale for denial and alternative treatment plan. PPGs must follow Health Net's provider information request process when submitting information on member appeals and pertinent case file documentation to Health Net.

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

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 participating physician group's (PPG's) written determination following its dispute resolution process 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 PPG's written determination.
- Challenge capitated PPG or hospital liability for medical services and payments that are the result of Health Net decisions arising from member grievances, appeals and other member services actions.
- Challenge capitation deductions that are the result of Health Net decisions arising from member billings, claims or member eligibility determinations.

Health Net does not charge providers of service who submit disputes to the Health Net Provider Appeals Unit or the Health Net Medi-Cal Appeals Unit for processing provider disputes and does not discriminate or retaliate against a participating provider who uses the provider dispute process. Further, providers participating through a Health Net PPG cannot be charged a processing fee when utilizing the PPG's 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 resolution process (PDF), a provider inquiry process is available for routine claim follow-up when a participating provider wants to:

- Inquire regarding 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 for members:

- Health Net Provider Services Center - Commercial (HMO, HSP, EPO, PPO)
- Health Net Medi-Cal Provider Services Center
- Community Health Plan of Imperial Valley Provider Services Center
- CalViva Health Provider Services Center

Overview for Physicians

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, the Health Net Provider Appeals Unit - IFP or the Health Net Medi-Cal Appeals Unit 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.
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To check the status of an appeal or dispute, contact the applicable Health Net Provider Services Center for members:

- Health Net Provider Services Center - Commercial (HMO, HSP, EPO, PPO)
- Health Net Medi-Cal Provider Services Center
- Community Health Plan of Imperial Valley Provider Services Center
- CalViva Health 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.

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.

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

B

- Bariatric Surgery
- Behavioral Health
- Blood

C

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

D

- Dental Services
- Dialysis
- Doula Services
- 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
- Incarcerated Members
- Injectables

J

K

L

M

- Maternity
- Medical Social Services

N

- Nuclear Medicine
- Nurse Midwife

O

- Obesity
- Outpatient Services

P

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

Q

R

- Rehabilitation Therapy
- Routine Physical Exam

S

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

T

- TMJ
- Transgender Services
- Transplants
- Tuberculosis Screening

U

V

- Vision

W

X

- X-Ray and Laboratory Services

Y

Z

Acupuncture

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

AIDS

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

This section contains general member benefit information on AIDS/HIV injectable medications. Refer to AIDS Definition for additional information.

Select any subject below:

- AIDS/HIV Injectable Medications
- Claims Submission

AIDS/HIV Injectable Medications

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

AIDS/HIV injectable medications are injectable medications that have been approved by the Food and Drug Administration (FDA) and Health Net for the treatment of AIDS/HIV. Refer to the Health Net Injectable Medication HCPCS/DOFR Crosswalk (PDF) for covered AIDS/HIV injectable medications.

Claims Submission

Participating Physician Groups (PPG)

To be reimbursed for AIDS-related claims through special risk reinsurance, participating physician groups (PPGs) must submit a Health Net Professional Batch form completed as follows:

- "Special Risk Reinsurance" must be written at the top of the form
- Attach CMS-1500 or UB-92 form, as follows:
  - Original copies or a very clear photocopy
  - Itemized bills attached to each inpatient claim
  - Itemized bills attached to each electronic claim
- Attach a copy of the explanation of check, if applicable
- Attach copies of authorization for nuclear medicine claims
- Specify AIDS-related conditions on the form (refer to Attachment A (PDF) for a list of Centers for Disease Control and Prevention (CDC) diagnosis criteria)
- Attach a completed Attachment A for first time claim submissions in place of the member's medical records. Include date member was first diagnosed with AIDS (symptomatic HIV infection). Form must be signed by PPG staff member ensuring records review occurred and case met criteria for special risk reinsurance program

- Attach a completed Attachment B (PDF) for all subsequent claim submissions for the same member
- Do not highlight on the form

Health Net has modified requirements for submitting requested medical records with respect to member confidentiality concerns. Health Net no longer requires regular submission of the following items, but may request them in individual cases.

- Medical records and lab reports (for example, CD4T - Lymphocyte count and HIV test result only) for members not established in special risk reinsurance to determine whether criteria are met
- Copies of medical records with each subsequent claim submission when diagnosis on claim does not match the criteria matrix
- List of medications prescribed to member. Medications should match the procedures or examination charges

Claims Processing and Reimbursement

Claims are processed in accordance with Health Net's procedures and the Provider Participation Agreement (PPA). Health Net subtracts from the calculated resource-based relative value scale (RBRVS) payment any copayments allowed for the type of service and any third-party amounts collected by the PPG.

A PPG that believes an error has been made in a claim processing decision should contact Health Net's Claims Unit. PPGs may appeal the final settlement to Health Net management.

PPGs must submit claims to Health Net within the time frame specified in their PPA (generally 120 days). If a PPG submits claims for reimbursement past the timely filing limit specified in their PPA, Health Net denies reimbursement for these claims and the PPG has full responsibility for these services.

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
- Co-Management Process
- Referral Process
- Substance Abuse Facilities
- Substance Abuse Rehabilitation Services
- Minor's Consent for 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.

Co-Management Process

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

Contact the Health Net Behavioral Health Services, which transfers the call to a care manager who coordinates care and completes the Medical-Behavioral Co-management Referral Form for alcohol and drug abuse, to include medical comorbidities contributing to or combined with a behavioral health disorder that needs coordination of care with a participating physician group (PPG) or Health Net.

Referral Process

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

For referrals, contact Behavioral Health Provider Services.

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.

Minor's Consent for Services

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

Minors ages 16 or older may consent to receive medications that use buprenorphine for opioid use disorder as narcotic replacement therapy without parent or guardian consent. Assembly Bill (AB) 816 (2023) revised Family Code Section 6929 and added Family Code Section 6929.1 that expands minor consent to include narcotic replacement therapy only in a detoxification setting. Parent of guardian consent is necessary for maintenance narcotic replacement therapy (NRT).

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)
- Authorization
- ModivCare
- 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 participating provider. Ambulance services in conjunction with emergency medical treatment provided outside the participating physician group (PPG) or Health Net service area are considered reinsured services. Services originating outside the PPG or Health Net service area and terminating inside the service area are also considered reinsured services. All emergency air and ground ambulance services are covered regardless of whether the services were obtained in or out of the service area. They 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.

Modivcare

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

Modivcare™ (formerly LogistiCare) is Health Net of California's capitated preferred provider for all covered, non-emergency transportation services for HMO members and fee-for-service (FFS) HMOs, and Medicare Advantage HMO members assigned to participating physician groups (PPGs) delegated for utilization management but not financially at risk for transportation services. These PPGs are not required to issue transportation authorization to Modivcare; however, all referral sources (PPGs, hospitals, skilled nursing facilities, etc.) are required to contact Modivcare to arrange for transportation services. Failure to do so may result in the denial of the claim for which you may be liable. Providers must request non-emergency transportation services (other than 911) through Modivcare.

Modivcare is Health Net of California's preferred provider for all covered, non-emergency transportation services for PPO members, subject to prior authorization from Health Net.

Health Net only reimburses for transports that are medically necessary and covered by the member's benefit plan.

Authorization

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

For non-emergency ambulance services, providers must contact Modivcare™ (formerly LogistiCare).

Autism Spectrum Disorders

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

Autism is the most common of a group of conditions collectively called 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

The primary care physician (PCP) is usually the first practitioner to see signs of autism, 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 visits after six months for borderline results are at the discretion 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 for Autism Spectrum Disorders are available online. Additional AAP autism resources are available Healthy Children.

Diagnostic Evaluation

Typically, a team of medical and behavioral specialists that generally includes the child's PCP or a behavioral pediatrician, child psychiatrist, speech and language pathologist, and other ancillary clinical specialists, as needed, provides 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 Services

Health Net arranges for covered medical services for ASD through its participating network of physicians, hospitals and other providers. The PCP provides a medical home for the member with ASD and, as such, provides preventive health screenings and immunizations and routine and urgent medical care, including referrals for specialty care. For members with ASD, medical referrals may include speech and language therapy, physical therapy, occupational therapy, and/or specialty management for seizure disorders and other appropriate services. Health Net has policies for standing referrals, which may be appropriate in some ASD cases, that assist members to obtain needed care without additional authorization approval. PCPs may also refer the member with ASD for any needed behavioral health services.

Behavioral Health Services

Behavioral health services can be accessed directly by parents or by referral from any treating physician. Health Net's participating network of child psychiatrists provides services such as medication management of specific symptoms related to the ASD as well as any comorbid psychiatric conditions. The network of therapists are available to provide 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. This treatment may be designed to help the family better understand how to cope with the disorder or treat a comorbid mood or anxiety disorder. Inpatient hospitalization is also available if the child with ASD becomes an acute danger to self or others or is behaviorally disruptive, requiring intensive intervention to restabilize the individual.

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 professional” 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

An important potential source of help 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 ABA, 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 ABA services for Health Net commercial members diagnosed with ASDs when coverage is mandated by the state).

Case Management/Comanagement

At the request of the provider, Health Net or the delegated participating physician group (PPG) provides a case manager who is knowledgeable about plan benefits to assist in the coordination of health care treatment services. Health Net has also implemented a comanagement process that encourages better communication and coordination with complex cases. Through this process, medical directors and case/care managers from Health Net or a PPG are able to work together to further integrate the various elements of the medical and behavioral treatment plan. Comanagement may be initiated by Health Net, the PPG, or the provider. Email or fax a completed Care Management Referral Form using the information noted on the form.

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 treatment 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.

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

ABA Forms

- Applied Behavioral Analysis (ABA) Prior Authorization Request Form (PDF) – ABA treating practitioners are required to submit a prior authorization request form along with an updated treatment plan to Health Net prior to delivering ABA services.
- Confirmation of Diagnosis: Autism Spectrum Diagnosis (ASD) Form (PDF) – This form must be completed by a licensed physician or licensed psychologist to establish a diagnosis of autism and recommend ABA services. Attach a copy of the member's most recent face-to-face evaluation and any additional supporting documentation (e.g., comprehensive diagnostic evaluation, prescription, physician letter, etc.)

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 – Prior Authorization.

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

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.

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.

Transition of Care

Provider Type: Participating Physician Groups (PPG)

New members who are currently under or anticipate receiving behavioral health care should be instructed by their employer or participating physician group (PPG) to contact Health Net as soon as possible to ensure continuity of care and a smooth transition into the behavioral health program.

Once notified, Health Net begins case management and assumes financial responsibility for the case as of the effective date of the member's behavioral health care coverage or on the first day that Health Net is notified of a case it has inherited and has approved ongoing care.

When a member is confined to a hospital on the effective date of the behavioral health care coverage and remains hospitalized after the effective date of coverage, the original vendor is responsible for the member's care until the member is discharged or moved to a lower level of care. At that point, Health Net assumes responsibility.

All notification calls from the PPG are handled through Health Net's established intake procedures. The decision either to transfer the member to a Health Net provider or initiate Health Net's out-of-network authorization is based on established procedure.

Minor’s Consent to Mental Health Services

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

Members ages 12 or older can consent to mental health treatment or counseling without needing to meet specific conditions. Additionally, mental health professionals can now consult with minors before involving their parents or guardians if they believe it's inappropriate to do so.

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 | Hospitals | sParticipating Physician Groups (PPG) | 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) | Hospitals | Ancillary

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

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

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. Although Dental Benefit Providers (DBP) administers the dental benefit for many Wellcare By Health Net plans, the vendor that administers the dental benefit is plan-specific.

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

DENTAL SERVICES FOR D-SNP MEMBERS

Managed care plans coordinating Medicare and Medi-Cal benefits expanded to members who are eligible for both programs. These members are Wellcare By Health Net Dual Special Needs Plan (D-SNP) members.

Wellcare By Health Net D-SNP members have additional dental benefits not covered by the Medi-Cal dental program. The additional dental benefits with Wellcare by Health Net D-SNP plan are offered by Delta Dental.

Wellcare by Health Net D-SNP dental benefits work in addition to the Medi-Cal dental coverage. Medi-Cal dental covers initial examinations, X-rays, cleanings and fluoride treatments, restorations and crowns, root canal therapy, and partial and complete dentures adjustments, repairs, and relines. For more information, refer to Smile California.

Wellcare by Health Net D-SNP members must obtain all D-SNP covered dental care from the Delta Dental network.

For more information about additional dental benefits for Wellcare by Health Net D-SNP members, contact Delta Dental.

FEHB Program

Provider Type: Physicians | Participating Physician Groups (PPG)

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

Restorative services and supplies necessary to repair promptly, but not replace, sound natural teeth are covered only for members who are federal employees. The need for these services must result from an accidental injury, not including biting or chewing. Additionally, examinations and treatment of the gingival

tissues (gums) when performed for the diagnosis or treatment of tumors are covered. A dental and emergency room copayment may apply to these services or exams.

Members who are federal employees may refer to their Federal Employee Health Benefits Program (FEHBP) brochure for information on copayment for the services described above and coverage descriptions.

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

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.

Submission of Claims

Provider Type: Participating Physician Groups (PPG)

Health Net prefers that participating physician groups (PPGs) submit claims electronically. Providers must specify the following information on the claim:

- Hemodialysis and the description relating to the RBRVS/CPT code
- The first date of treatment

Doula Services

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

This section contains general information on doula services. Doula services strive to prevent perinatal complications and improve health outcomes for birthing parents and infants.

- Doulas are birth workers who provide health education, advocacy, and physical, emotional and nonmedical support for pregnant and postpartum persons before, during and after childbirth (perinatal period) including support during miscarriage, stillbirth and abortion.
- Doulas also offer various types of support, including health navigation; lactation support; development of a birth plan; and linkages to community-based resources.
- Doulas are not licensed, and they do not require supervision. Doulas do not diagnose medical conditions, provide medical advice, or clinical assessment, exam, or procedure.

Eligibility requirements

- The member must be active and enrolled with Health Net.
- The member must be pregnant or have been pregnant within the past 12 months and would benefit from doula services.

Doula programs available

Members are offered a choice between two doula programs at no cost. A member may choose support under the Individual Doula Program or the Mahmee Virtual Doula Program, but not both.

1. **Individual doula services** – Members can receive doula services in person or virtually during the pregnancy in any setting, such as home, office hospital, or an alternative birthing center. Services include but are not limited to:

- An initial visit.
- Up to eight additional visits, including pre- and post-birth visits. All visits are limited to one per day, per member.
- Support during labor and birth.
- Up to two additional visits after birth to discuss breast feeding, mental health, and other concerns. Visits may last up to three hours.

How to find a doula

Call Health Net Provider Services 24 hours a day, 7 days a week:

2. **Mahmee virtual doula**

Mahmee offers virtual doula services via the Mahmee mobile app that is designed to better connect new moms with health care and support. Enrolled members get access to their digital program and access to a team of experts (wrap-around maternity support team) that includes doulas, registered nurses, lactation consultants, mental health coaches, nutrition coaches, infant feeding specialists and care coordinators. Providers connected to the Mahmee system can receive shared information. Services include but not limited to:

- Initial intake visit.
- Unlimited prenatal visits.
- Support during labor and birth.
- Up to two extended in-person postpartum visits (where available). Visits may last up to three hours.
- Members may work with one or more doulas during virtual and in-person visits.
- Mahmee offers in-person visits in select counties based on availability. Physicians and other providers can refer members to Mahmee directly to check availability of a doula in their county or contact the Health Net Member Services listed on the back of their member identification card.

Mahmee app

The digital platform gives the member access to one-on-one virtual visits, group chats, individual and group classes, coaching, and direct messaging. Plus, access to articles and videos.

How to enroll with Mahmee

Physicians and other providers can inform members to call Member Services. The number is on the back of their medical identification card. Members can also call Mahmee directly or register online at https://www.mahmee.com/ and select eligibility.

Note, a member may receive individual doula services or Mahmee virtual doula with wrap-around support, but not both.

Assistive services during visits

Doulas can also give assistive or supportive services during an in-home prenatal or postpartum visit. This support provides face-to-face interaction while helping with emotional or educational support, such as folding laundry or drying dishes with the pregnant member. An assistive or supportive activity with the member cannot be billed to the member.

Coordinating services

Doulas and Mahmee should work with the member's primary care physician or obstetrician and contact Health Net if the members need additional support.

- Doulas do not replace a doctor or the care provider and do not provide medical advice.
- Mahmee is not a network of doctors. They do not replace the member's current doctors or care providers. They act as a liaison between the member, doctor and their care team.

Non-covered doula services

The following are not covered under doula services:

- Belly binding (traditional/ceremonial)
- Birthing ceremonies (i.e., sealing, closing the bones, etc.)
- Group classes on babywearing
- Massage (maternal or infant)
- Photography
- Placenta encapsulation
- Shopping
- Vaginal steams
- Yoga

Durable Medical Equipment

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

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

Select any subject below:

Overview

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

Durable medical equipment (DME) is an essential component of standard medical treatment for the member's exclusive use. It is prescribed or authorized by the participating physician as a treatment for illness, disease or injury. DME serves a medical purpose, withstands repeated use and fulfills basic medical needs, as opposed to satisfying personal preferences regarding style and range of capabilities.

Ownership of DME Items

DME items may be rented or purchased. If rental is more expensive than purchase for long-term use, purchase is recommended. Health Net follows Medicare guidelines for ownership of DME items, which state members who rent certain types of DME own the equipment after paying copayments for the item for 13 months. There are other types of DME that members will own after paying copayments for the item for a specified number of months. There are also certain types of DME for which members will not acquire ownership no matter how many payments they make for the item while a Health Net member. A member's previous payments towards a DME item when they had Original Medicare (Part A and Part B) do not count towards payments made while a member of a Health Net plan.

Repairs

Repairs to equipment a member has purchased or already owns prior to Health Net membership are covered when necessary to make the equipment serviceable. Repairs to equipment purchased under Health Net coverage are also covered. Repair or replacement due to misuse or loss is not covered.

Apria Healthcare is the exclusive provider for DME services for membership capitated to Apria. Membership not included under DME capitation should still be referred to Apria as they are the preferred vendor for DME. Diabetic supplies (chemstrips and lancets) are also considered DME items for Health Net members.

Capitation is applicable to certain membership assigned to select participating physician groups (PPGs) only. The Division of Financial Responsibility (DOFR) allows a PPG to participate in DME capitation. If DME is Health Net or shared-risk, and is part of Health Net's current capitation agreement with Apria Healthcare, Inc. and E-Medical Supplies, a referral to Apria or E-Medical Supplies does not require authorization from Health Net or the PPG. Refer to the member's Evidence of Coverage (EOC) for plan-specific information.

Criteria for Apria Capitation

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

Medically necessary durable medical equipment (DME) is covered under all health plans. Refer to the Schedule of Benefits and Summary of Benefits and the member's Certificate of Insurance or Evidence of Coverage (EOC) as applicable to determine exclusions and limitations. It must be ordered or approved through the participating physician group (PPG) or Health Net in accordance with policies established by the PPG, Health Net and Medicare.

Covered DME and home respiratory services provided to fee-for-service (FFS) members or members affiliated with a shared-risk participating physician group (PPG) must be obtained through Apria, Health Net's preferred provider for most DME items. Specifically, shared-risk members are capitated to Apria, and shared-risk PPGs should utilize Apria or they will be liable for claims payments.

Apria services include, but are not limited to:

- Comprehensive continuous positive airway pressure (CPAP) services
- DME
- Enteral nutrition therapy
- Home oxygen equipment
- Negative pressure wound therapy

To access a complete list of all therapies and services provided by Apria, providers may log in to Apria's website at www.apria.com.

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 | Ancillary| Participating Physician Groups (PPG)

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.

Claims Submission

Provider Type: Participating Physician Groups (PPG) | Ancillary

The following is applicable to shared-risk participating physician groups (PPGs) or when Health Net is at risk. Claims for durable medical equipment (DME) must include the following information:

- A copy of the bill for each item attached to the completed claim form
- "EQUIP" written in the procedure column
- Name of the equipment written in the description column (more than one line may be used)
- Reference to the authorization number, when indicated

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 | Hospitals | Participating Physician Groups (PPG) | 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)

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) | 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) | 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) | 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 | 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).

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.

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 .
- 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.

Providers must use the Urgent Request for Continuing Home Health Services (PDF)form for HMO/POS, PPO, 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 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 (Medicare, HMO and PPO only)

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) | Hospitals | Ancillary

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

Select any subject below:

Hospice Services

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

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

Select any subject below:

Claims Submissions

Provider Type: Participating Physician Groups (PPG) | 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.

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) | 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.

Incarcerated Members

Provider Type: Physicians | Participating Physician Groups (PPG)

The California Board of Corrections, United States Marshall Service, or the city or county where the member is detained usually provides medical treatment for the incarcerated person. Incarcerated persons may decline medical treatment if they can receive treatment at their own expense.

California law prohibits a health care service plan or disability insurer from denying a claim for hospital, medical, surgical, dental, or optometric services for the sole reason that the member is incarcerated, provided the member is otherwise entitled to reimbursement for such services under the plan contract and incurs an expense for services performed.

Coverage for Incarcerated Members

Incarcerated members are covered for medical treatment, including urgent and emergency care, provided the coverage is received as stated in the member's Evidence of Coverage (EOC) or Certificate of Insurance (COI). The member is responsible for obtaining any required referrals or prior authorizations. The member is also responsible for obtaining any necessary court approval, transportation or security costs.

Medical treatment that is required as a result of an injury sustained during confinement or mandated medical testing is not covered; this is the responsibility of the institution where the member is detained.

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:

- Overview
- Chemotherapy
- Copayment Requirements
- Home Infusion
- Human Growth Hormone and Antihemophilic Factor

- Injectable Medication Coverage Policy
- Prior Authorization
- Therapeutic Injections and Other Injectable Substances

Overview

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

Standard definitions determine the Division of Financial Responsibility (DOFR) categories into which injectable medications are placed and include brand names, generic names and associated HCPCS codes. The categories mirror the DOFR matrix categories located in the Health Net Provider Participation Agreement (PPA) DOFR agreement.

For Medi-Cal members under age 21 with California Children's Services (CCS)-eligible conditions, injectable medications used in the treatment of CCS-related 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).

Injectable medications are separated into two primary categories - therapeutic injections and self-injectables. These categories are sub-divided into secondary categories as follows:

- Therapeutic injections
  - Allergy serum
  - Blood and blood products for hemophilia (carved out for Medi-Cal)
  - Chemotherapy
  - Chemo adjunct
  - Home health/infusion
  - Immunizations
  - Immunosuppressants for transplants
- Self-injectables
  - Chemotherapy
  - Chemo adjunct
  - Growth hormones
  - HIV/AIDS
  - Infertility medications

If an injectable medication does not have a secondary category, it defaults to the DOFR primary category. There are five secondary categories that are contingent on meeting specific criteria - chemotherapy, chemo adjunct injectable medications, HIV/AIDS, immunosuppressants for transplants and home health/infusion:

- Chemotherapy and chemo adjunct injectable medications must be associated with a cancer diagnosis using ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9. If the appropriate codes are not used, these injectables default to the primary category
- HIV/AIDS must be associated with a HIV or AIDS diagnosis. If the diagnosis is not HIV or AIDS, these injectable medications default to the DOFR therapeutic category

- Home health infusion must be administered in the home by a nurse or physician. If it is not, this injectable medication defaults to the DOFR primary category
- Immunosuppressants for transplants must be associated with an organ transplant. If they are not, these injectable medications default to the DOFR primary category

Injectable medications are categorized using a standardized methodology to ensure clear and proper benefit administration and reimbursement. Chemotherapy, chemo adjunct, HIV/AIDS, home health/infusion, and immunosuppressants for transplants are the only injectable medications that may change categories depending on whether contingent criteria are met.

For additional current information regarding injectable medications, refer to the Health Net Injectable Medication HCPCS/DOFR Crosswalk (PDF) table.

Allergy testing agents and immune globulins given intramuscularly and subcutaneously that produce passive immunizations are classified as therapeutic injectable medications. Certain vaccines (for example, BCG) are categorized as chemotherapy or a therapeutic injection based on the appropriate indication.

Growth hormones and injectables considered safe for self-administration at home and packaged for this purpose are classified in the primary category of self-injectable medications.

Additional information regarding clinical guidelines and coverage criteria for injectable medications can be found in the Health Net Prior Authorization guidelines on the provider portal.

Hemophilia

Antihemophilic agents include hemophilic factors VIII and IX and factors used in the treatment of bleeding episodes in hemophilia A or B members with inhibitors to factor VIII or IX (for example, coagulation factor VIIa and anti-inhibitor coagulant complex). These agents must be used for Food and Drug Administration (FDA)-approved indications. Refer to the Health Net Injectable Medication HCPCS/DOFR Crosswalk table for more information.

Hemophilic factors are covered under the blood and blood products for hemophilia category. Refer to the Schedule of Benefits to determine coverage for these services. If services are covered under the member's plan, the services must be pre-approved and obtained from a participating provider.

For Medi-Cal members, blood and blood products for hemophilia are carved out and billed to Medi-Cal. For Medi-Cal members under age 21, hemophilia is a CCS-eligible condition and treatment is not included in Health Net's coverage responsibilities under its Medi-Cal managed care contract with the DHCS.

Chemotherapy

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

The terms of compensation for chemotherapy medications are stated in the participating physician group's (PPG's) Provider Participation Agreement (PPA).

Chemotherapy and chemo adjunct medications are composed of antineoplastic and adjunctive medications. An antineoplastic medication is a compound used to destroy malignant cancer cells or shrink or kill malignant tumor cells circulating in the blood and lymphatic systems. Antineoplastics must be approved by the Food and Drug Administration (FDA) for a specific cancer indication or listed in the most recent bulletin by the Association of Community Cancer Centers to be eligible for coverage under a Health Net benefit plan.

Adjunctive medications are additional pharmaceutical agents added for the purposes of palliative symptomatic treatment of side effects directly related to the chemotherapy treatment regimen. The specific purpose of the adjunctive therapy is for a defined duration of therapy, for only as long as the chemotherapy is continued, and may not be used for chronic maintenance use. Adjunctive therapy may not include products that are already part of the outpatient pharmacy benefit program.

Refer to the Health Net Injectable HCPCS/DOFR Crosswalk (PDF) table for chemotherapy and chemo adjunct medications.

Chemotherapy medications may be administered by a participating provider in a hospital inpatient setting, at the PPG, at other patient settings, or in the member's home. Some chemotherapy agents may require prior authorization. Refer to the Health Net Injectable Prior Authorization Guidelines on the Health Net provider portal (Commercial, Medi-Cal).

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 a Health Net contracted home infusion provider.

Shared risk PPGs should utilize a Health Net contracted home infusion provider 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 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

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)

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 are required to screen for maternal mental health conditions once during pregnancy and once within the first six weeks postpartum.

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)

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
- PPG Responsibility

Coverage Explanation

Provider Type: Physicians | Participating Physician Groups (PPG)

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.

PPG Responsibility

Provider Type: Participating Physician Groups (PPG) | Hospitals

Participating physician groups (PPGs) are responsible for ensuring that medical social services are available to Health Net members. PPGs may provide these services directly or may refer members to providers who offer these services.

The following are available to support medical social services provided by the PPG:

- Medical social service departments in Health Net-participating hospitals
- Medical social service consultants through home health agencies

Nuclear Medicine

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

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.

Nurse Midwife

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

This section contains general member benefit information on nurse midwife services.

Select any subject below:

- Coverage

Coverage

Provider Type: Physicians

A certified nurse midwife (CNM) is a registered nurse who has received training in obstetrics and gynecology, and is certified by the American College of Nurse Midwives. A midwife assists in delivering infants, as well as providing antepartum and postpartum care. CNMs must be licensed by the state of California and working under the license of an actively practicing physician. CNM coverage is limited to services performed within the scope of a CNM's license and according to the terms of the member's plan. Home births are not covered. Services rendered by CNMs must be prior authorized to be considered for payment.

If a member is assigned to a primary care physician (PCP) participating with a delegated participating physician group (PPG), and the PPG does not have any participating CNMs in its network, a prior authorization request and authorization to the out-of-network CNM provider is required from the PPG prior to the member accessing services with the out-of-network, non-participating CNM.

Obesity

Provider Type: Physicians | Hospitals | Participating Physician Groups (PPG) | 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 Eat Right Now by Sharecare program.

Eat Right Now by Sharecare program. Eat Right Now by Sharecare is an evidence-based app designed to help patients make better food choices and practice healthy habits that lead to sustainable weight-loss. The program includes daily guided lessons, mindfulness exercises, craving tools, community support, and live weekly calls with a behavior change expert.

For more information on, select any subject below:

Bariatric Surgery Services (HMO and PPO only)

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 | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general member benefit information on outpatient services.

Select any subject below:

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.

Ambulatory Surgical Centers Payments

Provider Type: Participating Physician Groups (PPG)

Health Net considers payment claims for facility charges when the billing ambulatory surgical center (ASC) is licensed by the state of California, accredited by a recognized accreditation body, or certified by Medicare.

Participating physician group (PPG) coordinators and staff should notify ASCs that charges should be billed on a hospital form (UB-04). To document that it is a facility fee, a Medicare charge may be billed on a CMS-1500 with an SG modifier. If the Health Net Claims Department receives charges on any claim forms other than a UB-04 or a CMS-1500 for a Medicare charge for a facility fee, payment is delayed.

PPGs should verify whether the ASC contracts with Health Net. When the ASC contracts with Health Net, the facility charges are paid in accordance with the Provider Participation Agreement (PPA).

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).

Urgent Care Centers

Provider Type: Participating Physician Groups (PPG)

Health Net encourages participating physician groups (PPGs) to operate urgent care centers and endorse their use by Health Net members for medical conditions that require immediate attention. Additionally, members who cannot wait hours or days for a scheduled appointment with a primary care physician (PCP) may visit an urgent care center. These centers provide immediate medical care and reduce inappropriate emergency room encounters.

Health Net requires that PPG urgent care centers follow these standards:

- Maintain written policies, procedures and evaluation techniques
- Be located by and have a contracting relationship with a hospital emergency room
- Maintain extended hours with services available seven days a week
- Have staff that includes the following qualified physicians. Certified physician assistants (PAs) and nurse practitioners (NPs) must have on-site physician supervision at all times. Unlicensed residents must be directly supervised by licensed physicians.
    - Panel of available specialists
    - Registered nurses
    - Support staff - licensed vocational nurse (LVN), nursing assistant (NA), PA, technicians
- Minimum ancillary services, which include:
    - X-ray
    - Lab
- Medical records procedures (each urgent care center should have its own procedures for handling medical records information) for:

- Urgent care records
- Records of transfer to primary care
- Procedure for follow-up care

- Member access:
  - Available to all clinic patients (not prepaid only)
  - Procedure for managing member satisfaction and system flexibility to accommodate member needs
  - Methods used to educate members on correct use of the center prior to using it, obtaining follow-up care and follow-up care procedures
- Utilization management (UM) and quality improvement (QI) procedures:
  - Specific procedures for evaluating utilization
  - Reporting process
- Utilization review (UR) and QI committee (QIC) activity to:
  - Process and document procedures in place where the PPG's UR committee reviews utilization and quality of care provided at the urgent care center
  - Document activities of UR committee and report to urgent care center staff
  - Make Health Net's periodic UR available

Health Net performs utilization and quality audits by random selection or focused review, either on-site at the urgent care center, based on emergency room utilization reports, or at Health Net, with records copied and submitted by the urgent care center.

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.

Preventive Services

Provider Type: Physicians | Participating Physician Groups (PPG) | Hospitals | 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 Health Services
- Physical, Occupational or Speech Therapy Services Concurrent Review Forms
- Rehabilitation Therapy

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, 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.

Rehabilitation Therapy

Provider Type: Participating Physician Groups (PPG) | Ancillary

Coverage for rehabilitation therapy is limited to medically necessary treatment of conditions resulting from a defined disease, injury or surgical procedure. The services must be provided by a physical, speech or occupational therapist, or technician licensed to practice rehabilitation therapy.

The services must be at a level of complexity that requires the judgment, knowledge and skills of a licensed physical, speech or occupational therapist, be based on a treatment plan and be provided by such therapist or under the therapist's direct supervision. Such services are not covered when medical documentation does not support the medical necessity due to the member's inability to progress toward the treatment plan goals or when a member has already met the treatment goals.

The functional assessment of the member as related to the continuation of rehabilitation services is performed by one or more rehabilitation professionals.

Institutional and professional services provided for inpatient and outpatient rehabilitation are covered. The therapy must promote and maintain movement-related health and wellness. Refer to the Health Net Provider Participation Agreement (PPA) for financial responsibility information.

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

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

Dispute Resolution

Provider Type: Participating Physician Groups (PPG)

If there is a dispute between the member and the participating physician group (PPG) about the need for auxiliary aids and services, Health Net resolves it by filing an expedited appeal on the member's behalf. Health Net makes the final determination (which may include the use of an independent third-party reviewer) and assists the PPG in ensuring that any necessary auxiliary aids and services are provided.

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 | Participating Physician Groups (PPG) | Hospitals

When arranged and authorized by a member's participating physician group (PPG) or 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 and Summary 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 | Ancillary | Participating Physician Groups (PPG)

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 MEDICARE HMO

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

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
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 members for a transplant procedure.

Participation in Health Net's transplant network follows the Evaluation Process Standards to meet industry-accepted standards.

Responsibility for Inpatient Concurrent Review and Transfer for Transplant Evaluation

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

For members in need of an evaluation for transplant eligibility, responsibility for the transfer and continued concurrent review remain with the delegated entity until such time as a transplant event occurs or the member no longer requires an inpatient level of care and can be safely discharged. The financial risk upon transfer to a transplant facility will follow the standard Division of Financial Responsibility for inpatient admissions up to the day of transplant, when Health Net takes over risk for the transplant.

If, during the continued stay, the transplant occurs, the member's case is transitioned to Health Net's concurrent review team on the day of the transplant. Until that happens, the delegated entity maintains its concurrent review responsibilities even if the member is evaluated for transplant eligibility during that time.

Tuberculosis Screening

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

Screening for members ages 18 and older

Members ages 18 and older can be offered TB screening assessments if risk factors are identified using the following criteria:

- Adult members who receive primary care services in a facility, clinic, center, office, or other setting where primary care services are provided, **shall be offered a TB risk assessment and TB screening test**, if TB risk factors are identified, based on the latest screening indications recommended by the U.S. Preventive Services Task Force, unless the provider reasonably believes that one of the following conditions applies:
    - The member is being treated for a life-threatening emergency.
    - The member has previously been offered or has been the subject of a TB risk assessment, TB screening test, or both, and has no new TB risk factors since the last TB risk assessment or TB screening test, unless the provider determines that they should be offered again.
    - The member has a documented, previously positive Interferon-Gamma Release Assays test or has previously tested positive for a latent tuberculosis infection (LTBI).
    - The member lacks capacity to consent to the assessment or test and/or consent cannot be obtained from a person legally authorized to make medical decisions on the patient's behalf.
    - The member is being treated in the emergency department of a general acute care hospital.
- If a member accepts the offer of the TB screening test and the test is positive, providers are required to offer the member follow-up care or refer the member to a provider who can provide follow-up care.

For more information on TB reporting and care management, refer to the Communicable Diseases and Reporting section.

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

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.

PPG Responsibility

Provider Type: Participating Physician Groups (PPG)

The participating physician group (PPG) must develop a simple office-screening procedure to provide routine vision screening. The screening should include testing for a deviation of the eyes from normal. If the vision exam indicates a potential refractive problem, a referral must be made for a refraction exam only. Health Net suggests that the PPG use the Snellen and Jaeger tests and include the use of the Titmus Machine Vision Tester. This enables the PPG to screen out many potential referrals.

PPGs must provide members who want or need contact lenses a prescription for corrective lenses, including eye curvature measurements and fitting of contact lenses (a fitting could involve multiple visits).

After an optometrist or ophthalmologist performs a refractive vision exam and determines that a member's vision can be improved by eyeglasses, the member may obtain the eyeglasses either from the optometrist or ophthalmologist who performed the vision exam or elsewhere. If the optometrist or ophthalmologist determines that the member's vision can be improved only by contact lenses or the member prefers contact lenses and the optometrist or ophthalmologist determines that contact lenses are a medically viable way to correct the member's vision, the member may obtain the contact lenses either from the optometrist or ophthalmologist who performed the vision exam or elsewhere. If the member decides to obtain the eyeglasses or contact lenses elsewhere, the optometrist or ophthalmologist must give the member a prescription for the glasses or a prescription that includes the necessary measurements to enable purchase of the contact lenses.

Members enrolled in the EyeMed Vision Care vision plan must utilize EyeMed Vision Care participating providers.

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 | Participating Physician Groups (PPG) | Hospitals | 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 provider for laboratory services for the following lines of business:

- Point of Service (POS)
- PPO
- 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

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) | 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 | Participating Physician Groups (PPG) | Hospitals | Ancillary

If a participating physician group (PPG) or hospital 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 and resolution process.

Balance Billing

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

Balance billing is strictly prohibited by state and federal law under Title 22 California Code of Regulations section 53620, et seq. (the “Medi-Cal Fee Schedule”) and Health Net's Provider Participation Agreement (PPA).

Balance billing occurs when a participating provider balance bills Medi-Cal beneficiaries for amounts in excess of any Medi-Cal required copayments and deductibles 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 review for possible 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.

For Medi-Cal members, Health Net may cover a non-covered service if it is medically necessary. The provider must submit a pre-approval (prior authorization) request to Health Net with the reasons the non-covered benefit is medically needed. Participating providers can bill members for services that are classified as non-covered and not medically necessary. Before these services are provided, members must be informed that they will not be covered by their plan. Additionally, members must sign a consent form acknowledging this information prior to receiving any non-covered services.

A participating provider who exhibits a pattern and practice of billing members will be contacted by Health Net and is subject to disciplinary action.

For more information, select any subject below:

- 15-Day Letters MEDI-CAL
- Billing Medicare/Medi-Cal Members Prohibited MEDICARE
- Fee Prohibitions MEDI-CAL
- Hold Harmless Provisions MEDICARE

- Missed Appointments MEDI-CAL

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
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

Form Fields	Electronic	CMS-1500	UB-04
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
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)

Form Fields	Electronic	CMS-1500	UB-04
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

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
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 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	UB-04 box 66-70 UB-04 box 71	Section 3 [1]Non-standard submission or equivalent
75	The claim(s) submitted has missing, illegible or invalid value	When box 24 is completed, then box 24G must be	CMS-1500 box 24D and 24G	N/A

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
	for anesthesia minutes	completed as well		
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) 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.	CMS-1500 box 22 UB-04 box 4 and 64	Section 4 [1]Non-standard submission or equivalent
77	Type of bill or place of service invalid or missing	Enter the appropriate type of bill (TOB) code as specified by	UB-04 box 4	N/A

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
		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 – 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	CMS-1500 box 24D UB-04 box 43	N/A

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
		of these elements are missing, the claim will reject		
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 shaded area or box 32	N/A
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	UB-04 box 67–67Q and 72A–72C	N/A

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
		see Reject code 17)		
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
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.	UB-04 box 70a, b, c	N/A

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
		Otherwise, do not populate		
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 description see Reject code 17)	CMS-1500 box 21 UB-04 box 66	N/A
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.

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, HMO 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 box to indicate the patient's sex/gender. M= Male or F= Female	Required
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.	Conditional

Field number	Field description	Instruction or comments	Required, conditional or not required
		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 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.	Conditional

Field number	Field description	Instruction or comments	Required, conditional or not required
		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 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

Field number	Field description	Instruction or comments	Required, conditional or not required
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 information must then be shown in box 11	Required
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	Conditional REQUIRED when other insurance is available

Field number	Field description	Instruction or comments	Required, conditional or not required
		insurance. If box 10 a, b or c is marked Y, this field should be populated	
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. Enter the claim number assigned by the payer	Conditional
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

Field number	Field description	Instruction or comments	Required, conditional or not 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 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	Conditional

Field number	Field description	Instruction or comments	Required, conditional or not required
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
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

Field number	Field description	Instruction or comments	Required, conditional or not required
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. New form - for resubmissions only: - Replacement of Prior Claim - Void/Cancel Prior Claim	Conditional - For resubmissions or adjustments, enter the 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	If authorization, then conditional If CLIA, then required If both,

Field number	Field description	Instruction or comments	Required, conditional or not required
		information on services requiring referral and/or prior authorization. CLIA number for CLIA waived or CLIA certified laboratory services	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 to Appendix IV of this guide	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
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	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		"From" date. If identical services (identical CPT/HCPC code(s)) were performed, each date must be entered on a separate line	
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 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	Required - Ensure NDC or UPIN is included if applicable

Field number	Field description	Instruction or comments	Required, conditional or not required
		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-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	Required
24 F Unshaded	Charges	Enter the charge amount for the claim line item service billed.	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		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	
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 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

Field number	Field description	Instruction or comments	Required, conditional or not 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, RHC/FQHC general medical exam)	Required
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

Field number	Field description	Instruction or comments	Required, conditional or not required
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), enter 00 in the area to the right of the vertical line.	Required
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	Conditional REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing

Field number	Field description	Instruction or comments	Required, conditional or not required
		justified. Up to eight characters are allowed (i.e., 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to the right of the vertical line	
30	Balance due	REQUIRED when field 29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payer). Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to the right of the vertical line	Conditional REQUIRED when field 29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payer)
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	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		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	
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 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-	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
		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 by the taxonomy code (no spaces). Atypical providers: Enter the 2-character qualifier 1D (no spaces)	Conditional REQUIRED if the location where services were rendered is different from the billing address listed in field 33
33	Billing provider INFO & PH#	Enter the billing provider's complete name, address (include the ZIP + 4	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		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 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	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		address listed in field 33. Enter the 10-character NPI .	
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

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 | Participating Physician Groups (PPG) | Hospitals | 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

Field number	Field description	Instruction or comments	Required, conditional or not required
3	Patient's birth date and sex	Enter the patient's eight-digit date of birth (MM/DD/YYYY), and mark the appropriate box to indicate the patient's sex/gender. M= Male or F= Female	Required
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	Conditional

Field number	Field description	Instruction or comments	Required, conditional or not required
		such as (803)5551414. Note: Patient's telephone does not exist in the electronic 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	Conditional

Field number	Field description	Instruction or comments	Required, conditional or not required
		such as (803)5551414. Note: Patient's telephone does not exist in the electronic 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,	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		b and c). Do not enter a Yes and No in the same category/line. When marked Yes, primary insurance 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	Conditional

Field number	Field description	Instruction or comments	Required, conditional or not required
		For worker's compensation of property and casualty: Required if known. 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	Enter the six-digit (MM/DD/YY) or eight-digit	Conditional

Field number	Field description	Instruction or comments	Required, conditional or not required
	Injury (Accident) or Pregnancy (LMP)	(MM/DD/YYYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last 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)

Field number	Field description	Instruction or comments	Required, conditional or not required
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
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	Required - Include the ICD indicator

Field number	Field description	Instruction or comments	Required, conditional or not required
		be rejected or denied for payment	
22	Resubmission code / original REF	For resubmissions or adjustments, enter the original claim number of the original claim. New form - for resubmissions only: - Replacement of Prior Claim - Void/Cancel Prior Claim	Conditional - For resubmissions or adjustments, enter the 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:	Conditional - The shaded top portion of each service claim line is used to report supplemental information for:

Field number	Field description	Instruction or comments	Required, conditional or not required
		• NDC • Narrative description of unspecified codes • Contract rate • For detailed instructions and qualifiers refer to Appendix IV of this guide	NDC Narrative description of unspecified codes Contract rate
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

Field number	Field description	Instruction or comments	Required, conditional or 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 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	Required - Ensure NDC or UPIN is included if applicable
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	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. ICD-10-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

Field number	Field description	Instruction or comments	Required, conditional or not 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 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	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		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, 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	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		characters are allowed (i.e., 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to the right of the vertical line.	
29	Amount paid	REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199999.99). Do not use commas. Do not enter a dollar sign ($). 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	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
		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	
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.)	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
		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 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	Conditional

Field number	Field description	Instruction or comments	Required, conditional or not required
		rendered is different from the billing address listed in field 33. Typical providers: Enter the 2-character qualifier ZZ followed by the taxonomy code (no spaces). Atypical providers: Enter the 2-character qualifier 1D (no spaces)	REQUIRED if the location where services were rendered is different from the billing address listed in field 33
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-	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		digit ZIP code (ZIP + 4 code), include the hyphen. Do not use a hyphen or space as a separator within the 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

Indicator	Description
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 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. HMO, 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

Field number	Field description	Instruction or comments	Required, conditional or 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 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).	Required
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,	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		radiology, and dialysis may be billed using a date span. All other outpatient services must be billed using the actual date of service (MMDDYY).	
7	Unlabeled field	Not used.	Not required
8a	Patient name	8a - Enter the first nine digits of the identification number on the member's ID card.	Not required
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.	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		Enter the patient's complete mailing address.	
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
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.	Required for Inpatient claims. Leave blank for Outpatient claims. Exceptions: Type of bill codes 012x, 022x, 032x, 034x, 081x, and

Field number	Field description	Instruction or comments	Required, conditional or not required
		• 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. • 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.	082x require boxes 12–13 to be populated.
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

Field number	Field description	Instruction or comments	Required, conditional or not 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 • 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	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		• 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. • 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.	Conditional - Enter the time using two-digit military times (00-23) for the time of the inpatient or outpatient discharge
17	Patient status	REQUIRED for inpatient and outpatient claims. Enter the two-digit disposition of the patient as of the "through" date for the	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		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 • 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	

Field number	Field description	Instruction or comments	Required, conditional or not required
		is based on DRG) • 40 - Expired at home (hospice use only) • 41 - Expired in a medical facility (hospice use only) • 42 - Expired-place unknown (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	

Field number	Field description	Instruction or comments	Required, conditional or not required
		units of a hospital • 63 - Discharged/ transferred to a Medicare certified long-term care hospital (LTCH) • 64 - Discharged/ transferred to a nursing facility 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	Conditional REQUIRED when condition codes are used to identify conditions relating to the bill that may affect payer processing

Field number	Field description	Instruction or comments	Required, conditional or not required
		sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual	
29	Accident state	N/A	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	Conditional REQUIRED when occurrence 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
		present on the same line (31a-34a). Enter the date for the associated occurrence code in MMDDYY format	
35-36 a-b	Occurrence SPAN code and Occurrence date	Occurrence span code: REQUIRED when applicable. Occurrence codes are 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.	Conditional REQUIRED when occurrence 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
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
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.	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
		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 ($) 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

Field number	Field description	Instruction or comments	Required, conditional or not 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 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)	Conditional - Enter the number of pages. (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/	Conditional REQUIRED for outpatient claims when an appropriate CPT/HCPCS code exists for the service line revenue code billed

Field number	Field description	Instruction or comments	Required, conditional or not required
		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	
45 Lines 1-22	Service date	REQUIRED on all outpatient claims. Enter the date of service for each service line billed (MMDDYY). Multiple dates of service may not be combined for outpatient claims	Conditional REQUIRED on all outpatient claims. Enter the date of 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

Field number	Field description	Instruction or comments	Required, conditional or not 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
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.	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		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'	
53	ASG. BEN.	Enter 'Y' (yes) or 'N' (no) to indicate a signed form is on file authorizing payment by the payer directly to the provider for services	Required
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

Field number	Field description	Instruction or comments	Required, conditional or not 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
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	Conditional - Enter the 12-character original claim number of the paid/denied claim when submitting a replacement or void on the corresponding

Field number	Field description	Instruction or comments	Required, conditional or not required
		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	A, B, C line reflecting Payer from field 50
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	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
		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 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	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		acceptable as a primary diagnosis. Note: Claims with missing or invalid diagnosis codes will be denied	
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. 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	Required
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	Conditional - Enter the ICD-10 procedure code that identifies the

Field number	Field description	Instruction or comments	Required, conditional or not required
		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).	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 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).	Conditional REQUIRED on inpatient claims when a procedure is performed during the date span of the bill
75	Unlabeled field	N/A	Not required

Field number	Field description	Instruction or comments	Required, conditional or 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 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	Required
77	Operating physician	REQUIRED when a surgical procedure is performed.	Conditional REQUIRED when a surgical procedure is performed. Enter the NPI and name of the

Field number	Field description	Instruction or comments	Required, conditional or not required
		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: • 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.	physician in charge of the patient care
78 & 79	Other physician	Enter the provider type qualifier, NPI and name of the physician in charge of the patient care.	Conditional

Field number	Field description	Instruction or comments	Required, conditional or not required
		• (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 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) | 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.

To see claims status, please log in to the provider portal.

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.

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.

- Excessive Fees by Hospital-Based Providers (HMO)
- Shared-Risk Claims (Medi-Cal (LA))
- Anesthesia Procedure Code Modifiers with the Minute Qualifier (HMO, PPO, Medicare, Medi-Cal)

Excessive Fees by Hospital-Based Providers

Provider Type: Participating Physician Groups (PPG)

When charges by hospital-based providers are for capitation services and the participating physician group (PPG) has encountered fees that appear to be excessive when compared to fees charged for similar services by local providers, the PPG is entitled to question the provider about the fee.

Of paramount importance in these instances is Health Net's legal obligation to provide medical care coverage to its members and to protect them from any indebtedness to a provider who is not satisfied with a reimbursement received for covered services. The member is, as always, obligated to pay any copayment amount specified in the Evidence of Coverage (EOC).

Health Net encourages PPGs to communicate with providers before paying less than the amount charged, in order to prevent problems for the member. If a PPG pays a hospital-based physician less than the amount charged and the provider bills the member for the difference, the PPG is required to pay that portion of the charge immediately. The PPG may initiate a peer review of the matter later through the local medical society.

Inform members that any bill received for care provided or authorized by the PPG is to be sent to the PPG. If a member ignores a bill and collection activities are initiated, both Health Net and the PPG are implicated in not having protected the member.

When a PPG encounters a charge it considers excessive, Health Net recommends the following steps:

1. Determine whether complications or other factors justify the charge. If there is justification, pay the amount billed and end the process. If there is no justification, proceed to the next step.
2. Contact the provider and attempt to resolve the difference. If there is no resolution, proceed to the next step.
3. Pay all outstanding charges, but notify the provider that this is being done under protest and that the PPG intends to seek a peer review of the matter by the local medical society.
4. Call the California Component Medical Societies for assistance in selecting the appropriate California county medical society to hear the protest. The correct county medical society is the one located in the same geographical area as the provider whose charge is in dispute.

5. Call the county medical society and ask for instructions for submitting cases for peer review.
6. If the PPG is informed that a member has been contacted by a collection agency, in addition to paying all outstanding charges, inform the collection agency in writing that the PPG is responsible for paying for the service and that the PPG has made payment, but that the validity of the charge is in dispute. State that the disputed excessive fee is to be subjected to a medical society peer review. Request that, in view of these facts, the collection agency take no action that might impair the credit rating of the member.

Anesthesia Procedure Code Modifiers with the Minute Qualifier

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

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 | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section includes general information on member eligibility and capitation.

Select any subject below:

Capitation Payments

Provider Type: Participating Physician Groups (PPG) | Hospitals

Health Net sends a monthly payment by the tenth of each month to capitated providers via the Checkwrite system. Capitation payments to providers who are on a direct-deposit system vary according to their contract with Health Net. A capitation reimbursement summary is also prepared and sent with the payment to identify the amount payable by financial pool. The capitation check includes payment for the current month as well as any retroactivity reported since the last capitation cycle.

Capitation Rates

| Participating Physician Groups (PPG) | Hospitals

Capitation rates are member-based and adjusted by age, gender and plan type. If a member has a non-standard effective or cancel date, the capitation rate is prorated by the actual number of days the member is active.

In addition, premiums for professional stop loss levels, withhold funds, AIDS, transplant reinsurance costs, and transfer reinsurance costs can be subtracted from the capitation rate.

Premiums are subtracted from the institutional capitation rate for in-area and out-of-area reinsurance costs if purchased from Health Net.

Dual Risk

Provider Type: Participating Physician Groups (PPG) | Hospital

The dual-risk program is an optional program in which the participating physician group (PPG) establishes a capitated incentive arrangement with a primary hospital that is capitated and financially responsible for in-area

hospital services provided to Health Net members. Hospitals are liable for in and out-of-area services up to the reinsurance limit. This program is only offered to a limited group of PPGs and hospitals.

The PPG must give Health Net a written description of incentive arrangements and any changes to the incentive arrangements within 60 calendar days of its establishment of any amendments.

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.

Hospital Liability Payment

Hospitals

In some instances, Health Net pays for services considered the primary hospital's liability, otherwise known as capitated services. The decision to pay hospital liability services typically occurs as a result of a quality assurance review.

Health Net requires that the primary hospital respond to Health Net and provide the necessary documentation demonstrating that the claim has been resolved via fax or mail within 10 calendar days of the hospital's receipt of Health Net's request for information. If the primary hospital does not provide an acceptable response to Health Net, Health Net may pay the claim on behalf of the hospital. Health Net may pay claims at the lesser of Health Net's contract rate with the provider, provider subcontract terms or provider's billed charges. Hospital liability claims that Health Net pays on behalf of the primary hospital are deducted from the monthly hospital services capitation.

Each hospital receives a copy of the monthly Hospital Liability Claims Paid in Error Report.

PPG Liability Payments

Participating Physician Groups (PPG)

In some instances, Health Net pays for services considered the participating physician group's (PPG's) liability, otherwise known as capitated services. PPG liability claims that Health Net pays on behalf of the PPG may be the result of the PPG accessing Health Net's contract rates with another provider or of a quality assurance review. PPG liability claims that Health Net pays on behalf of the PPG are deducted from the monthly professional services capitation.

Health Net strongly encourages all PPGs to establish contractual agreements with providers used by the PPG. Health Net accommodates the PPG's request to adjudicate and pay PPG liability claims to providers without a contractual agreement in place with the PPG as stated in the PPG's Provider Participation Agreement (PPA).

Health Net requires that the PPG respond to Health Net and provide the necessary documentation demonstrating that the claim has been resolved via fax or email within 10 calendar days of the PPG's receipt of Health Net's request for information. If the PPG does not provide an acceptable response to Health Net, Health Net may pay the claim on behalf of the PPG. Health Net may pay claims at the lesser of Health Net's contract rate with the provider, provider subcontract terms or provider's billed charges.

Each PPG receives a copy of the monthly PPG Liability Claims Paid by Health Net Report.

Professional Stop Loss Levels

Participating Physician Groups (PPG)

The professional stop loss levels for each participating physician group (PPG) are listed in the Provider Participation Agreement (PPA).

Reports

Provider Type: Participating Physician Groups (PPG) | Hospitals

The following site-level reports are generated monthly by Health Net and sent to participating providers. Consolidated- and physician-level reports are available on request.

Report Option	Description
Consolidated	Allows the participating physician group (PPG) and all satellite offices to receive one integrated report
Site	Allows the PPG to have all its satellites receive their own sets of reports
Physician	Allows each PCP within a PPG to receive an individual report. This option is only available for the Eligibility and Remittance Detail files

The following ACE reports are available to PPGs:

- BRM 42 - Expanded Eligibility Report
- BRM 11 - Activity Analysis Report - All member-related activities during the prior month
- BRM 12 - Remittance Detail Report
- BRM 13 - Eligibility Summary by Employer Group Report
- BRM 78 - SB 260 Reconciliation Report
- BRW 11 - Weekly Analysis Report

Refer to the Eligibility Reports topic for more information.

Eligibility Guarantee

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

Eligibility guarantee is a payment of the amount agreed upon by Health Net and the capitated participating physician group (PPG) for payment of claims for services performed in good faith by any participating provider for a member who is later determined to have been ineligible on the date of service. In these cases, Health Net is liable up to the limits set forth in the PPG's Provider Participation Agreement (PPA) for the care provided before Health Net notifies the PPG of the member's ineligibility due to the retroactive addition or cancellation of the member. Unless otherwise specified in the PPG's PPA, the terms of the eligibility guarantee program are described below.

The eligibility guarantee does not apply if the PPG does not verify eligibility with Health Net for members who are receiving continuing services and who do not appear on the eligibility report (PPG and hospital only) within 60 days after the initial visit.

If a member is ineligible due to a retroactive addition or cancellation, Health Net adjusts the PPG's or hospital's capitation accordingly.

For more information, select any subject below:

Eligibility Guarantee Under COBRA

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 create 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. When COBRA continuation ends, COBRA members qualify for Health Net conversion coverage in the usual manner.

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.

Conversion After COBRA

When the member completes an Eligibility Certification form, the member is entitled to the same coverage that was available under the prior Health Net group health plan. The identity of that prior plan can be determined in several ways:

- Refer to the member's Health Net identification card
- If the identification card is not available, refer to the last Eligibility Report on which the member's name appeared
- Hospitals and PPGs may also call the Health Net Medicare Programs Provider Services Department

Eligibility Reports

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 of these groups are not entitled to COBRA continuation coverage, but they are entitled to Health Net conversion coverage.

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).

Request for Payment Submission and Processing

Participating Physician Groups (PPG)

Participating physician groups (PPGs) must submit all eligibility guarantee payment requests with a completed PPG Professional Batch Form (PDF), and with a copy of the treating provider's original claim or invoice and proof of payment (such as the Explanation of Benefits (EOB) or Explanation of Payment (EOP) by the PPG to the Health Net Reinsurance Unit.

In addition, the PPG must:

- Write "Eligibility Guarantee" on the front of the PPG Professional Batch Form.
- If applicable, attach a copy of the substitute or replacement insurance plan's EOB or EOP (denying the claim) or copies of two billings sent to the member or person having legal responsibility for the member.

Indicate on all requests for payment from what source initial eligibility confirmation was obtained and the date obtained, as well as from what source and when ineligibility was confirmed. For example, "Eligibility Report dated March 2021, telephone verification February 23, 2021," or "Eligibility Certification Form signed by the member."

Eligibility Guarantee Processing

Eligibility guarantee requests for the calendar year must be submitted prior to February 28 of the following year. Health Net processes eligibility guarantee requests for payment on an ongoing basis and according to the terms of the eligibility guarantee in the PPG's Provider Participation Agreement (PPA).

Exclusions and Limitations

The following exclusions and limitations apply to eligibility guarantee:

- In order for Health Net to pay the PPG, the PPG must have contacted Health Net to verify eligibility for any member requiring emergency or inpatient hospital care.
- Members who come to the PPG for services without a valid Health Net identification (ID) card must sign an Eligibility Certification form. This form must also be signed if the member is not listed on the

most recent Eligibility Report. PPGs should not call Health Net to verify eligibility for services provided within the PPG.
- PPGs do not receive eligibility guarantee payments for current members who transfer into the PPG.
- Health Net limits final eligibility guarantee payments to professional charges (capitated services and insured services).
- If any insured services are provided before the PPG is notified of the member's ineligibility, they are considered subject to eligibility guarantee requests for payment only if they have not been included in claims made to Health Net directly by treating providers through insured service liability.
- If a member is determined by Health Net to have been ineligible at the time of receiving hospital services (or other shared-risk benefits), Health Net is not responsible for payment. The member is liable for these charges.

Telehealth Billing Requirement

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

When billing for a covered service delivered appropriately through a telehealth modality, providers must use the appropriate American Medical Association (AMA) CPT and HCPCS codes that are most descriptive for the service delivered.

For Medi-Cal members, bill for telehealth services in accordance with theDHCS Provider Manual Telehealth requirements.

For Commercial members:

- Use the normal place of service code (11, 23, etc.) – excluding FQHC/RHCs.
  - Use of place of service codes "02" or "10" are accepted when used correctly per the code's descriptor. Pricing using the Medicare physician fee schedule will result in payment parity in either situation for commercial claims.
- Use appropriate modifiers – excluding FQHC/RHCs.
  - Modifier 95 (synchronous, interactive audio and telecommunications systems); or
  - Modifier GQ (asynchronous store and forward telecommunications systems).

For Medicare members:

- Bill in accordance with CMS requirements.
- Use of place of service codes "02" or "10" are accepted when used correctly per the code's descriptor. Any related pricing using the Medicare physician fee schedule will apply the applicable Medicare rate for the place of service code used (facility rate for place of service "02" and non-facility rate for place of service "10") in accordance with CMS guidelines

Below are some examples (not exhaustive) of benefits or services that would not be appropriate for delivery via a telehealth modality:

- Performed in an operating room or while the patient is under anesthesia.
- Require direct visualization or instrumentation of bodily structures.
- Involve sampling of tissue or insertion/removal of medical device.
- Require the in-person presence of the patient for any reason.

Emergency Claims Processing

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

Health Net, its participating physician groups (PPGs) and hospitals are required to reimburse each complete emergency claim or portion of each claim as soon as possible, but not later than 45 business days after receipt of the complete claim. A PPG or hospital may contest or deny a claim or portion of a claim by notifying the provider in writing that the claim is contested or denied within 45 business days after receipt of the claim. The notice must identify the portion of the claim that is contested by revenue code, and the specific information needed from the provider to reconsider the claim. The notice that a claim is denied must identify the portion of the claim that is denied, and the specific reasons for the denial.

If a claim or portion of a claim is contested on the basis that the PPG or hospital has not received information reasonably necessary to determine payer liability for the claim, the PPG or hospital has 45 business days after receipt of this additional information to complete reconsideration of the claim. If the claim being reconsidered is not reimbursed within the respective 45 business days after the PPG's or hospital's receipt of the additional information, the PPG or hospital must pay interest or late charges.

A PPG or hospital may delay payment of an uncontested portion of a complete claim for reconsideration of a contested portion of that claim as long as the PPG or hospital pays interest.

Complete Emergency Claims

A complete emergency claim meets the following definitions:

- A paper claim from a hospital is deemed complete when submitted on a completed UB-04 and includes submission of a legible emergency room (ER) report and other reasonable relevant information requested.
- An electronic claim from a hospital is deemed complete when submitted on an electronic equivalent to the UB-04 and reasonable relevant information is requested. If Health Net or the PPG requests a copy of the ER report, Health Net or the PPG may also request additional reasonable relevant information, at which time the claim is deemed complete.
- A claim from a provider is deemed complete when submitted on a completed CMS-1500, or its electronic equivalent, and reasonable relevant information is requested.

Delegation

The obligations of Health Net, to ensure that claims are processed in a timely manner and with appropriate interest and late charges, if appropriate, are not waived when Health Net requires its PPGs to pay claims for covered services. Health Net may assign, by written contract, the responsibility to pay interest and late charges to PPGs or other contracting entities.

Interest Charged for Late Payment

The late payment by a PPG or hospital on a complete emergency claim, or portion thereof, that is neither contested nor denied, must automatically include the greater of $15 for each 12-month period or portion thereof on a non-prorated basis, or interest at 15 percent per year for the period of time that the payment is late. If the late payment does not automatically include interest, an additional $10 is paid to the provider.

If Health Net fails to notify the provider of service in writing of a denied or contested claim, or portion thereof, and ultimately pays the claim in whole or part, computation of the interest begins 45 business days after the date the claim was originally received.

Exceptions

Payment of interest or late charges does not apply to claims where there is evidence of fraud and misrepresentation, where the patient is determined to be ineligible for coverage, or instances where Health Net has not been granted reasonable access to information under the provider's control. Health Net specifies, in a written notice sent to the provider within the 45-business-day time frame, which of these exceptions apply to the claim.

Fee-For-Service Billing and Submission

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

This section contains general fee-for-service (FFS) claims billing and submission information.

Select any subject below:

- Electronic claims Submission
- Electronic claims Submission (IFP)
- FFS Claims Submission
- General Billing Guidelines

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, and PPO 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 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

Insured Services

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

Insured services are contracted services that are arranged or paid for by the participating physician group (PPG), and for which the PPG and Health Net have negotiated specific provisions in the PPG's Provider Participation Agreement (PPA) whereby Health Net has agreed to pay a negotiated amount to the PPG in each

case where the contracted services are rendered to a member assigned to the PPG. Such payments are in addition to the capitation paid per member. The specific description, definition and terms of payment for each insured service are outlined in the PPG's PPA addendum. Unless otherwise provided in the applicable addendum to the PPG's PPA, the terms of the insured services are described below.

Types of Insured Services

Pre-Existing Pregnancy

In addition to monthly capitation, Health Net pays a standard, flat fee to the PPG for costs it incurs in paying treating providers for professional maternity care and delivery services provided to any Health Net member who selects or is assigned to the PPG and gives birth within six months after enrollment with Health Net.

The following information is required when submitting a request for payment:

- Health Net Professional Batch Form (PDF) with completed member information
- Copy of treating provider's delivery service claim (CMS-1500)
- Related hospital bill (UB-04) to document date of delivery, or copy of authorization

IVF/GIFT/ZIFT (Advanced Infertility Treatments)

Health Net pays the PPG for the costs it incurs in compensating treating or participating providers for prior-authorized and case-managed treatment provided by a fertility center approved by Health Net, provided that: (i) Health Net member is entitled to advanced infertility treatments as a covered benefit per the Evidence of Coverage (EOC), and (ii) Health Net member's PPG, primary care physician (PCP) and Health Net's case management agree that the advanced infertility treatments meet the medical criteria for coverage. Payment is in accordance with the applicable PPA addendum, subject to scheduled copayments for infertility treatment services. Refer to the Family Planning topic and the member's EOC for a detailed description of covered services, exclusions and limitations.

The following information is required when submitting a request for payment:

- Health Net PPG Professional Batch form (PDF) with completed member information
- Copies of all treating providers' claims (CMS-1500) relating to the advanced infertility treatments
- Proof of payment, to include the PPG contract amounts paid to treating providers for each service

Additional Insured Services

Additional services may be designated as Insured Services by an agreement between Health Net and PPG.

Requests for Payment Submission Requirements

The PPG must submit all requests for payment with a copy of the original CMS-1500 or UB-04 as applicable, from the treating provider, and with the completed Health Net PPG Professional Batch form. The requests for payment must be submitted to Health Net within 120 days from the date of service or as stated in the applicable PPA addendum. All requests for payment must be sent to the Health Net Reinsurance Unit.

Requests for Payment Processing

Payment for each pre-existing pregnancy is a specified flat fee. Payment for advanced infertility treatments is described in the applicable PPG PPA addendum.

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.

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.

Professional Stop Loss

Participating Physician Groups (PPG)

The following applies to participating physician groups (PPGs) participating in the Health Net professional stop loss program. Unless otherwise specified in the PPG's Health Net Provider Participation Agreement (PPA), the terms of the program are described below.

Professional stop loss limits the PPG's liability for providing capitation services rendered by participating providers to Health Net members. The PPG's liability for capitation services provided to a Health Net member in a calendar year for a standard contract is limited to the amount specified in the PPA. PPGs must select a professional stop loss level that is acceptable to Health Net and inform Health Net of its selection 60 calendar days prior to the beginning of the calendar year the stop loss level becomes effective. The cost of professional stop loss is deducted from the PPG's monthly capitation; however, if permitted under the PPG's PPA, the PPG may elect to purchase stop loss from a third party. If a PPG elects to purchase stop loss from a third party, it must provide Health Net with proof of stop loss acceptable to Health Net in accordance with the PPA. Self-insurance or stated reserves for Incurred But Not Reported (IBNR) is not stop loss.

When the PPG has made payments exceeding the applicable professional stop loss level and has purchased professional stop loss from Health Net, the PPG must complete and submit a Health Net PPG Professional Claim form (PDF) to Health Net.

Payment Request Submission Requirements

The allowable payment for claims of treating providers under the stop loss program is based on terms set forth in the PPA. If, after Health Net's calculation, the PPG finds that its costs for capitated services provided to a member have exceeded the stop loss threshold, the PPG may make a request for payment under the stop loss program.

Professional stop loss is calculated and paid on a calendar year basis. The PPG notifies the Health Net Reinsurance Unit about eligible professional stop loss cases by supplying the member's name and subscriber identification number.

Treating providers' professional claims submitted through the automated encounter submission process qualify for inclusion in the professional stop loss program, subject to the following exceptions:

The PPG must submit hard copy claims (CMS-1500 or UB-04) of treating providers for multiple surgical procedures, unlisted procedures or unclassified medications, anesthesia time units for anesthesia charges, and any other procedures that are required for further clarification. The PPG should provide its proof of payment (such as Explanation of Benefits (EOB) or Explanation of Payment (EOP)) to treating providers. In order to receive timely payments, the PPG must submit requests for payment and encounter data to Health Net within the timely filing limit set forth in the PPG's PPA.

Requests for payment of the PPG's costs are not processed if the treating provider's claims are incomplete or inaccurate. To receive credit for treating providers' claims, the PPG must resubmit them to Health Net with complete and accurate information. Final adjudication reports, if required, are forwarded to the PPG.

Professional stop loss requests for payment for the current year must be submitted by the PPG on or before April 30 of the following year or within the timely filing limit set forth in the PPA.

Requests for Payment Processing

Health Net excludes all non-covered items from a treating provider's claim prior to processing a PPG's request for payment under the professional stop loss program. The following are not reimbursable through professional stop loss:

- Services eligible for payment or paid through insured services, shared-risk or eligibility guarantee.
- Services during a period in which the member's contract is not in effect.
- Services not covered as a benefit through the plan in which the member is enrolled.
- Services provided in connection with workers' compensation.
- Services for which benefits are reimbursable through coordination of benefits (COB) and third-party liability.
- Copayments required to be paid by Health Net members.

Health Net bases final payment under the professional stop loss program on the calculation of expenses incurred in reaching the professional stop loss level in accordance with terms of the PPG's PPA.

Any amounts exceeding the PPG's attachment point are reimbursed at a negotiated rate specified in the PPA.

The first step in processing the treating provider's claim is calculating the total allowable amount for the claim excluding non-covered items. If the allowable amount does not exceed the PPG's attachment point, the PPG's request for payment pertaining to that treating provider's claim is denied. If the total allowable amount for the treating provider's claim exceeds the PPG's attachment point, a negotiated percentage of the amount exceeding the attachment point is credited to the PPG. Health Net is not under any obligation to pay the PPG for any request for payment not submitted within 120 days of the treating provider's rendition of contract services.

Each PPG must maintain records of services provided by a treating provider in order to determine when the level of liability for covered capitation services has been reached under the stop loss program. The PPG calculates the allowable amounts for professional stop loss monthly, based on the payment schedule set forth in the PPA.

PPGs must maintain the following records for at least one year:

- Services provided by the treating provider, including medical records and accounting records showing copayments paid, for any third-party liability or coordination of benefits (COB) payments.
- Billing from referring physicians or agencies showing the direct cost of the services.
- Treating provider's surgical reports for multiple surgical procedures (modifier -51) and unusual surgical procedures (modifier -22), as well as any surgical procedures with no unit values (BR, SV and RNE).
- Anesthesia time from surgical reports.

Refunds

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

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.

- 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 HMS, Optum, Rawlings, or GB Collects, 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:

- Emergency Claims
- Endoscopies Classification Reimbursement
- Reimbursement Amount
- Pharmacist Services

Emergency Claims

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

Health Net, and its delegated and capitated participating physician groups (PPGs) and hospitals (payers), are required to reimburse, deny or contest each complete emergency claim or portion of each claim as soon as practical, but not later than 45 business days after receipt of the complete claim. Payers may contest or deny a claim or portion of a claim by notifying the provider in writing that the claim is contested or denied within 45 business days after receipt of the claim. If a claim is contested, the notice must identify the portion of the claim that is contested by revenue code, and the specific information needed from the provider to reconsider the claim. The notice that a claim is denied must identify the portion of the claim that is denied, and the specific reasons for the denial.

If a claim or portion of a claim is contested on the basis that a payer has not received information reasonably necessary to determine payer liability for the claim, the payer has 45 business days after receipt of this additional information to complete reconsideration of the claim. If reconsideration of the claim (including payment, if appropriate), is not completed within the respective 45 business days after the payer's receipt of the

additional information, the payer must pay statutory interest and any other applicable penalties described in California Health and Safety Code section 1371.35(b).

Complete Emergency Claims

A complete emergency claim is defined as follows:

- A paper claim from a provider is deemed complete when submitted on a completed UB-04 and includes submission of a legible emergency room (ER) report and other reasonable relevant information requested
- An electronic claim from a provider is deemed complete when submitted on an electronic equivalent to the UB-04 and other requested reasonable relevant information has been received. If the payer requests a copy of the ER report, the payer may also request additional reasonable relevant information
- A claim from a provider is deemed complete when submitted on a completed CMS-1500, or its electronic equivalent, and any requested reasonable relevant information has been received

Delegation

The obligations of Health Net to ensure compliance with claims settlement laws are not waived when Health Net contracts with delegated and capitated PPGs or hospitals that agree to assume risk and pay claims for covered services.

Interest Charged for Late Payment

A payer's late payment of a complete emergency claim, or portion thereof, that is neither contested or denied, must automatically include the greater of $15 for each 12-month period or portion thereof on a non-prorated basis, or interest at 15 percent per year for the period of time that the payment is late. If the late payment does not automatically include interest, an additional $10 is paid to the provider of service.

If the responsible payer fails to notify the provider of service in writing of a denied or contested claim, or portion thereof, and ultimately pays the claim in whole or in part, computation of the interest begins 45 business days after the date the claim was originally received.

Exceptions

Payment of interest or late charges does not apply to claims where there is evidence of fraud and misrepresentation or instances where a payer has not been granted reasonable access to information under the provider's control. Health Net specifies, in a written notice sent to the provider within the 45-business-day time frame, which of these exceptions apply to the claim.

Endoscopies Classification Reimbursement

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

Health Net uses the Endoscopy Matrix to classify an outpatient endoscopy as a diagnostic test or therapeutic (surgical) procedure, regardless of place of service. If the Provider Participation Agreement (PPA) does not include CPT codes specific to endoscopies identifying them as diagnostic testing or therapeutic (surgical) procedures, providers should refer to the Endoscopy Matrix (PDF). Once the provider has determined whether the endoscopic procedure is a diagnostic test or therapeutic (surgical) procedure, the claim is processed as follows:

- Diagnostic test - Health Net determines financial responsibility and reimbursement methodology according to the Division of Financial Responsibility (DOFR) for diagnostic testing in the PPA.
- Therapeutic (surgical) procedure - Health Net determines financial responsibility and reimbursement methodology according to the DOFR for therapeutic (surgical) procedures in the PPA.

If the PPA includes specific reimbursement language regarding endoscopies that is inconsistent with the information above, Health Net determines financial responsibility according to the language in the PPA. The matrix is not intended to be used to determine a patient's covered benefits or copayment obligations.

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.

Pharmacist Services

Provider Type: Participating Physician Groups (PPG)

Pharmacists may bill for covered services that are within the pharmacist's scope of practice and follow certain conditions for members. Pharmacists must be reimbursed for these services under the member's medical benefit.

Participating physician groups (PPGs) must pay pharmacists for services that are within their professional scope. This applies to pharmacist services delivered in both in-network pharmacies and, if the member has this covered in their pharmacy benefit, out-of-network pharmacies. Pharmacists will only be reimbursed under the following conditions:

- Services performed are within the lawful scope of practice of the pharmacist.
- The member's coverage provides reimbursement for identical services performed by other licensed health care providers.

PPGs are responsible for reimbursing duly licensed pharmacist delivered services under their Division of Financial Responsibility for the category of the service description.

Reinsurance

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

This section includes general information on reinsurance processes.

Select any subject below:

- Hospital Reinsurance
- Shared Risk Reinsurance
- Special Risk Reinsurance
- Transfer Reinsurance

Hospital Reinsurance

Provider Type: Hospitals

Hospitals that receive capitation to provide institutional risk services are referred to as capitated dual-risk hospitals. Unless otherwise provided in the hospital's Provider Participation Agreement (PPA), the terms of the program are described below.

The capitated hospital's liability for institutional risk services provided to a Health Net member in a calendar year is limited to a negotiated amount. This amount is known as the attachment point or hospital reinsurance level.

When the capitated hospital provides institutional risk services that exceed the applicable hospital reinsurance level per member per calendar year, the hospital submits reinsurance requests for payment to the Health Net Reinsurance Unit. Capitated hospitals are required to purchase reinsurance from Health Net. The cost of hospital reinsurance is deducted from the hospital's monthly capitation, as stated in the PPA. However, if

permitted under the hospital's PPA, the hospital may elect to purchase reinsurance from a third party. If a hospital elects to purchase reinsurance from a third party, it must provide Health Net with proof of insurance acceptable to Health Net in accordance with the PPA. Self-insurance or stated reserves for Incurred But Not Reported (IBNR) is not reinsurance.

Non-Covered items

The following charges are not included or payable through hospital reinsurance:

- Services eligible for payment through insured services, professional stop loss, eligibility guarantee, or out-of-area reinsurance.
- Services provided when the member is not eligible.
- Services not covered through the plan in which the member is enrolled.
- Services that are the PPG's liability and covered through capitation.
- Services provided in connection with workers' compensation or services for which benefits are reimbursable through coordination of benefits (COB) and third-party liability.
- Copayments required by a member's Health Net plan.

Requests for Payment Submission

Attach the following information to the hospital reinsurance request for payment:

- PPG Professional Batch form (PDF) and cover letter from the hospital specifying that the request for payment is under the hospital reinsurance program.
- Dual-risk claims from treating hospitals, with Explanation of Benefit (EOB) or explanation of payment (EOP) by capitated hospital attached.
- Medical records and operation reports.

Requests for Payment Processing

Requests for payment are processed by calculating the total allowable amount. If the amount does not exceed the hospital's attachment point (refer to the hospital's PPA for the attachment point), the request for payment is denied. If the total allowable amount exceeds the attachment point, the amount exceeding the attachment point is credited to the hospital.

Shared Risk Reinsurance

Provider Type: Participating Physician Groups (PPG)

Health Net shared-risk reinsurance limits the participating physician group's (PPG's) responsibility under the shared-risk program to a negotiated limit for shared-risk services and out-of-area emergency services. Unless

otherwise provided in the PPG's Provider Participation Agreement (PPA), the terms of the shared-risk reinsurance program are described below.

Shared-risk PPGs are required to purchase reinsurance from Health Net. The cost of shared-risk reinsurance is deducted from the PPG's shared-risk budget. However, if permitted under the PPG's PPA, the PPG may elect to purchase reinsurance from a third party. It must provide Health Net with a copy of the declaration page from the reinsurance policy on an annual basis. Self-insurance or stated reserves for Incurred But Not Reported (IBNR) is not reinsurance.

Out-of-Area Urgent and Emergency Services

Out-of-area urgent and emergency (collectively, emergency) services are covered under the shared-risk reinsurance program. Health Net processes and pays treating provider claims for hospital and professional emergency services provided more than 30 air miles from the member's primary care physician's (PCP's) office or outside the PPG's service area as defined in the PPG's PPA. Ambulance charges for transporting the member are also included in costs eligible for shared-risk reinsurance.

When a member gives birth (including cesarean section) outside the member's PPG's service area, professional and institutional charges are treated as arising from an out-of-area emergency and are eligible for shared-risk reinsurance. The member's PPG must arrange for or authorize any follow up care in order for the delivery and follow up care to be eligible for shared-risk reinsurance.

The costs of treating providers' claims for non-emergency treatment outside a 30 air mile radius from the member's PCP's office, or outside the PPG's service area as defined in the PPG's PPA, are excluded from the shared-risk reinsurance program and are the responsibility of the member unless authorized by the PPG. Refer to the Out-of-Area Emergency Services topic in the PPA for additional information.

Shared-Risk Claims from Treating Providers

The PPG must forward shared-risk claims received from providers of service or members to the Medicare Advantage Claims Department, HMO Claims Department for processing within 10 business days following the receipt of the claims.

All shared-risk claim payments are made directly to the provider of the service, unless it is indicated that the member has already made payment. Incomplete claims are returned to the provider of service. Out-of-area claims payments in conjunction with a non-participating hospital are paid to the member, unless there is an assignment of benefits. Health Net pays claims included in the shared-risk reinsurance program throughout the year.

Settlement of Reinsurance

The monthly Shared-Risk Report sent to PPGs shows claims over the attachment point included as the PPG's shared-risk costs for shared-risk services. At the end of each year, these claims are removed from the shared-risk cost account. Out-of-area emergency claims do not appear on the monthly Shared-Risk Services Report.

Health Net settles costs associated with payments it makes to treating providers under the shared-risk reinsurance program, which exceed the attachment point for a calendar year at the same time Health Net makes the shared-risk settlement. At that time, Health Net identifies costs attributable to members' claims that

have exceeded the attachment point and issues a report. Adjustments are made to the PPG's shared-risk budget based on this report.

Special Risk Reinsurance

Provider Type: Participating Physician Groups (PPG) | Hospitals

The following applies to capitated participating physician groups (PPGs) or hospitals that have purchased special-risk reinsurance from Health Net, as indicated in the PPG and hospital Provider Participation Agreement (PPA). Unless otherwise provided in the PPG or hospital's PPA, the terms of the special-risk reinsurance program are described below.

Special-risk reinsurance limits PPG or hospital liability for some of the expenses incurred for claims of professional, institutional and pharmacy providers for services they provide to members with AIDS. When purchased by the PPG or hospital, Health Net pays the PPG's or hospital costs attributable to these services.

Reinsurance amounts for HMO members are deducted from the PPG's or hospital's monthly capitation, as set forth in the PPA. For Point of Service (POS) members, reinsurance premiums are deducted from the PPG's capitation and shared-risk budget in accordance with the terms of the PPG's PPA.

PPGs and hospitals that elect not to participate in the special-risk reinsurance program are financially responsible for paying treating providers' and facilities' claims for services related to members diagnosed with AIDS, including AIDS-related pharmacy claims, where it is their financial responsibility under the PPA Division of Financial Responsibility (DOFR). When the PPG or hospital does not participate in the special-risk reinsurance program, AIDS-related pharmacy claims that are the PPG's or hospital's respective responsibility and paid by Health Net are deducted from the PPG or hospital's monthly capitation to cover these claims.

Diagnoses Associated with AIDS

Special-risk reinsurance also covers the cost of treating members with specific diagnoses associated with AIDS, notwithstanding whether the member is positive for HIV.

Specific diagnoses include:

- Candidiasis of esophagus, trachea, bronchi, or lungs
- Cryptococcosis, extrapulmonary
- Cryptosporidiosis with diarrhea in a person older than one month
- Cytomegalovirus disease of an organ other than liver, spleen, or lymph nodes in a person older than one month
- Kaposi's sarcoma in a person under age 60
- Lymphoma of the brain (primary) in a person under age 60
- Mycobacterium avium complex/M. kansasii disease, disseminate
- Pneumocystis carinii pneumonia
- Progressive multifocal leukoencephalopathy
- Toxoplasmosis of the brain in a person older than one month
- Herpes simplex virus with an ulcer lasting longer than one month or herpes simplex virus with bronchitis, pneumonia or esophagitis in a person older than one month

Additional diagnoses associated with AIDS require a positive HIV status in order to be covered through special-risk reinsurance. These diagnoses include:

- CD4 T-lymphocyte count less than 200
- More than one episode of recurrent pneumonia in one year
- Invasive cervical cancer
- Coccidiomycosis, disseminated
- HIV encephalopathy
- Histoplasmosis, disseminated
- Isosporiasis with diarrhea in an individual older than one month
- Non-Hodgkin's lymphoma
- Tuberculosis
- Recurrent salmonella septicemia
- HIV wasting syndrome

Covered Services and Payment Determination

Special-risk reinsurance covers the cost of treating members with specific diagnoses associated with AIDS, with or without HIV positivity. Claims for members who have an HIV-positive test only, with no symptoms, are not qualified to be processed through special-risk reinsurance.

In the event that the PPG or hospital fails to receive prior authorization from Health Net for an elective AIDS-related admission or fails to notify Health Net of such an admission, Health Net has the right to deny requests for payment under the special-risk reinsurance program. The costs not covered under the special-risk reinsurance program are applied to shared-risk costs or are the PPG's or hospital's financial responsibility.

Elective AIDS Admissions

PPGs and hospitals must receive prior authorization from the Health Net Medical Management Department for an elective AIDS-related admission. PPGs and hospitals must notify Health Net's Medical Management Department in a timely manner of urgent or emergency AIDS-related admissions for members with AIDS who are receiving anti-viral home infusion treatments and members with AIDS who are receiving total parenteral nutrition. Timely notification is defined as within 24 hours of admission or initial treatment, or the next business day following an admission or initial treatment on a holiday or weekend.

Requests for Payment Submission

To request payment for AIDS-related costs through special risk reinsurance, PPGs and hospitals must submit requests for payment to the Health Net Reinsurance Claims Unit. A Health Net PPG Professional Batch form (PDF) must be completed as follows and submitted with applicable documentation:

- Special-Risk Reinsurance written at the top of the form
- CMS-1500 or UB-04 form from treating provider:
    - Original copies or a very clear photocopy
    - Itemized bills attached to each inpatient claim
    - Itemized bills attached to each electronic claim
- Copy of the Explanation of Benefits (EOB) or payment

- Items are not highlighted
- Copies of authorization for nuclear medicine claims by treating provider
- A completed Special-Risk Pool Member Identifier Form A (PDF) for first time requests for payment in place of the member's medical records. Include date member was first diagnosed with AIDS (symptomatic HIV infection). Form must be signed by PPG staff member ensuring records review occurred and case met criteria for special-risk reinsurance program
- AIDS-related conditions specified (refer to Attachment A for a list of Centers for Disease Control and Prevention (CDC) diagnoses criteria)
- A completed Special Risk Pool Claims Submission Form B (PDF) for all subsequent requests for payment for the same member

Health Net has modified the requirements for submitting requested medical records in view of member confidentiality concerns. Health Net no longer requires regular submission of the following items, but may request them in individual cases:

- Treating provider's medical records and lab reports (for example, CD4T - Lymphocyte count and HIV test result only) for members not established in special-risk reinsurance to determine if criteria are met
- Copies of treating provider's medical records with each subsequent claim submission when diagnosis on claim does not match the criteria matrix
- List of medications prescribed by a treating provider to member. Medications should match the procedures or examination charges

PPGs and hospitals must submit all requests for payment and related records within 120 days of the date of service. Health Net denies reimbursement for claims received after 120 days of the date the service is provided, and the PPG or hospital has full responsibility for the service.

Send the claim and attachments to the Health Net Reinsurance Claims Unit.

Requests for payment are processed in accordance with Health Net's procedures and terms of the PPA. Health Net subtracts from the payment the amount due to the PPG or hospital, such as any copayments the provider of service may collect and any third-party amounts the PPG or hospital collects.

Transfer Reinsurance

Provider Type: Participating Physician Groups (PPG) | Hospitals

Health Net's member transfer policy allows members undergoing medical treatment to transfer to an alternate participating physician group (PPG). The Transfer Reinsurance program is designed to mitigate PPG and hospital financial risk under the member transfer policy. This program is offered in Los Angeles, Riverside, and San Bernardino counties. Health Net reserves the right to discontinue this program after any calendar year. Unless otherwise provided in the Provider Participation Agreement (PPA), the terms of the Transfer Reinsurance program are described below.

Hospitalized members are required to wait until they are discharged before Health Net approves a transfer, and members must work or live within the service area of the selected PPG.

Cost

The cost of transfer reinsurance is stated in each PPG's and hospital's PPA. The cost is split with capitated hospitals, if applicable. Shared-risk PPGs and hospitals have the cost of transfer insurance deducted equally from professional capitation and the shared-risk pool.

Exclusions

The Transfer Reinsurance program does not include members enrolled in Medicare Supplement, Flex-Funded, and Point-of-Service (POS) benefit programs. Requests for payment of costs related to claims of treating providers for services to members assigned to a PPG through new member or open enrollment or due to a change of home or work address, are not eligible for payment under the Transfer Reinsurance program.

Members covered under the Special-Risk Reinsurance program do not qualify for coverage under this program.

If a member qualifies for coverage under the Transfer Reinsurance program and another Health Net reinsurance program, the other reinsurance program applies.

Thresholds

The PPG's cost for services provided to the member must reach the threshold amounts stated in the hospital or PPG PPA before the Transfer Reinsurance program covers costs for treating providers' claims related to any service. These threshold amounts must be incurred within 180 days of the effective date of the member's transfer and assignment to the PPG in order for transfer reinsurance to take effect.

Requests for Payment Submission

Submit requests for payment on a Health Net PPG professional Batch form (PDF), with Transfer Reinsurance written at the top, to the Health Net Reinsurance Unit. Requests for payment must be submitted within 120 calendar days after meeting the threshold.

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.

Shared Risk

Provider Type: Participating Physician Groups (PPG) | Ancillary

The shared-risk program is a financial agreement in which Health Net and the participating physician group (PPG) share responsibility for costs of services as defined by the PPG's Provider Participation Agreement (PPA). Shared-risk services may include health services when provided by a hospital, skilled nursing facility, home health agency, residential facility, ambulance service, other specified ancillary services, and outpatient pharmacy costs, as set forth in the PPA.

For more information, select any subject below:

- Shared Risk Settlement
- Shared-Risk Reporting

Shared-Risk Reporting

Provider Type: Participating Physician Groups (PPG)

At the end of each month, all claim payments made by Health Net to treating providers (reconciliation claims) in that month are listed on the CLRM02S-ICE Shared-Risk Paid Claims Report and the Actuarial Injectable Risk Report is available on the provider portal websites > Reports under Welcome.

These reports list each reconciliation claim that Health Net paid using funds from the participating physician group's (PPG's) shared-risk budget. The CLRM02S-ICE report does not take into account the terms of specific individual Provider Participation Agreements (PPAs).

Health Net also provides the PPG with electronic monthly shared-risk reports within 60 days following the end of the month that is being reported. Health Net also provides the PPG with shared-risk status reports showing an estimated mid-year settlement within 90 days following the end of the first six months of the calendar year.

CLRM02S-ICE Version Shared-Risk Paid Claims Report Dispute

If a PPG feels that a claim was charged erroneously to the shared-risk budget, the PPG must document the charges in question (subscriber identification number, member's name, dates of service, amount paid, and other necessary information) and send this information to the Health Net Research and Resolution Unit within 90 days from the date the payment by Health Net was first reported to the PPG.

Actuarial Injectable Risk Report Dispute

If a PPG feels that a claim was charged erroneously to the shared-risk budget, the PPG must document the charges in question (subscriber identification number, member's name, dates of service, amount paid, and other necessary information) and send this information to the PPG's provider network representative within 90 days from the date of payment.

Paid Claims Report Field Descriptions

Field descriptions for the shared-risk paid claims report are contained in the CLRM02S-ICE Report located on provider portal websites > Reports under Welcome.

Shared Risk Settlement

Provider Type: Participating Physician Groups (PPG)

Shared-risk settlement (PDF) is calculated by using the shared-risk formula and is based on both paid and incurred claim costs during the year. A final settlement is made within 120 days after the end of a calendar year. Claims incurred in the calendar year, but not received within 90 days after the end of that year, are charged against the following year's shared-risk budget.

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
- Reproductive Privacy Act
- Provider Offshore Subcontracting Attestation
- Communicable Diseases Reporting
- DMHC-Required Statement on Written Correspondence
- 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.

Reproductive Privacy Act

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

Reproductive rights, privacy and the exchange of information

Certain businesses handling medical information on sensitive services must develop security policies for data related to gender-affirming care, abortion, abortion-related services, and contraception. California law also prohibits health care providers, plans, contractors, or employers from sharing medical information for investigations or inquiries from other states or federal agencies regarding lawful abortions unless authorized by existing law.

Data for gender-affirming and abortion-related services must be omitted from data exchanged via health information exchanges (HIEs) and not be transmitted to California HIEs.

State law specifically states:[1]

- **A business that electronically stores or maintains medical information on the provision of sensitive services**, including, but not limited to, on an electronic health record system or electronic medical record system, on behalf of a provider of health care, health care service plan, pharmaceutical company, contractor, or employer, must have capabilities, policies, and procedures that enable all of the following:
  - **Limit user access privileges** to information systems that contain medical information related to gender-affirming care, abortion and abortion-related services, and contraception only to those persons who are authorized to access specified medical information.
  - **Prevent the disclosure, access, transfer, transmission, or processing of medical information** related to gender-affirming care, abortion and abortion-related services, and contraception to persons and entities outside of the state of California
  - **Segregate medical information** related to gender-affirming care, abortion and abortion-related services, and contraception from the rest of the patient's record.
  - **Provide the ability to automatically disable access** to segregated medical information related to gender-affirming care, abortion and abortion-related services, and contraception by individuals and entities in another state.

Additionally, state law prohibits the collection or disclosure of information outside California for operational claims payment purposes. State law includes requirements for provider licensing, enhanced protections for individuals and providers in sensitive services and "legally protected health care activity," including preventing the disclosure of medical information related to sensitive services outside the state, segregating such information from the patient's record, and enabling automatic disabling of access by entities outside the state.

- **Legally protected health care activity** includes, but is not limited to:
  - Reproductive health care services,
  - Gender-affirming health care services, and
  - Gender-affirming mental health care services.

- **Sensitive services** include, but are not limited to:
  - Services related to mental/behavioral health,
  - Sexual and reproductive health,
  - Sexually transmitted infections,
  - Substance use disorder,
  - Gender affirming care, and
  - Intimate partner violence.

Requirements for providers

Physicians and other health care providers must incorporate and/or adhere to the following:

- Specified businesses that store or maintain medical information regarding sensitive services must develop specific policies, procedures and capabilities that protects sensitive information.
- Health care service plans, providers and others may not cooperate with any inquiry or investigation from any individual, outside state, or federal agency that would identify an individual that is seeking, obtaining, or has obtained an abortion or related services that are lawful in California. Exceptions may be authorized if the individual has provided authorization for the disclosure.
- The exchange of health information related to abortion and abortion-related services is excluded from automatically being shared on the California Health and Human Services Data Exchange Framework.

[1]Information taken or derived from Assembly Bill 352, Senate Bill 345, or information at https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB352 or https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB345.

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.

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.

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

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.

COB Payment Calculations

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

As the secondary carrier, the plan coordinates benefits and pays balances, up to the member's liability, for covered services, unless the maximum allowable is paid by the primary care insurer. However, the dollar value of the balance payment cannot exceed the dollar value of the maximum allowable amount that would have been paid had the plan been the primary carrier.

In most cases, members who have coverage through two carriers are not responsible for cost shares or copayments. Therefore, it is advisable to wait until payment is received from both carriers before collecting from the member. Copayments are waived when a member has other insurance as primary coverage. If a participating provider contracts with two HMOs and the member belongs to both, all prior authorization requirements for both carriers must be complied with in order to coordinate benefits. For example, if the primary carrier as well as the plan require authorization for a procedure or service, and authorization is

requested and approved by the primary carrier, the plan does not require authorization for that procedure or service. However, if the primary carrier requires authorization and authorization is not requested or approved from the primary carrier, and the plan requires authorization, the plan does not make payment as the secondary carrier unless the prior authorization is requested and approved by the plan

Disagreements with Other Insurers

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

Not all insurers operate under the jurisdiction of the California Department of Managed Health Care (DMHC) or California Department of Insurance (CDI). In some instances, insurers do not operate under any legal authority at all regarding coordination of benefits (COB). For this reason, hospitals may encounter insurers, administrators and others who would ordinarily be the primary carrier but refuse to pay. There is no practical recourse if they have different rules in their state or are a self-funded plan.

When disagreements arise with insurers due to differences in applicable law, abides by the rules employed by the state in which the other insurer operates. For self-funded plans, the plan abides by the conditions in the self-funded plan's evidence of coverage. After dealing with the immediate matter of providing or paying for a covered service, the hospital can still make an effort to recover payment from the other insurer.

Duplicate Plan Coverage

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

If a member is covered by more than one group plan and is enrolled with a single participating provider, all copayments must be waived for eligible services.

In addition, when coverage states a maximum number of visits, the member is entitled to the number of visits in the plan that covers the most. For example, if one plan covers 20 visits and the other 50 visits, the member's coverage is limited to 50 visits.

If the member is covered by more than one group plan and is enrolled with two different participating providers, coverage is determined by applying coordination of benefits (COB) rules. Applicable copayments are required from the member.

Medicare Plus (Plan J or HJA)

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

If the member has conversion or Medicare Plus (Plan J or HJA) coverage:

- Medicare is primary
- The plan is always secondary

Medicare Plus (Plan J or HJA) is non-group coverage for Medicare beneficiaries who have lost eligibility through group or conversion plans.

Medicare Plus is available to subscribers and their spouses when:

- They are age 65 or older.
- Their previous group or conversion coverage has ended.
- They are covered by both Parts A and B of Medicare (current employment does not affect eligibility for Medicare Plus).
- They are not enrolled in another HMO plan through a Medicare HMO contract.

When the plan discovers that a Plan J or HJA member is not covered through both Parts A and B of Medicare or that the member is enrolled in another HMO plan through a Medicare HMO contract, the plan cancels the member's Plan J or HJA coverage.

Application for Medicare Plus must be made within 31 days of the member's last date of group or conversion coverage.

Order of Benefit Determination

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

Apply these rules in the order in which they are listed in determining which plan is primary and which is secondary:

- Rule One - Insurer without coordination of benefits (COB) provision - If one contract contains a COB provision and the other does not, the insurer without the provision is the primary carrier.

The following rules apply when there are two insurers and both contracts contain a COB provision:

- Rule Two - Insurer covering member as policy holder or subscriber - When the member is the policy holder or subscriber with one insurer and the dependent with another, the insurer that covers the member as the policy holder or subscriber is the primary carrier.
- Rule Three - Member is a dependent child with both insurers (birthday rule) - The insurer of the subscriber whose birthday is earlier in a calendar year is the primary carrier for dependents covered under that subscriber's group health plan. The insurer of the subscriber whose birthday is later in the calendar year is the secondary carrier for dependents covered under that subscriber's group health plan. This birthday rule applies to dependent children whose parents are living together but have never married. It does not apply to dependent children whose parents have been divorced or legally separated. Refer to the Order of Benefits for Dependent Children (PDF) chart for assistance in COB situations.
- Rule Four - Divorced or legally separated parents of dependent child with court decree - If the parents of a dependent child are legally separated or divorced and a court decree directs one parent to be financially responsible for the child's medical, dental or other health care expenses, the insurer of the parent who is financially responsible is the primary carrier.

- Rule Five - Divorced parents of dependent child with legal custody - When parents of a dependent child are divorced and the court has not assigned financial responsibility for the child's medical, dental or other health care expenses, and the parent with legal custody of the child has not remarried, the insurer of the parent with legal custody of the child is the primary carrier for the child, and the insurer of the parent who does not have legal custody is the secondary carrier.
- Rule Six - Stepparents - In the case of a divorced parent, when the court has not assigned financial responsibility for the child's medical, dental or other health care expenses, the insurer who covers the child as the dependent of the parent with legal custody of the child is the primary carrier, and the spouse of the parent (stepparent) with legal custody's insurer is the secondary carrier. The insurer of the parent without custody is tertiary.
- Rule Seven - When the court orders joint custody - When the court has awarded joint custody of dependent children to divorced or legally separated parents, the plan applies the birthday rule (rule three).
- Rule Eight - Retired and laid-off employees - When a retired or laid-off employee has more than one coverage, the insurer who provides coverage to the patient as an active employee is primary; the insurer providing coverage as a retirement benefit is secondary.

When rules one through eight do not establish an order of benefit determination, the insurer who has covered the member the longest is the primary carrier.

Right to Receive and Release Information

The plan and other health plans may share information for the purpose of applying these rules and determining benefits payable under multiple health plans covering the person claiming benefits. The plan need not tell, or obtain the consent of, any person prior to doing this. Each person claiming benefits from the plan must give the plan any facts it needs to apply these rules and determine benefits payable.

Recovery of Excessive Payments

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

If the amount of the payment made by the plan is more than it should have paid under the coordination of benefits (COB) provision, the plan may recover the excess from one or more of those it has paid or from any other person or organization that may be responsible for the benefits or services for the covered person. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

Services Instead of Cash Payments

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

An allowable expense is a health care service or expense, including deductibles and copayments, covered at least in part by any of the health plans covering the person. When a health plan provides benefits in the form of services, the reasonable cash value of each service is considered an allowable expense and a paid benefit. An expense or service that is not covered by any of the health plans is not an allowable expense. The reasonable cash value of any services provided to the covered individual by any service organization is deemed an expense incurred by the individual, and the liability of the plan through the member's Evidence of Coverage (EOC) is reduced accordingly.

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.

TRICARE/CHAMPVA

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

The plan is primary in all instances when a member is covered by TRICARE or CHAMPVA.

Note that TRICARE/CHAMPVA takes the position that if a benefit is potentially available through an HMO, but the member does not comply with the requirements of the HMO that would enable the member to receive the benefit, such as in the case of a self-referral, TRICARE/CHAMPVA does not pay anything at all.

They do, however, cover services that the HMO excludes, but require that the member provide them with written documentation from the HMO that the service is excluded from the plan. Contact the Provider Services Department with any requests for this sort of documentation.

Veterans' Administration

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

The Veterans' Administration (VA) is a provider of care rather than an insurance program to which Congress granted the following rights:

Right to Require Payment

When participating providers must pay the VA for services, the VA has the right to require payment from private insurers, to the extent that benefits are available, for services they provide to qualified veterans for non-military service-related disabilities. This means that if the participating provider authorizes a service that has been or will be performed by the VA, and the participating provider would ordinarily pay for the service, the participating provider also has to pay the VA. The plan does the same regarding services for which it ordinarily makes payment

If a concern arises over whether an illness or injury is due to a military service-connected disability, the VA's determination is accepted. Federal law provides that the VA determination is not subject to review, even in the courts. On request, the VA must provide documentation to substantiate its decision.

Administrative Procedures

Providers must conduct administrative procedures as usual when the VA provides services to a member. The members should seldom require services from a VA participating provider. When it does happen, and the services have been authorized and referred, or a legitimate emergency necessitates services that were authorized after the fact, the participating provider should carry out all administrative procedures throughout the entire process in the usual manner as if the VA were not involved

Assignment of Benefits

The VA sends the insurer a copy of assignment of benefits. When a member is treated by the VA, federal regulations state that the VA must immediately send the insurer a copy of an assignment of benefits (this might be sent to either the participating provider or the plan). The VA cooperates with requests for medical records. Charges are based on stipulated formulas, but the VA does not expect to receive payment greater than would ordinarily be paid to other participating providers in the geographic area. The VA may receive a Medicare payment for services rendered.

When the Plan is the Primary Carrier

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

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
- Collection of Copayments
- Collection of Copayments for Referrals
- 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).

Collection of Copayments

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

Participating providers collect copayments for professional services when services are provided. If immediate collection of a copayment is not possible, the provider must send a bill to the member for the copayment at a later date.

The participating provider may not impose a surcharge on a Health Net member for covered services provided. If Health Net receives notice of any surcharge, action is taken in response.

Collect required office visit copayments when a member is seen by a physician, physician assistant (PA), nurse practitioner (NP), or any qualified professional provider for basic medical care. Refer to the member's plan chart in the Schedule of Benefits for specific copayment information and additional guidance or a list of sample situations that may be useful in determining the appropriate type and number of copayments. A copayment must be collected according to the service provided and not according to the licensure of the professional providing the service. This underlying principle must be considered when determining whether an office visit copayment is required.

Participating providers may not collect a copayment or any other fees for a missed appointment. The provider has the option of having the member transferred to another participating provider after three missed appointments.

Primary Care Physician and Specialist Copayments

A service rendered by any provider type other than the member's assigned primary care physician (PCP) may have a separate and different copayment amount. The specialist office visit copayment is required each time the member receives services from the specialist (not limited to the first visit).

When a member receives services from a PA or NP for a PCP office visit, the PCP office visit copayment applies. When a member receives services from a PA or NP certified in a particular specialty, the specialist office visit copayment applies. If the member's PCP or any PCP from the member's participating physician

group (PPG) provides services, the PCP copayment is applied. Refer to the specific plan chart for copayment amounts.

Urgent Care Copayment

The copayment amount due for care at an urgent care facility owned and operated by the member's PPG is the applicable office visit copayment instead of an urgent care copayment. This provision is reflected in the member's Evidence of Coverage (EOC).

Collection of Copayments for Referrals

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

Outside referrals include:

- Emergency rooms or urgent care centers.
- Inpatient or outpatient hospitalizations.
- Home health care services and visits.

Collection of copayments for outside referrals, other than those mentioned above, must be arranged with the provider of service or collected by the participating physician group (PPG) or primary care physician (PCP).

An emergency room copayment is collected as a partial reimbursement for services received at the facility. If the emergency room claim is split (for example, one claim is sent for facility services and another is sent for professional services), the emergency room copayment only applies to the facility claim. Professional services billed separately and received during an emergency room visit do not require an emergency room copayment.

Out-of-Pocket Maximum

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

Health Net members may be required to pay copayments for covered professional or hospital services. Copayments are limited to an established annual amount, referred to as the out-of-pocket maximum (OOPM), which is specified in the member's Evidence of Coverage (EOC). No further copayments for covered services may be imposed on a Health Net member once the OOPM has been met for the calendar year. OOPM amounts are subject to change annually.

Aggregate deductible/OOPM plans: Many plans have a member-level OOPM, two-party OOPM and a family-level maximum for the entire family. No individual member has to pay a greater copayment amount than the

amount required for a single-party contract in a calendar year. All copayments paid by all members in a family are added together to reach the applicable family OOPM (PDF).

Exclusions and Limitations

The terms of a member's Evidence of Coverage (EOC) lists in detail out-of-pocket costs that do not apply to the out-of-pocket maximum (OOPM). The following listing summarizes some costs that do not apply toward the OOPM amount:

- Expenses incurred for non-covered services
- Eyewear expenses
- Copayments for prescription medications. May not apply to some plans; refer to the Schedule of Benefits for specific information.

Some plans exclude expenses incurred for specific covered services. These exclusions are noted on the benefit plan chart in the Schedule of Benefits.

General Filing Requirements

When a member reaches the specified out-of-pocket maximum (OOPM) amount for any calendar or plan year, a claim can be submitted to Health Net. All claims must be submitted on a Health Net Out-of-Pocket Maximum Notification Form (CLM 114) (front of form (PDF), back of form (PDF). Once Health Net receives the claim form and establishes that the OOPM has been met, the member is released from any further copayment liability for that calendar or plan year. OOPM claims are reimbursable on a calendar or plan year basis only. Instruct members who wish to claim their OOPM for a particular year to contact the Health Net Member Services Department . Members should also refer to their Evidence of Coverage (EOC) to obtain their OOPM amount.

Participating physician groups (PPGs) or primary care physicians (PCPs) may request a Health Net Out-of-Pocket Maximum Notification Form (CLM 114) by contacting the Health Net Provider Services Center.

The subscriber is responsible for keeping a record of all copayments paid by all members on the plan. Proof of paid copayments include receipts and cancelled checks. Members mail the Health Net Out-of-Pocket Maximum Notification Form (CLM 114) and copies of all receipts and cancelled checks to the Health Net Claims Department.

Settlement of OOPM Claims

On receipt of a Health Net Out-of-Pocket Maximum (OOPM) Notification Form (CLM 114) (front of form (PDF), back of form (PDF) and copies of all receipts and cancelled checks, Health Net:

- Checks for eligibility
- Determines whether the services the member received were covered benefits
- Verifies receipts or cancelled checks
- Adds all copayments paid to verify that they equal the annual OOPM

When the OOPM has been satisfied, Health Net sends a letter (PDF) to the subscriber stating that no further copayments will be collected for the remainder of the calendar year. Health Net sends a copy of the letter (PDF) to the member's participating physician group (PPG) or primary care physician (PCP) and Health Net

retains a copy in its files. If the contract changes during the year, additional copayments may be collected, depending on the conditions in the new contract.

If the amount of copayments paid by the subscriber exceeds the OOPM, the Health Net Claims Department takes the following steps:

- **For shared-risk services:** Health Net reimburses the subscriber (proof that payment has been made required) for copayments made on shared-risk services and out-of-area claims. For the remainder of the calendar year, the shared-risk fund covers the required copayment for inpatient hospital charges on some plans, or the copayment required by the majority of plans for emergency room or urgent care center treatment within the selected PPG and PCP service area. A letter (PDF) is sent to the PPG or PCP administrator, with a copy retained on file at Health Net.
- **For capitation and insured services:** Health Net sends a letter (PDF) to the member's PPG or PCP to notify them that the member is due reimbursement. For the remainder of the calendar year, all professional services are covered by capitation and no additional copayments may be collected by the PPG or PCP. The copayment amounts are not deducted from professional stop loss payments if the PPG or PCP states on the professional stop loss claim that the member has reached the OOPM.

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 | Participating Physician Groups (PPG) | 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 | Participating Physician Groups (PPG) | Hospitals | Ancillary

This section contains general information for claims and service denials.

Select any subject below:

- Claims Denial Letter Requirements
- Denial of Investigational or Experimental Treatment for a Terminal Illness
- Service Denial Templates
- Member Denial Letter Templates
- Notification Delays
- Required Elements for Provider Notification Letters
- Requirements for Notification of Utilization Management Decisions

Claims Denial Letter Requirements

Provider Type: Participating Physician Groups (PPG) | Hospitals

Participating physician groups (PPGs) and capitated hospitals are required to notify the member and provider in writing within 45 business days when a claim is denied if the member has any financial responsibility for the charges. If denying the letter, PPGs are encouraged to use the Industry Collaboration Effort (ICE) Claim Denial Letter located under Approved ICE Documents on the ICE website at www.iceforhealth.org/library.asp. Claim denial letters must specify:

- Date of denial notice
- Member name

- Provider name
- Specific service
- Date of service
- Denied amount
- Member responsibility amount
- Reason for the denial - Claim denials for members must include a claim denial message. Use the ICE Commercial HMO Claim Denial Reasons Guide located under Approved Documents on the ICE website at www.iceforhealth.org/library.asp
- Provider and member appeals process and information, including plan name, address and telephone number for appeals. For disputes, include the Department of Managed Health Care (DMHC) Required Statement.

PPGs and hospitals may not send denial notices to capitated members if they are not financially liable for the services.

For emergency room (ER) claims denials, use the ICE Commercial Member ER Claim Denial Letter located under Approved ICE Documents on the ICE website at www.iceforhealth.org/home.asp.

Denial of Investigational or Experimental Treatment for a Terminal Illness

Provider Type: Participating Physician Groups (PPG) | Hospitals

In accordance with standards established by the Department of Managed Health Care (DMHC), Health Net has five calendar days to respond to member requests for investigational or experimental treatment for a terminal illness. Health Net is required to review all requests for these procedures and, in the case of a denial, is responsible for issuing the denial letter. Participating physician groups (PPGs) are required to notify Health Net immediately of member requests or proposed services for expedited investigational or experimental treatment for a terminal illness.

Terminal illness is defined as a member having a life expectancy of six months or less as stated in writing by his or her attending physician or surgeon, or the member has an incurable or irreversible condition that has a high probability of death within one year.

PPGs must immediately forward all pertinent documentation for investigational or experimental treatment for a terminal illness via fax to Health Net's Continuity and Coordination of Care Department. PPGs must not direct members to contact Health Net for approval of these services. It is the PPG's responsibility to contact and provide Health Net with pertinent information and documentation.

Health Net's Coordination of Care Department has a dedicated fax number and address to receive PPGs' requests for investigational or experimental treatment for terminal illnesses to ensure timely processing. For an initial review of a request for services, Health Net does the following:

- Give written notice to the member within five business days of the decision. The notice must state the medical and scientific reasons for the denial and state an alternative treatment that Health Net does cover. It also includes Health Net's appeals and grievance procedures or complaint form, or both, which advise the member of the right to request a conference to discuss the denial

- If the member requests a conference, the conference is held by a person with the authority to uphold the denial or approve coverage. The conference is held within 30 calendar days from the receipt of Health Net's decision, unless the treating participating physician determines the effectiveness of the proposed or alternative treatment would be reduced if not provided at the earliest possible date. In that case, the conference must be held within five business days. The member is entitled to have a designee attend. This could be an attorney or, in the event the member is a minor, a parent or guardian

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.

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.

Notification Delays

Participating Physician Groups (PPG) | Hospitals

Financial penalties may be imposed on Health Net by regulators if specified time limits are not met. Reasonable delays include Health Net or the participating physician group (PPG) with delegated utilization management (UM) functions experiencing the following:

- Have not received requested information reasonably necessary to determine the medical necessity of the services requested
- Requires a consultation with an expert reviewer
- Have requested an additional examination or test on the member (provided the test is reasonable and consistent with good medical practice)

Health Net or PPGs with delegated UM functions are required to notify both the provider and member in writing about the delay, either immediately on expiration of the allowed time or as soon as Health Net or the PPG with

delegated UM functions becomes aware that it will not meet the time requirement, whichever comes first. The provider must also be notified initially by telephone. Refer to the Health Industry Collaboration Effort (HICE) website to obtain the ICE Notice of Action (NOA) template located under Approved ICE Documents. The notification delay letter must include the reason for the delay, specific information pertaining to the additional information or consultation being requested, and the anticipated date of the decision. Once the additional information is received, the same time limits apply.

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:

COBRA Continuation

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

Required Responses to Provider Inquiries Regarding Coverage

A qualified beneficiary may take up to 60 days to elect Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation coverage from the day that the COBRA election notice is mailed to the qualified beneficiary or the date of the qualifying event, whichever is later. During this election period, a qualified beneficiary may seek health services. Participating providers following eligibility verification procedures may contact the plan to determine if the qualified beneficiary has coverage.

Health plans are required to provide a complete response to provider inquiries regarding a qualified beneficiary's right to coverage during the COBRA election period and during the grace period for COBRA premium payments. Responses must include information on retroactive reinstatement or termination of coverage in accordance with the beneficiary's election and payment status.

Election Period Requirements

Each qualified beneficiary has a period of time, called the election period, in which to elect COBRA continuation coverage. The election period is the later of:

- 60 days following the date the qualifying event would cause the qualified beneficiary to lose coverage

- 60 days following the date the notice is provided to the qualified beneficiary of the right to elect COBRA continuation coverage

To elect coverage, the qualified beneficiary must submit a request for continuation coverage to the employer sponsor of the prior plan.

Complete Responses During an Election Period

Under COBRA regulations, it is not sufficient for a plan to respond to a provider's inquiry about eligibility by merely stating that the individual is or is not covered. Additional explanation must be made regarding the qualified beneficiary's right to coverage in accordance with the beneficiary's election and payment status.

If a health plan's eligibility roster lists a qualified beneficiary who has not yet made a COBRA election as an active member, the plan's responses to provider inquiries must include the statements:

- The individual is a COBRA-qualified beneficiary with the right to elect and pay for continued coverage.
- The individual's coverage is subject to retroactive termination if the COBRA premium payment is not made.
- If the election and payment are made on time, coverage is reinstated retroactively to the date of the qualifying event (or loss of coverage date, if different)

Health Net's standard coverage considers a qualified beneficiary who has not yet made a COBRA election to be not covered or ineligible.

Grace Period Requirements

The grace period is the time between the day that the qualified beneficiary elects COBRA continuation coverage and the day that the premium payment is made. Under the COBRA regulations, health plans are prohibited from requiring payment of any premium prior to 45 days after the date of the COBRA election.

Complete Responses During a Grace Period

Once a qualified beneficiary has elected COBRA, he or she has 45 days to submit the first payment. Upon receipt of the application, the member's information is entered in to the system and he or she is enrolled as active. If the member's payment is not received within the 45 days, the member is not eligible for COBRA coverage.

COBRA Coverage Terminates While Member Is Hospitalized or In SNF

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

Members may qualify for extended benefits as outlined in their Evidence of Coverage (EOC). A member is not required to submit a written request to Health Net that benefits be extended. If a member is entitled to extended benefits, all services and benefits included in the member's EOC prior to coverage termination are provided, but only for the condition that required admission to the hospital or skilled nursing facility (SNF).

In cases where a member's coverage terminates and the succeeding carrier is a federally qualified HMO, the succeeding HMO carrier has an obligation to take over the member's care. All care must be transferred immediately to the succeeding federally qualified HMO.

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:

- Adding and Deleting Members
- Eligibility Certification Form
- Eligibility Verification Methods
- Health Net Identification Card
- Monthly Eligibility Reports
- Temporary ID Card

Adding and Deleting Members

Provider Type: Participating Physician Groups (PPG)

Adding Members

Health Net discourages employer groups from retroactively adding members after the applicable monthly billing is reconciled. Only unavoidable administrative errors by the group or its agent may form a basis for retroactively adding a new member after the monthly billing has been reconciled. Health Net may make exceptions for groups that pay a super-composite rate or when a newly eligible dependent must be added to an existing family contract.

If Health Net must retroactively assign a new member to a participating physician group (PPG), capitation payment for that member is made and the PPG is responsible for all services due to the member from the date the member became eligible.

The Evidence of Coverage (EOC) issued to members upon enrollment informs them that they have 30 days from the date of acquiring a dependent to add the dependent to the contract (certain employer groups have exceptions to the 30-day enrollment time limit). After 30 days, the subscriber must wait until the employer's open enrollment or other qualifying event to make the addition. It may take up to three months before the dependent appears on the PPG Eligibility Report, due to the employer group's Health Net billing cycle.

The EOC also instructs subscribers to add dependents within the required time. Health Net encourages the PPG to urge the subscriber to add the member officially through the employer's human resources office (or Health Net, if a non-group conversion) as soon as possible in order to avoid problems that can arise if the member is not timely added.

Exceptions to this time limit exist. The 30-day requirement is waived when subscribers are already on a family contract or are employed by an employer group that pays a super-composite rate.

The PPG must continue to provide care to the dependent even if that individual does not appear on the Eligibility Report after 30 days. Members must sign an Eligibility Certification before services are provided. Contact the Health Net Provider Services Center for assistance in determining whether the contract provision applies in a particular case.

Deleting Members

If Health Net terminates the coverage of any member covered under the group agreement, the prepaid subscription charges received by Health Net applicable to periods after the cancellation date are refunded within 30 days. Neither Health Net nor any participating provider has any further responsibility to the member.

In the event of a retroactive cancellation, retroactive capitation adjustments are made in accordance with the Provider Participation Agreement (PPA).

Eligibility Certification Form

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

A person seeking medical attention who claims to be an eligible Health Net member, but who does not have a valid permanent Health Net identification (ID) card and does not appear on the most recent Eligibility Report (capitated participating physician groups (PPGs) and hospitals only), must be questioned by the PPG or provider to determine if the person is a new member or has transferred from another PPG. The PPG or provider must contact the Health Net Provider Services Center to verify eligibility, but must not delay providing or authorizing care to a Health Net member. If the patient is determined to be a new member, he or she must sign an Eligibility Certification Form before receiving services.

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.

Health Net Identification Card

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

All Health Net members are issued a Health Net identification (ID) card. This card serves as identification for medical, prescription medication and vision coverage. It displays the effective date of coverage at the participating physician group (PPG) selected by the member, the subscriber ID number, the group number, the group's re-rate month, the office visit copayment, the emergency room copayment, and the Health Net plan code. In addition, the PPG's name, address and telephone number are displayed on the card. If the subscriber's employer offers optional prescription drug benefits, the ID card states "PLAN WITH PHARMACY."

Even when a valid ID card is presented to the PPG, hospital, or ancillary provider, the Eligibility Report (capitated PPGs and hospitals only) must be checked or the Health Net Provider Services Center must be contacted, as members may have terminated coverage or changed PPGs or plans after the card was issued.

The Health Net ID card should be carried by the member at all times, and must be presented to the PPG, hospital or ancillary provider when seeking medical services and at participating Health Net pharmacies when purchasing prescription medications. A member who has lost a Health Net ID card should be advised to call the Health Net Member Services Center to request a replacement card. If a member produces a valid Health Net ID card indicating eligibility at another PPG, before providing services, the PPG, hospital or ancillary provider should call the Health Net Provider Services Department to determine if the transfer was approved by Health Net. The date of the call and the name of the responding representative must be noted. The PPG, hospital and ancillary provider must take these steps to verify the member's eligibility in order to receive compensation for services provided.

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.

Temporary ID Card

Provider Type: Participating Physician Groups (PPG) | Hospitals

A temporary Health Net identification (ID) card is attached to the Health Net Enrollment Form. In the event members need to visit their participating physician group (PPG) before receiving their permanent ID cards, they may either detach and complete this card or use the goldenrod or other copy of their enrollment form until the permanent Health Net ID card is received.

Suspension of Coverage Letter

Provider Type: Participating Physician Groups (PPG)

Members' eligibility is suspended if they are delinquent on premium payments during months two and three of the three-month federal premium delinquency grace period. Health Net or delegated CommunityCare participating physician groups (PPGs) must customize the templates, as described below, and send these letters to applicable providers no later than day 15 of months two and three of the grace period. The letter templates notify providers of a member's delinquent status upon Health Net's receipt of a claim for a delinquent member.

Provider Notice of Suspension Letter Descriptions

The following five letters pertain to Health Net delegated CommunityCare plans:

- Type 1-APTC Pend Claim letter (PDF) - Informs providers of a member's premium delinquency status. Delegated PPGs must send this notice to their contracting providers upon receipt of a claim for service dates occurring in months two and three of the premium delinquency grace period.
- Type 3A-APTC Primary Care Physician (PCP)/PPG letter (PDF) - Informs assigned PCPs of a member's premium delinquency status and notifies providers that coverage is suspended until the member's premium is paid in full.
- Type 3B-APTC Claims Look-Back letter (PDF) - Informs providers of a member's premium delinquency status. Delegated providers must send the letter to participating and nonparticipating providers who submitted claims for the APTC enrollee during the two months prior to the enrollee's federal grace period.
- Type 4-APTC Authorization Rescind letter (PDF) - Informs providers that unless certain services have been rendered, Health Net or the delegated PPG rescinds authorization for coverage of the service, effective immediately.
- Type 5-APTC Inpatient Authorization Rescind letter (PDF) - Reminds members that their eligibility is suspended and informs them that the request for authorization of additional inpatient days is denied until outstanding premiums are paid in full, effective immediately.

Eligibility Reports

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

This section contains information on eligibility reports to assist providers with determining eligibility.

Select any subject below:

- Active Analysis Report

Active Analysis Report

Provider Type: Participating Physician Groups (PPG) | Hospitals

The Activity Analysis Report (BRM 11M) identifies and summarizes the following membership activity for the reporting period:

- Additions and cancellations
- Reinstatements
- Transfers in and out of the participating physician group (PPG)
- Contract changes
- Plan-type changes

The Activity Analysis Report is available monthly at the site level, but may be requested at the consolidated level.

PPGs may use the report to update their eligibility database, note new members, monitor retroactive cancellations, or identify members who should receive new member welcome letters.

Additional information on file layouts and formatting of the Activity Analysis Report is available as follows:

- Sample Activity Analysis Report (PDF)
- Sample Activity Analysis Report Field Descriptions - Report key (PDF)
- Electronic Media Format - Activity File (PDF)

Eligibility Report

The Eligibility Report (BRM 42I and 42P) lists alphabetically all members eligible for at least one day in the reporting month. Participating physician groups (PPGs) must use this report to verify that a member is eligible to receive services for the dates of service.

PPGs may use the Eligibility Report in conjunction with the Remittance Detail Report to verify that they have received the correct capitation, and that the capitation includes members added retroactively. The summary portion of this report lists the number of members or contracts eligible with the PPG at least one day during the month and at month's end. The Eligibility Report is distributed monthly by site level, but may be requested at the consolidated or physician level.

The Eligibility Report reflects membership information as it appears in the computer on the date the report is run. If a newly added employer group is not included by the date the report is run or if an existing employer group has not reported all membership changes, the Eligibility Report does not reflect this information. Refer to the Eligibility Guarantee discussion under the Claims and Provider Reimbursement topic for additional information.

The Eligibility Report is generated at the end of the month for the following month.

Additional information on file layouts and formatting of the Eligibility Report is available as follows:

- Sample Eligibility Report - Institutional (PDF)
- Sample Eligibility Report Field Descriptions - Report key (PDF). Frequently Asked Questions (PDF)
- Electronic Media Format - Eligibility Report (PDF)

Eligibility Summary by Group Report

The Eligibility Summary by Group Report (BRM 13A and 13B) lists, by employer group, the number of members the participating physician group (PPG) has enrolled, and identifies each employer group's plan code and rerate month. The PPG may use this report to verify a group's open enrollment, plan code, benefits, or copayment amount.

The Eligibility Summary by Group Report is distributed to all PPG sites monthly.

Additional information on file layouts and formatting of the Eligibility Summary by Group Report is available as follows:

- Sample Eligibility Summary by Group Report - Group Name/Provider (PDF)
- Sample Eligibility Summary by Group Report - Group ID/Provider (PDF)
- Sample Eligibility Summary by Group Report Field Descriptions - Report key (PDF)
- Electronic Media Format - Eligibility Summary by Group (PDF)

Remittance Detail Report

The Remittance Detail Report (BRM 12A) displays the capitation remittance for each member and is used to reconcile monthly capitation payments and review adjustments made to capitation. The amounts reported are the current month capitation amounts plus any retroactive or current adjustment amounts. The report lists all members.

The summary portion of the report helps participating physician groups (PPGs) maintain accrual-based accounting records. It specifies the total capitation paid for the reporting month in the Net Remittance field. The report also summarizes adjustments made to this amount by adjustment type and month.

The Remittance Detail Report is distributed monthly by site level but may be requested at the consolidated or physician level.

Additional information on file layouts and formatting of the Remittance Detail Report is available as follows:

- Sample Remittance Detail Report (PDF)
- Sample Remittance Detail Report Field Descriptions - Report key (PDF)
- Electronic Media Format - Remittance Detail Report (PDF)

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
- Non-Participating Hospital Request for Authorization to Provide Post-Stabilization Services
- Out-of-Area Emergency or Urgently Needed Care

- PPG Responsibilities

Overview

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

Emergency care is covered for an emergency medical condition, which is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the patient's health in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Active labor is considered an emergency medical condition. Active labor means labor at the time that either of the following could reasonably be expected to occur: (1) there is inadequate time to effectively transfer safely to another hospital prior to delivery; or (2) a transfer poses a threat to the health and safety of the member or unborn child.

Emergency care includes:

- Medical screening, examination and evaluation by a physician (or other personnel to the extent permitted by applicable law and within the scope of his or her license and privileges) to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.
- Additional screening, examination and evaluation by a physician (or other personnel to the extent permitted by applicable law and within the scope of his or her license and privileges) to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, either within the capability of the facility or by transferring the member to a psychiatric unit within a general acute hospital or to an acute psychiatric hospital as medically necessary.
- Air and ground ambulance and ambulance transport services provided through the 911 emergency response system.

Health Net makes final decisions about emergency care.

Refer to definition of phychiatric emergency medical condition for more information.

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.

Hospital Request for Authorization to Provide Post-Stabilization Services

Participating Physician Groups (PPG)

Participating physician groups (PPGs) who receive a request for authorization for post-stabilization services from a non-participating hospital, or if the request comes from a participating hospital but the PPG is not delegated for inpatient services, must immediately notify the Health Net Hospital Notification Department upon receipt of any request from a hospital for authorization to provide post-stabilization services to members who

have received emergency services. Do not issue an authorization or tracking number or confirmation of eligibility to the non-participating hospital.

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, and arranging for member transfers or discharges, as appropriate. A PPG participating in a dual risk relationship should notify Health Net of any member admissions to non-participating hospitals. Notification to Health Net must be done immediately for the Plan to abide by the regulatory requirements of having a response within 30 minutes of the initial request.

Health Net calls the hospital back with the information necessary to initiate transfer of the member or provide an authorization for post-stabilization care. For hospitals in California, pursuant to enactment of Assembly Bill 1203 (2008), which amended Health and Safety Code section 1262.8 (b)(3), after the emergency condition of the patient has been stabilized, a non-participating hospital is required to provide Health Net with the identity of the treating physician and surgeon's diagnosis and relevant medical information reasonably necessary for Health Net to coordinate with the PPG to assume management of the member's care by arranging for transfer of the member, or to provide authorization for medical necessity post-stabilization care.

Under Health and Safety Code section 1317.1(j) 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. For hospitals outside of California, post-stabilization services are not subject to authorization as it is included in ER services pursuant to the No Surprises Act.

Refer to Emergency Services for more information specific to the member's health plan.

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.

PPG Responsibilities

Provider Type: Participating Physician Groups (PPG)

This section describes participating physician groups' (PPGs') responsibility when a member seeks emergency services.

Select any subject below:

- Notification of Admission

- Emergency Room Closures

Notification of Admission

Provider Type: Participating Physician Groups (PPG)

The treating emergency department of a participating hospital is required to complete and send the hospital face sheet to Health Net's Hospital Notification Department for hospital admissions. The participating physician group (PPG) is required to notify the Health Net Medical Management Department and supply the PPG authorization number if treatment has been authorized.

For notification of hospital admission from a non-participating hospital, refer to the non-participating hospital request for authorization to provide post-stabilization services.

24-Hour Access

The California Health and Safety Code and the California Code of Regulations, Title 28 section 1300.67(g)(1) requires that the participating physician group (PPG) provide uninterrupted access to medical services 24 hours a day, seven days a week.

Emergency Room Closures

Participating Physician Groups (PPG)

Within 30 days of Health Net or its participating physician groups (PPGs) receiving notice that an acute care hospital intends to reduce or eliminate its emergency services, affected PPGs must notify members by mail. Health Net works with affected PPGs to help them comply with this requirement.

Encounters

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

This section contains general information about encounter data submission.

Select any subject below:

- Overview
- Dual-Risk Contracts Encounter Data Submission
- Error Notification

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.

Dual-Risk Contracts Encounter Data Submission

Participating Physician Groups (PPG) | Hospitals

Participating physician groups (PPGs) who are contracting for dual risk are responsible for submitting encounter data to Health Net monthly for all professional and hospital services in a complete, accurate and timely manner. Health Net requires PPGs to submit their encounter data according to the terms of the Provider Participation Agreement (PPA).

The following applies to Medicare dual-risk contracts:

- The Centers for Medicare & Medicaid Services' (CMS') payment methodology is a risk-adjusted payment rate based on hospital encounter data submitted to the health plans. Payment is based on

demographic factors and reported health conditions. Payments for members with no reported conditions are reduced, while payments for members with specific reported conditions can be significantly increased. For the hospital to receive increased payments, the condition needs to be reported via encounter data. Failure to report these encounters can have significant impact on the PPG's and hospital's revenues.
- CMS requires hospitals to submit full UB-04 data. Providers needing assistance should contact the Capitated Claims/Encounter Department.
- Upcoding of ICD-10 diagnosis codes is not allowed. CMS audits hospital medical records to ensure that this does not occur.
- Continue to include the Medicare HCPCS code on the UB-04 form for each hospitalized member.

Inpatient Admissions

In accordance with the PPA, Health Net and the member's PPG require notification to Health Net and the applicable PPG of a member's inpatient admission within 24 hours for the following types of admissions:

- Acute inpatient
- Skilled nursing facility (SNF)
- Inpatient rehabilitation
- Inpatient hospice

Error Notification

Participating Physician Groups (PPG) | Ancillary | Hospitals

Encounter data submitted to Health Net can fail at the file level or the encounter level. If there is a file failure, the submitter is notified by the Capitated Claims/Encounter Department. The file must be corrected and resubmitted.

If the encounter file passes on to encounter level edits, the following reports are produced:

- Claims/Encounters Control Summary Reports - reports receipt/accept/reject totals for reconciliation.
- Encounter/Claims Rejection Report - identifies specifics for encounters that failed edits and require correction and resubmission.

Contact the Capitated Claims/Encounter Department if record-specific resubmission cannot be generated.

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.

Noncompliance with Encounter Data Submission

Participating Physician Groups (PPG) | Ancillary | Hospitals

Capitated providers, facilities and facilities with dual-risk contracts are contractually required to submit data for all services provided. Ongoing, uncorrected noncompliance with encounter data requirements is reported to the Health Net Delegation Oversight Committee (DOC).

Professional and Institutional Capitated Encounter Submission Requirements

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

Providers may submit encounters to Health Net through an authorized electronic data interchange (EDI) clearinghouse, utilizing Snip level 1-5. To initiate or discuss the submission of encounter data files, contact the Capitated Claims/Encounter Department.

All professional and institutional encounters must be submitted in an electronic format. For additional information about how to submit encounters electronically, refer to 837 Institutional Transaction Standard Companion Guide (PDF), 837 Professional Standard Companion Guide (PDF) or 837 5010 Professional & Institutional Standards for Trading Partners (PDF).

Capitated providers are contractually required to submit complete and correct data for all professional and institutional services performed. Before submitting encounter data, the submitter should contact the Health Net

Encounter Department to discuss submission format and data requirements. Health Net currently accepts the ANSI 837 5010 X12 format.

All data should be submitted according to the terms of the *Provider Participation Agreement (PPA).* If the participating physician group (PPG) does not submit data within this time frame, the PPG is excluded from incentive programs.

Enrollment

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

This section contains general information and procedures regarding member enrollment.

Select any subject below:

- Dependent Documentation Provided to Non-Subscriber
- Subscriber and Member Identification Numbers
- Use of Social Security Numbers
- Administration of New Member Procedure
- Conditions for Transfer Between PPGs
- Late Enrollment Rules Waived
- Member Terminations

Dependent Documentation Provided to Non-Subscriber

Provider Type: Physicians | Participating Physician Groups (PPG)

AB 2130 (ch. 809, 2000) and SB 943 (ch. 755, 2001) require Health Net to provide a copy of a dependent's identification (ID) card, disclosure form, Evidence of Coverage (EOC) or Certificate of Insurance (COI), and any other information regarding the dependent's health care coverage to a non-covered parent or any person having legal custody of the dependent. The information must also be provided to the local child support agency when requested.

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.

Administration of New Member Procedure

Provider Type: Participating Physician Groups (PPG)

A new member may require medically necessary services before receiving their identification (ID) card. Health Net has developed the following standard new member procedure:

- Health Net charges applicable hospital fees to the member's selected participating physician group's (PPG's) shared risk. If the PPG finds a hospital claim has been erroneously added to the monthly Shared Risk Report after the member has been retroactively canceled, the PPG must notify the Health Net auditor in writing to remove the claim from the Shared Risk Report.
- Health Net pays professional charges administratively. If the PPG has determined eligibility by the member's ID card, Enrollment form, Eligibility Report, Eligibility Certification form, or a telephone call to Health Net and care is provided to an ineligible patient, Health Net is liable for any professional care provided prior to notification of the patient's ineligibility.

Health Net verifies eligibility guarantee requests for reimbursement for professional services provided in the hospital or emergency room. Health Net then determines whether eligibility was given to the PPG.

A member ID card is not a guarantee of eligibility; therefore, the PPG must always contact the Health Net Provider Services Department (commercial HMO or Medicare Advantage) to verify eligibility prior to rendering services. PPGs retain a copy of the fax-back confirmation. If speaking directly with a representative, the PPG must also include the date the PPG called Health Net for verification of eligibility and the name of the representative.

Members must re-establish eligibility with Health Net for any services provided 60 days after the initial visit if the member still does not appear on the Eligibility Report.

Conditions for Transfer Between PPGs

Provider Type: Participating Physician Groups (PPG)

This section contains general information and guidelines for the transfer of members between participating physician groups (PPGs).

Select any subject below:

- Guidelines for Transfer
- Just-Cause Request to Transfer

Guidelines for Transfer

Provider Type: Participating Physician Groups (PPG)

Procedure for Member initiated Transfer

The monthly participating physician group (PPG) transfer policy allows the subscriber and each family member one PPG transfer each month for any reason; however, such transfer request is denied if the member is inpatient.

The member must request the provider change on or before the last day of the month in order for the change to be effective on the first of the following month. For example, a request received on July 31st is effective August 1st.

Procedure for PPG Initiated Transfer

The Health Net Member Services Department screens all transfer requests. The participating physician group (PPG) can only request transfer in case of just cause and must forward any requests for transfer to the Health Net Member Services Department for review. Only Health Net may approve or deny the transfer requests.

The Health Net Member Services Department may call the existing PPG to determine whether the member is hospitalized or pregnant. If the member is pregnant and gives birth within six months of the effective date with Health Net and is still enrolled in the new PPG at time of delivery, the delivery is covered under insured services.

The existing PPG assumes the expense for reproducing the member's medical records when the member transfers to another PPG.

Transfer of Newborns

A newborn, whether the subscriber's or subscriber's spouse's natural child, an adopted child or a child for whom the subscriber or spouse has become the legal guardian, is eligible for covered services for the first 30 days from birth regardless of whether the child is enrolled in the plan within those 30 days if the subscriber's or spouse's plan includes coverage for dependents. 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.

When the biological mother of a newborn child is an enrolled member, the newborn must also be enrolled with the mother's participating physician group (PPG) at least until the first of the month following the date of birth. If the baby is ill at birth and confined to a hospital, the baby can be transferred on the first day of the month following discharge from the hospital. If the biological mother moves within the first 30 days of the baby's life and her PPG changes, the baby's PPG also changes, as long as the baby is not hospitalized at the time of the move.

When the biological mother of the newborn child is not enrolled, the child is automatically assigned to the subscriber's PPG until the first of the month following the date of birth. If the subscriber moves within the first 30 days of the baby's life or if the baby is ill at birth, the same conditions apply as noted above.

When the parents elect subsequently to transfer the child to a different PPG, they may do so, effective the first of the month following the newborn's date of birth, provided the newborn is a well baby. If a well baby becomes ill during the birth month and is hospitalized, transfer to another PPG is delayed until the first day of the month following hospital discharge.

Just-Cause Request to Transfer

Provider Type: Participating Physician Groups (PPG)y

Member-Initiated Just-Cause Transfers

The following situations are considered just-cause reasons for members to request a participating physician group (PPG) transfer at any time:

- Legal action - The subscriber has initiated legal action against the PPG or primary care physician (PCP) and the action has caused a breakdown in the relationship between a physician in the PPG and the member, with all physicians refusing to treat the subscriber and members enrolled by the subscriber.
- Member dissatisfaction - In rare instances where the relationship between the PPG and the member breaks down and the member requests a transfer based on this breakdown, the plan researches all the facts surrounding the case. On some occasions, transfers may be arranged by the plan in order to accommodate the member's request to transfer at a non-standard time.

PPG-Initiated Just-Cause Transfers

The PPG may request that a member be transferred only when there is just-cause for the transfer. Just-causes are those circumstances that result in a breakdown in the relationship between the member and provider, such as legal action or member behavior.

The PPG is asked to supply documentation and an opinion on the merits of the case. The plan expects the PPG to take reasonable action to satisfy the member by arranging a transfer to a different physician or attempting to remedy the problem before the plan arranges a transfer.

Case documentation must include the PPG's written notification to the member, as required according to the procedures for level A behavior, level B behavior and level C behavior. The written member notification must include:

- Specific information concerning the member's unacceptable behavior.
- Reasons why the behavior is unacceptable.
- Actions the member has to take in order to correct the unacceptable behavior.
- Possible consequences to the member if the member does not comply.

The plan reviews all information and decides whether to honor the request based on the compiled results of all research. In cases involving legal action or member dissatisfaction, the PPG initiates the transfer request by sending the Transfer and Termination Incident Report - Commercial (PDF) or Transfer and Termination Incident Report - CalMediConnect/Medicare (PDF)) to the Transfer/Termination (T/T) Request Unit, outlining the problem and attaching all supporting documentation. The plan researches the situation and informs the affected PPG of its decision. The effective date of the transfer is determined on a case-by-case basis depending on the circumstances; however, a current date is always the optimum choice.

When the plan approves a transfer for just cause, the PPG to which the subscriber is being transferred is informed of the transfer and when it will occur. In these instances, as with open enrollment and address changes, the receiving PPG must accept the member. Refer to the Provider Participation Agreement (PPA) provisions addressing the PPG's acceptance of all HMO members provided that the PPG and its participating physicians have the capacity to provide contracting services, and PPG and participating physicians continue to accept new members from any other health care service plan.

The plan, at its own discretion, determines whether a member is transferred for just-cause without receiving PPG approval. Such transfers are arranged as necessary.

Each month, the plan mails each PPG copies of letters sent to members indicating a PPG transfer. The PPG is expected to review these letters and use them to update the current eligibility list. The PPG is also expected to provide or deny services.

PCP-Initiated Just-Cause Transfers

When a PCP or specialist determines that they are unable to continue to provide care to a member because the patient-physician relationship has been compromised and mutual trust and respect are lost, a just-cause member transfer may be appropriate. In the United States, the treating physicians and PPGs must always work within the code of ethics established through the American Medical Association (AMA). For information regarding the AMA code of ethics, refer to the AMA website at www.ama-assn.org.

Under the code of ethics, the physician must provide the member with notice prior to discontinuing as the treating physician to enable the member to contact the plan and make alternate care arrangements. However, prior to sending such notice, physicians must also coordinate such transfers with their PPGs' administration department. The plan conducts a fair investigation of the facts before any involuntary transfer for any reason is carried out.

Late Enrollment Rules Waived

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

The late enrollment rule does not apply when members decline Health Net HMO coverage because they were, or a family member was, enrolled in Medi-Cal, and lost coverage because they exceeded Medi-Cal's income limits

Late enrollment rules are waived if the individual meets all of the following requirements:

- Requests enrollment within 30 days after termination of coverage or employer contribution toward coverage provided under another employer health benefit plan
- Requests enrollment within 60 days after termination of Medi-Cal program coverage

Member Terminations

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

This section contains general information on termination of member coverage.

Select any subject below:

- Termination Effective Date
- Process for Requesting Termination or Transfer

Termination Effective Date

Provider Type: Participating Physician Groups (PPG)

After the decision to terminate has been made, the subscriber is sent written notice by first-class mail. The termination is effective the first of the month following the date of the notice (but in no case with less than 10-day notice), allowing the subscriber an opportunity to obtain other health care coverage. Under no circumstances is a termination retroactive.

Employer Group Is Given Termination Date

The subscriber's employer group is notified of a member's termination, along with the effective date of the termination and a reminder to the employer group to remove the member from the next bill.

Submit copies of all notification letters, requests for termination or transfer, and supporting documentation to the Health Net Transfer/Termination (T/T) Request Unit.

The Federal Employee Health Benefits Program (FEHBP, also known as FEP) is controlled by complex laws enforced by governmental agencies. Health Net may not dispose of cases involving disruptive FEHBP/FEP members or terminate members who refuse to cooperate with prudent medical advice, unless the individual employer agrees with this action. As a result, it may take longer to work out such problems when the member belongs to a FEHBP/FEP group.

Process for Requesting Termination or Transfer

Provider Type: Participating Physician Groups (PPG)

All Levels of Behavior

Formally document each incident of unacceptable behavior on the Transfer/Termination (T/T) Incident Report form (PDF) and send the T/T Request Unit. Include documentation of any counseling sessions with the member regarding unacceptable behavior and any follow-up written notifications. If the counseling session is documented in the member's medical record by the physician, physician assistant (PA) or registered nurse practitioner (RNP), attach a copy of this documentation to the T/T Incident Report. Incidents of unacceptable behavior can often occur in rapid succession, so it is important that the participating physician group (PPG) remain current in its discussions and notification letters. Incidents must be documented as they occur, not retroactively.

When a primary care physician (PCP) or specialist determines that he or she is unable to continue to provide care to a member because the patient-physician relationship has been compromised and mutual trust and respect are lost, a just-cause member transfer may be appropriate. In the United States, the treating physicians and PPGs must always work within the code of ethics established through the American Medical Association (AMA). For information regarding the AMA code of ethics, refer to the AMA website at www.ama-assn.org.

Under the code of ethics, the physician must provide the member with notice prior to discontinuing as the treating physician to enable the member to contact the plan and make alternate care arrangements. However, prior to sending such notice, physicians must also coordinate such transfers with their PPGs' administration department. The plan conducts a fair investigation of the facts before any involuntary transfer for any reason is carried out.

Legally, the plan cannot consider termination unless the PPG or PCP follows the proper procedures outlined below for the applicable level of behavior. The plan must have time for follow-up communication with the member and must allow the member a reasonable time to respond.

- When sending the T/T Request Unit, the notification letters and T/T Incident Report, include all documentation relating to the incident. The plan and the PPG must have thorough documentation of each occurrence as a former member may take legal action. To ensure that all documentation is current, it is important for the PCP to go through the PPG administration department in contacting the plan.

- Any T/T Incident Report received in the T/T Request Unit without a copy of the member notification letter is considered incomplete and is returned to the originating PCP or PPG
- The T/T Request Unit staff assesses the member's warning level and any possible transition of care concerns.
- A copy of the T/T Incident Report is forwarded to the appropriate provider relations & contracting specialist (formally provider network administrator).
- The plan must receive the member's statement within 20 calendar days from the time of the plan's receipt of the PPG's notification letter to allow the plan an opportunity to mediate the situation informally

For commercial lines of business, these behaviors can result in a transfer, but not in termination of coverage, except in the case of fraudulent activity.

Level A Behavior

Level A behavior is:

- Failure to pay the required copayments after at least two billings. The copayment balance (if applicable) must exceed $50 before the plan considers transfer of the member.
- Three missed appointments within 12 consecutive months without timely cancellation.

Level A behavior must occur at least three separate times within 12 consecutive months and persist despite the following warnings of both the participating physician group (PPG) and the plan to warrant termination:

- First occurrence of level A behavior - The PPG must counsel the member, including asking for the member's perspective, and document the counseling session. A letter must be written to the member indicating that such behavior is unacceptable. If the member is under age 18, the subscriber must be notified of the incident. It is recommended that the letter be sent by registered mail with return receipt requested. The PPG is required to keep a copy of the letter and the Transfer/Termination (T/T) Incident Report (PDF).

In addition, a copy of the letter, documentation and the T/T Incident Report must be mailed or faxed to the T/T Request Unit.

The provider relations & contracting specialist (formally provider network administrator) must receive a copy of the T/T Incident Report.

- Second occurrence of level A behavior - The PPG takes the same action as with the first occurrence. At this point, the plan sends the member a warning letter outlining the behavior problem and the possible consequences if the behavior persists.
- Third occurrence of level A behavior - The PPG may request, in writing, a transfer or termination of the subscriber or member from the contract. The plan reviews the PPG documentation outlining the continued unacceptable behavior.

The plan is allowed up to 60 calendar days to mediate the situation again on receipt of the second warning letter.

For commercial lines of business, these behaviors can result in a transfer, but not in termination of coverage.

Level B Behavior - HMO & Medicare

Level B behavior is:

- A provider's request to transfer a member to another provider if the member and current provider cannot agree on a treatment plan (note: members have the right to refuse care), and after reasonable notification is made to the member and an alternate provider is obtained
- Disruptive or abusive behavior exhibited to the primary care physician (PCP) office staff, a referral physician, or a hospital emergency department. This behavior must be deemed so disruptive or abusive that the physicians involved determine that the member-physician relationship has deteriorated to such a level that it cannot be resolved satisfactorily to both parties

Level B behavior must occur twice to two different providers in the participating physician group (PPG) within 12 consecutive months to warrant termination from the PPG. Upon first occurrence, the PPG must counsel the member, including asking for the member's perspective, and write to the member stating that such behavior is unacceptable. The counseling session must be documented. Mail or fax a copy of the letter, documentation of the incident and a copy of the Transfer/Termination (T/T) Incident Report (PDF) to the T/T Request Unit.

A copy of the T/T Incident Report is sent to the provider relations & contracting specialist (formally provider network administrator). The PPG keeps a copy of the letter and the T/T Incident Report. The plan sends the member a warning letter, outlining the behavior problem and the possible consequence (termination) if such behavior persists.

For Level A or B behavior, the plan is allowed up to 60 calendar days after receipt of the request for transfer or termination (sent only after the above procedure for the previous occurrence is followed) before the subscriber is officially notified of the transfer or termination. This is to allow the plan adequate time to:

- Review the supporting documentation.
- Allow legal counsel to review the case, if needed.
- Attempt another informal transfer or removal of the member.
- Allow the Case Management Department and regional medical director review as appropriate.

For commercial lines of business, these behaviors can result in a transfer, but not in termination of coverage.

Level C Behavior

Level C behavior is:

- Fraudulently applying for any benefits under the plan contract.
- Dangerous behavior exhibited in the course of seeking or receiving care (for example, threatened or attempted physical abuse of participating physician group (PPG) staff or other patients). There must be an eyewitness to the occurrence who is willing to document the incident in writing.
- Receipt of a notice of a subscriber's intent to pursue legal action. Refer to the Just-Cause Request to Transfer discussion under the Guidelines for Transfer discussion for additional information.

Level C behavior need only occur once for the PPG to request immediate transfer or termination. The PPG must formally document the incident, including written notification to the member. Mail or fax the PPG's transfer or termination request with all supporting documentation to the Transfer/Termination (T/T) Request Unit.

As this is the plan's first awareness of a problem with the subscriber or member, and given the seriousness of level C behavior, the plan is allowed up to 60 calendar days to review the case and respond. During this time, the plan may:

- Obtain legal counsel to determine the validity of the charge (fraud cases).

- Inform the member by certified mail that the PPG has requested transfer or termination and offer the member an opportunity to respond.
- Inform the provider relations & contracting specialist (formally provider network administrator) of the incident.
- Examine documentation to determine if transfer or termination is warranted with assistance from the regional medical director, Legal Department and Case Management Department, as appropriate.

For commercial lines of business, these behaviors can result in a transfer, but not in termination of coverage, except in the case of fraudulent activity.

ID Cards

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

A new identification (ID) card is automatically sent when:

- A member enrolls
- A member changes their name, physician or participating physician group (PPG)
- A dependent is added or deleted from the policy and the group number changes
- The medical plan changes at renewal (applies to commercial ID cards only)

Refer to the following samples to view a picture and descriptions of the fields on the Health Net member ID card:

- Identification card (IFP Ambetter HMO) (PDF)
- Identification card (Elect Open Access (PDF)
- Identification card (HMO) (PDF)
- Identification card (Select POS) (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 | Hospitals | Participating Physician Groups (PPG) | 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 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 | Hospitals | Participating Physician Groups (PPG) | 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 trial1 after which the provider, health care service plan, pharmaceutical company, or contractor is no longer authorized to disclose the medical information.

Real Time Data Exchange of Health Information

The following entities shall exchange health information or provide access to health information to and from every other of these same entities in real time as specified by the California Health and Human Services Agency pursuant to the California Health and Human Services Data Exchange Framework data sharing agreement for treatment, payment, or health care operations.

- General acute care hospitals.
- Physician organizations and medical groups.
- Skilled nursing facilities that currently maintain electronic records.
- Health care service plans and disability insurers that provide hospital, medical, or surgical coverage that are regulated by the Department of Managed Health Care or the Department of Insurance, and Medi-Cal managed care plans contracted with the State Department of Health Care.
- Clinical laboratories regulated by the State Department of Public Health.
- Acute psychiatric hospitals.

Exceptions

The exchange of health information described above does not apply to:

- Physician practices of fewer than 25 physicians, rehabilitation hospitals, long-term acute care hospitals, acute psychiatric hospitals, critical access hospitals, and rural general acute care

hospitals with fewer than 100 acute care beds, state-run acute psychiatric hospitals, and any nonprofit clinic with fewer than 10 health care providers until January 31, 2026.
- Abortion and abortion-related services.

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 | Hospitals | Participating Physician Groups (PPG) | 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 | Hospitals | Participating Physician Groups (PPG) | 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

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:

- Overview
- Authorization for Admission to Hospital or SNF
- Ambetter HMO PPGs
- Hospice Authorization
- How to Secure Prior Authorization on Health Net Provider Portal
- NIA - Prior Authorization
- PPGs' Responsibilities for Authorization
- Prior Authorization Process for Direct Network Practitioners
- Peer-to-Peer Review Requests

Overview

Provider Type: Participating Physician Groups (PPG)

Delegated participating physician groups (PPGs) are responsible for providing all professional services to members. At times, PPGs may be required to use non-participating physicians, health care professionals, or facilities in order to provide a full scope of services.

Health Net has developed prior authorization request forms Inpatient California Health Net Commercial Prior Authorization (PDF) and Outpatient California Health Het Commercial Prior Authorization (PDF) to assist PPGs with their processes for using non-participating providers. PPGs may use their own systems and authorization forms if they have been approved by Health Net.

Authorization for Admission to Hospital or SNF

Provider Type: Participating Physician Groups (PPG)

When a participating physician determines that inpatient or outpatient hospital services are necessary for a member, the participating physician group (PPG) coordinator makes the necessary arrangements following established procedures for review and approval.

Authorization Requirements for Maternity Inpatient Stay

As required by law, Health Net provides mother and newborn coverage for minimum hospital stays of at least 48 hours following a vaginal delivery or at least 96 hours following a cesarean section without authorization. Coverage for inpatient hospital care may be for less than 48 or 96 hours, respectively, only if both the treating physician and the member agree to an earlier discharge. Refer to the Maternity discussion under the Benefits topic for additional information.

If a member is discharged earlier than the 48 or 96 hours allowed by law, the treating physician has discretion to prescribe a post-discharge follow-up visit at home, in a facility, or in the physician's office within 48 hours after discharge. This covered visit must be provided by a licensed health care provider whose scope of practice includes postpartum and newborn care.

Length of stays longer than noted above require authorization and notification in order to conduct utilization management activities.

PPG Must Report SNF - Confined Members to Health Net

PPGs are required to identify and report to the Hospital Notification Unit all members who are scheduled for admission to a skilled nursing facility (SNF) or are confined to an SNF.

Ambetter HMO PPGs

Provider Type: Physicians | Participating Physician Groups (PPG)

Health Net Ambetter HMO members may select and be assigned to a primary care physician (PCP) affiliated with a participating physician group (PPG) that is participating in the Ambetter HMO network. For these members, the PPG is responsible for medical management. Providers are required to adhere to the prior authorization requirements included in the Commercial Prior Authorization Requirements and contact the PPG for prior authorization requests.

Hospice Authorization

Provider Type: Participating Physician Groups (PPG)

When requesting authorization for hospice services, attach the member's signed election statement and the physician's signed certification of terminal illness and medical prognosis. Refer to the Hospice Care discussion under the Benefits topic for additional information.

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.

PPGs' Responsibilities for Authorization

Provider Type: Participating Physician Groups (PPG)

Delegated participating physician groups (PPGs) perform the initial utilization review and authorization functions, while Health Net Medical Management staff manages services performed by non-delegated providers. Health Net is jointly responsible with the PPG for such functions when services are covered under shared-risk agreements.

Each PPG is responsible for:

- Contracting or arranging with licensed and certified providers for a full range of primary and specialty care services, as well as with key ancillary and subspecialty providers such as psychologists, family counselors, social workers, chiropractors, podiatrists, audiologists, and physical therapists
- Submitting copies of all referral provider contracts to Health Net for review and approval
- Monitoring the quality of care and the cost associated with services based on referrals to non-participating providers
- Obtaining encounter data from each referred physician
- Assuring timely payment to referral providers for covered services

PPGs must pay referred providers for covered services as soon as possible, and within 45 business days from receipt of the bill or as otherwise required under the PPGs' contracts with such providers in cases involving services to Medicare Advantage HMO members. If the PPG does not pay the referred provider within 45 business days of the date billed, Health Net has the option to pay the charges and deduct the amount from any payment due the PPG under the Health Net Provider Participation Agreement (PPA).

PPGs are responsible for using the following guidelines when authorizing services:

- Records of authorized services - The PPG must keep records of all authorized member services. This allows the PPG to monitor utilization of services by participating physicians and to compare the PPG records to the monthly reports provided by Health Net. Refer to the Medical Data Management Reporting discussion for additional information
- PPGs may not withdraw authorization after services are provided or when a member acts against medical advice - After a PPG authorizes a hospitalization, authorization cannot be withdrawn or

payment denied because the member refuses to follow the directions of the attending physician. An example is a member self-discharging from the hospital against the attending physician's medical advice. Refer to the conditions for transfer between PPGs information under the Enrollment topic for additional information
- Collection of copayments for referrals - Refer to the plan chart in the Health Net Schedule of Benefits for each service provided to determine if a copayment is to be collected

PPGs may collect copayments or arrange collection of copayments for services based on referrals to non-participating providers, other than those mentioned above, with the providers of service. Health Net recommends, however, that the member pay copayments directly to the PPG for services based on referrals to non-participating providers so the PPG can monitor the fees charged and determines the correct copayments to be collected from the member. The PPG then reimburses the referred provider for their services.

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 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.

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 can fax requests for prior authorization to the Health Net – Prior Authorization 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, phone or online.

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 – Prior Authorization 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.

Peer-to-Peer Review Requests

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

The Plan aims to promote treatment that is specific to the member's condition and consistent with medical necessity, clinical practice, and appropriate level of care. An authorization request will be denied if the information provided does not meet the coverage requirements for the requested medical treatment. The Plan will notify the provider and the member of the reason for the adverse determination.

Providers may contact the Plan to discuss the adverse determination with a medical director (known as peer-to-peer review or P2P) using the instructions below.

Peer-to-peer reviews may not be used in certain situations

The peer-to-peer review does not apply to:

Appeals. Once you or a member submits an appeal, you cannot request a peer-to-peer review. If the member submits the appeal for an adverse determination you have issued, we will reach out to you for any additional information you may have.

Post-discharge. For adverse concurrent review determinations, you must request a peer-to-peer review prior to the member's discharge. Once the member has been discharged from a facility, you cannot request a peer-to-peer review. If a member is discharged on the weekend, please call prior to discharge and leave a message for your peer-to-peer request to be considered timely. Beyond this time, an appeal may be filed.

Initial adverse determinations beyond five business days. You have five business days to request a peer-to-peer review following issuance of an adverse prior authorization determination. Beyond this time, an appeal may be filed.

How to request a peer-to-peer review

Contact the applicable Peer-to-Peer Review Request Line with the necessary information available to request a peer-to-peer review.

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:

- Point of Service (POS) Product
- Ambetter HMO
- Elect Open Access Two Tier Plan
- Elect Two Tier Plan
- ExcelCare
- HMO
- HMO SmartCare
- Leased PPO Benefit Program
- Select Three Tier Plan
- Select Two Tier Plan

Point of Service (POS) Product

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

Health Net's Point of Service (POS) product offers a two- or three-tier plan. Members decide which tier to access based on the provider they use and how they obtain care. Members receiving care from HMO in-network providers have lower out-of-pocket costs than when receiving care from out-of-network providers. Members may choose either benefit level when seeking care.

Ambetter HMO

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

The Plan offers Ambetter HMO plans through Covered California and directly through the Plan to residents of Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino and San Diego counties. The Ambetter HMO product consists of platinum, gold and silver benefit plans provided through a tailored network of select providers to offer an affordable product for California residents in these counties. The Ambetter HMO product also includes bronze and minimum coverage plans in Kern County only.

Members who enroll in a Ambetter HMO plan are assigned to a primary care physician (PCP) and obtain professional and institutional services through the tailored network of Ambetter HMO participating providers. A key difference between Ambetter HMO plans and other Plan HMO plans is that many physicians participating in the Ambetter HMO network are directly contracting with the Plan.

Members Assigned to Direct Network

Some Ambetter HMO members may select and be assigned to a directly contracting PCP for primary care services. In these cases, the member identification (ID) card reflects the participating physician group (PPG) name: "Direct Network: So. Calif." or "Health Net Direct FFS Commercial". For these members, the Plan is responsible for medical management, providers are required to adhere to Plan prior authorization requirements and request prior authorization from the Plan, and providers are required to submit claims directly to the Plan. Direct Network PCPs and Essential Community Providers (in-network clinics) may refer members to any directly contracted provider in the Ambetter HMO network.

Members Assigned to a PCP Affiliated with a PPG Participating in Ambetter HMO

Some Ambetter HMO members may select and be assigned to a PCP affiliated with a PPG that is participating in the Ambetter HMO network. The member ID card reflects a specific PPG name. The PPG is responsible for medical management for these Ambetter HMO members, and providers are required to adhere to prior authorization requirements and contact the PPG for prior authorization requests. With the exception of select PPGs participating in the CommunityCare HMO network, the provider is required to submit claims directly to Health Net.

Elect Open Access Two Tier Plan

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

This section contains general information about the Elect Open Access health plan.

Select any subject below:

Elect Open Access Tier 1 (HMO) Benefit Level

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

The Elect Open Access Tier 1 (HMO) plan offers comprehensive care at a lower cost to members who use Health Net's participating providers for care. Elect Open Access Tier 1 is similar to a traditional HMO plan. The member chooses a primary care physician (PCP) who is responsible for providing or coordinating the member's care. If the member requires services outside the PCP's scope of practice, the PCP refers the member to a specialist or other ancillary provider.

Elect Open Access Tier 2 (PPO Limited Benefit) Plan

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

Under the Elect Open Access Tier 2 (PPO limited benefit) plan, the member can self-refer to obtain consultation services from any provider in the Health Net PPO network without a referral. Services are limited to physician office visits and care that can be performed in the physician's office (for example, laboratory and radiology services). All other covered services, including hospitalization, maternity care, outpatient surgery, and home health care, must be obtained through the member's HMO level of benefits under Elect Open Access Tier 1 (HMO). Members receiving care from PPO providers incur higher out-of-pocket expenses than they would at the Elect Open Access Tier 1 level.

Elect Two Tier Plan

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

This section contains general information about the Elect Two-Tier health plan.

Select any subject below:

- Elect Tier 2 (PPO In-Network) Benefit Level

Elect Tier 1 (HMO) Benefit Level

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

The Elect Tier 1 (HMO) plan offers comprehensive care at a lower cost to members who use Health Net's participating providers for care. Elect Tier 1 is similar to a traditional HMO plan. The member chooses a primary care physician (PCP) who is responsible for providing or coordinating the member's care. If the member requires services outside the PCP's scope of practice, the PCP refers the member to a specialist or other ancillary provider.

Elect Tier 2 (PPO In-Network) Benefit Level

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

Under Elect Tier 2 (PPO in-network), the member is free to obtain treatment from any provider in the Health Net PPO network without a referral. Members receiving care from PPO providers incur higher out-of-pocket expenses than they would at the Elect Tier 1 (HMO) level. Certain prior authorization requirements may apply, refer to the Prior Authorization topic for more information.

ExcelCare

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

In order to meet customer demands for lower-priced health care alternatives, Health Net expanded its portfolio of HMO products to include the Health Net ExcelCare plan, formerly known as HMO Silver Network. This HMO offering provides all the same benefits as existing Health Net HMO plans, but members access these benefits through a select network of providers.

ExcelCare is offered in all or parts of Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Francisco, Santa Clara, Stanislaus, and Ventura counties, and is comprised of selected participating physician groups (PPGs) in these counties contracting with Health Net for the HMO line of business. PPGs were chosen to participate based on meeting Health Net's criteria of cost efficiency for assigned membership.

PPGs do not need to modify existing administrative procedures to accommodate ExcelCare members. Members enrolled in a Health Net ExcelCare plan receive and access services in the same manner as other Health Net HMO members. For example, members must obtain most services through their selected ExcelCare primary care physician (PCP) or PPG.

Employer groups may purchase acupuncture and chiropractic riders as additions to the ExcelCare plan, with these services provided through American Specialty Health Plans, Inc. (ASH Plans). Further, as for other Health Net HMO members, behavioral health benefits are administered by MHN, Health Net's behavioral health subsidiary.

Members receive an ExcelCare identification (ID) card, as applicable, to enable providers to readily identify the member's Health Net plan.

HMO

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

Health Net's HMO plan is a delivery system that offers comprehensive health care, including preventive services. In return, the member is responsible for a copayment, which is a fixed dollar amount per service. Members are required to select a primary care physician (PCP) and a participating physician group (PPG) upon enrollment. Each family member may select a different PCP. The PCP is responsible for providing or coordinating all health care services. If a member requires services outside the PCP's scope of practice, the PCP refers the member to a specialist or other ancillary provider. Members who bypass their PCP risk loss of coverage for the services provided without the PCP's referral.

HMO SmartCare

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

In order to meet customer demands for lower-priced health care alternatives, Health Net expanded its portfolio of HMO products to include the Health Net HMO SmartCare plans. These HMO offerings provide all the same benefits as existing Health Net HMO plans, but members access these benefits through a select network of providers.

The HMO SmartCare plans for Small Groups are offered in all or parts of Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Cruz, and Santa Clara counties. HMO SmartCare plans for Large and Custom Groups are offered in all or parts of Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Marin, Napa, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, Tulare, and Yolo counties. HMO SmartCare is comprised of selected participating physician groups (PPGs) in these counties contracting with Health Net for the HMO line of business. PPGs were chosen to participate based on meeting Health Net's criteria of cost efficiency for assigned membership.

PPGs do not need to modify existing administrative procedures to accommodate HMO SmartCare members. Members enrolled in a Health Net HMO SmartCare plan receive and access services in the same manner as other Health Net HMO members. For example, members must obtain most services through their selected HMO SmartCare primary care physician (PCP) or PPG. An acupuncture and chiropractic rider is included as part of the HMO SmartCare plans, with these services provided through American Specialty Health Plans, Inc. (ASH Plans). Further, as for other Health Net HMO members, behavioral health benefits are administered by MHN, Health Net's behavioral health care subsidiary. Additionally, SmartCare plans include a $50 wellness

benefit administered by Alere.™ Some SmartCare members also have access to CVS® MinuteClinic as part of their plan design; refer to the member's identification (ID) card for more information on this benefit.

Leased PPO Benefit Program

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

Health Net may lease its provider network to other payors, including but not limited to, administrative services organizations (ASOs) or self-funded employer groups. Health Net notifies participating providers of payors utilizing the leased PPO. Members should be encouraged to utilize participating providers.

Select Three Tier Plan

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

This section contains general information about the Select Three Tier health plan.

Select any subject below:

- Select Tier 1 (HMO) Benefit Level
- Select Tier 2 (PPO In-Network) Benefit Level
- Select Tier 3 (Indemnity Out-of-Network) Benefit Level

Select Tier 1 (HMO) Benefit Level

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

The Select Tier 1 (HMO) plan offers comprehensive care at a lower cost to members who use Health Net's participating providers for care. Select Tier 1 is similar to a traditional HMO plan. The member chooses a primary care physician (PCP) who is responsible for providing or coordinating the member's care. If the member requires services outside the PCP's scope of practice, the PCP refers the member to a specialist or other ancillary provider.

Select Tier 2 (PPO In-Network) Benefit Level

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

Under Select Tier 2 (PPO in-network), the member is free to obtain treatment from any provider in the Health Net PPO network without a referral. Members receiving care from PPO providers incur higher out-of-pocket expenses than they would at the Select Tier 1 (HMO) level. Certain prior authorization requirements may apply, refer to the Prior Authorization topic for more information.

Select Tier 3 (Indemnity Out-of-Network) Benefit Level

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

Health Net's Select Tier 3 (indemnity out-of-network) allows the member to obtain treatment from any licensed provider, including providers outside the Health Net HMO and PPO provider networks. In exchange, the coverage level is lower. The member's coinsurance amount is higher than at the PPO level. The member also incurs the highest out-of-pocket expense at the indemnity out-of-network level. Certain prior authorization requirements may apply, refer to the Prior Authorization topic for more information. The member is responsible for the deductible, coinsurance amount, and any amount billed by the provider above the maximum out-of-network amount covered by the plan.

Select Two Tier Plan

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

This section contains general information about the Select Two Tier health plan.

Select any subject below:

- Select Tier 1 (HMO) Benefit Level
- Select Tier 2 (PPO/Indemnity Out-of-Network) Benefit Level

Select Tier 1 (HMO) Benefit Level

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

Select Tier 1 (HMO) benefit level offers comprehensive care at a lower cost to the member who uses Health Net's participating providers for care. Select Tier 1 is similar to a traditional HMO plan. The member chooses a primary care physician (PCP) who is responsible for providing or coordinating the member's care. If the member requires services outside the PCP's scope of practice, the PCP refers the member to a specialist or other ancillary provider.

Select Tier 2 (PPO/Indemnity Out-of-Network) Benefit Level

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

Health Net's Select Tier 2 (PPO/Indemnity out-of-network) plan allows the member to self-refer to obtain treatment from any licensed provider, including providers outside the Health Net HMO and PPO provider networks. In exchange, the coverage level is lower. The member incurs the highest out-of-pocket expense at the indemnity out-of-network level. Certain prior authorization requirements may apply, refer to the Prior Authorization topic for more information. The member is responsible for the deductible, coinsurance amount and any amount billed by the provider above the maximum out-of-network amount covered by the plan.

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:

- Provider Oversight Overview
- Calendar of Required PPG Submissions
- Corrective Action Plan
- Fraud, Waste and Abuse
- Member Appeals and Grievances
- Monitoring Provider Exclusions
- Monitoring Provider Sanctions for the Federal Employees Health Benefit Program
- Subdelegated Functions
- Contractual Financial and Administrative Requirements
- Delegated Medical Management

- Facility and Physician Additions, Changes and Deletions
- Service and Quality Requirements

Provider Oversight Overview

Participating Physician Groups (PPG)

Health Net measures, monitors and oversees provider compliance and requires corrective actions when deficiencies are verified. Delegation may be revoked and the provider's contract terminated if the corrective action process does not resolve the deficiency.

In addition to routine data collection, monitoring, evaluation, and analysis, the Health Net staff is available to assist providers with:

- Alerting the delegated entity regarding possible areas of non-compliance
- Sharing information regarding regulations
  - Available in the Delegation Oversight Interactive Tool
- Developing corrective action plans (CAPs)
  - Managed within the Delegation Oversight Interactive Tool
- Sharing best practices
- Offering guidance regarding on-site review by outside agencies

Delegation Oversight Committee

The Health Net Delegation Oversight Department is under the direction of the senior vice president of Compliance. The Delegation Oversight Committee (DOC) is chaired by the senior vice president of Compliance. The committee meets quarterly and comprises, but is limited to, senior management representatives from the Health Net Provider Network Management, QI, Health Care Services, Medical Management, Provider Services, Member Services, Actuarial, Appeals and Grievances (A&G), Claims, Encounters, Credentialing, Delegation Oversight, Program Accreditation, and Finance departments.

The committee reviews monthly compliance reports and hears recommendations from the Delegation Oversight Workgroup (DOW) and other departments regarding provider compliance deficiencies. The committee collaboratively makes decisions to remedy noncompliance as quickly as possible. Those actions may include closer monitoring by the oversight staff, developing CAPs, escalating to Joint Operations Meetings (JOM) & Committees (JOC) revoking delegation of specific functions, imposing progressive sanctions (such as freezing enrollment and financial sanctions), and when necessary, notifying providers of contract breaches and contract termination.

Credentialing and Recredentialing

Failure to meet compliance with Health Net standards for credentialing and recredentialing is reported to the Health Net DOC for review and discussion if actions to resolve deficiencies and may result in revocation of delegation status.

HEDIS® Reporting

Participating physician groups (PPGs) are required to measure and report data elements necessary to determine compliance with Healthcare Effectiveness Data and Information Set (HEDIS®) quality benchmarks.

Member Complaints, Appeals & Grievances

The Health Net Member Services or Appeals & Grievances departments work to resolve individual member complaints. All member complaints and inquiries are entered into Health Net's Appeals & Grievance System of records for tracking, and reports are generated quarterly to allow for tracking and profiling within and between providers. The quarterly complaint report aggregates the type of complaint by PPG and by region. Health Net's Credentialing Committee, regional medical directors (RMDs), the Delegation Oversight director, and Quality Improvement (QI) staff reviews the reports. A corrective action plan (CAP) is implemented, if necessary, and tracking and follow-up evaluations continue to monitor the success of the action plan.

Member complaints with potential quality of care issues are reviewed by the Health Net Clinical Appeals & Grievances Department as part of the appeals & grievances process, which conducts an investigation of each issue and tracks trends for quality of care issues by provider, PPG and type of issue. Provider-specific cases are prepared and presented to the Health Net Peer Review Committee for review and action.

During the investigation of potential quality of care issues, the QI specialist may request additional information, medical records or implementation of provider-specific action plans from the PPG. Noncompliance with these requests may lead to sanctions, such as freezing enrollment of Health Net members until the issue is resolved or possible termination of the Health Net contract.

Preventive Care Guidelines

Health Net provides feedback to PPGs on their preventive care services, in an effort to encourage delivery of such services. Techniques include quality of care and service report cards, discussions at physician forums, onsite meetings with PPG staff, and financial incentives to increase the amount of preventive care services. Member education is also part of this effort.

Health Net requires that PPGs and participating primary care physicians (PCPs) follow the clinical practice guidelines recommended by the United States Preventive Services Task Force (USPSTF), the American Congress of Obstetrics and Gynecology (ACOG), the American Cancer Society (ACS), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP) in the treatment of Health Net members. A Health Net member's medical history and physical examination may indicate that further medical tests are needed. As always, the judgment of the treating physician is the final determinant of member care.

Refer to the preventive care guidelines discussion under the Benefits topic for more information.

Notice to Change PPA

If a participating provider needs to request a change to the information currently in their Health Net Provider Participation Agreement (PPA), the request must be made in writing. The request can be made in one of the following ways:

- Certified U.S. mail with a return receipt requested, postage prepaid
- Overnight courier
- Fax

The request should be sent to Health Net's main corporate address.

Calendar of Required PPG Submissions

Provider Type: Participating Physician Groups (PPG)

Documents to be Submitted	Due Date
Financial Statements (Annually Audited)	150 days after close of fiscal year
Financial Statements (Quarterly Updates)	45 days after close of quarter
Monthly Encounter Data Submission	Within 30 days of end of month of service

Delegated Service	LOB Detail	Report Description	Frequency	Due Date
UM	Complex Case Management (COM, MCL, MCR)	Complex Case Management Report	Quarterly	15th of the month following the end of the quarter
UM	Commercial	UM Authorization Source Data - COMM	Monthly	15th calendar day of the following month
UM	Commercial	Specialty Referral Access Timeliness - COMM	Quarterly	15th of the month following the end of the quarter

Delegated Service	LOB Detail	Report Description	Frequency	Due Date
UM	Special Needs Plan - Dual & Chronic	Special Needs Plan MOC Report - Case Management	Monthly	15th calendar day of the following month
UM	Medi-Cal, Medi-Cal CalViva, Medi-Cal Community Health Plan of Imperial Valley and Medi-Cal Molina	UM Authorization Source Data - MCAL, MOLN, CALV	Monthly	15th calendar day of the following month
UM	Medi-Cal, Medi-Cal CalViva, Medi-Cal Community Health Plan of Imperial Valley and Medi-Cal Molina	Specialty Referral Access Timeliness - MCAL, MOLN, CALV	Quarterly	15th of the month following the end of the quarter
UM	Medicare (HMO-H0562, SAP-H3561)	Standard and Expedited Organization Determinations (OD)	Monthly	15th calendar day of the following month
UM	Medicare (HMO-H0562, SAP-H3561,	UM Reopens	Quarterly	15th of the month following the end of the quarter
UM	Medicare (HMO-H0562, SAP-H3561), Commercial, Medi-Cal, Medi-Cal CalViva, Medi-	UM Work Plan	Annually Semi-annual Quarterly	All LOB Initial - Annual: February 15 MCR & COMM - Semi-annual: August 15 Medi-Cal, Medi-Cal Molina

Delegated Service	LOB Detail	Report Description	Frequency	Due Date
	Cal Community Health Plan of Imperial Valley and Medi-Cal Molina			and CalViva - Quarterly: Last day of the month following the end of the quarter
Claims	Medicare (HMO-H0562, SAP-H3561)	Provider Dispute Organization Determinations - MCR	Monthly	15th calendar day of the following month
Claims	Medicare (HMO-H0562, SAP-H3561)	Organization Determinations Claims - MCR	Monthly	15th calendar day of the following month
Claims	Medicare (HMO-H0562, SAP-H3561	Claims Reopens	Quarterly	15th of the month following the end of the quarter
Claims	Commercial	AB72 IDRP Delegated Contact List	Annually	31-Oct-22
Claims	Commercial	Claims Organization Determinations-COMM	Monthly	15th calendar day of the following month
Claims	Commercial	Provider Disputes Organization Determinations - COMM	Monthly	15th calendar day of the following month
Claims	Commercial	Federal Employee Health Benefit Program (FEHBP) Claim Reports	Semi-annual	Semi-annual - April 1 and October 1

Delegated Service	LOB Detail	Report Description	Frequency	Due Date
Claims	Commercial	Provider Dispute Summary Report - COMM	Quarterly	15th of the month following the end of the quarter
Claims	Commercial	Claims Settlement Practice Report - COMM	Quarterly	15th of the month following the end of the quarter
Claims	Commercial	Timeliness Summary Reports - COMM	Quarterly	15th calendar day of the following month after each quarter end.
Claims	Medi-Cal, Medi-Cal_CalViva, Medi-Cal Community Health Plan of Imperial Valley and Medi-Cal_Molina	Claims Organization Determinations - MCAL, CALV, MOLN	Monthly	15th calendar day of the following month
Claims	Medi-Cal, Medi-Cal_CalViva, Medi-Cal Community Health Plan of Imperial Valley and Medi-Cal_Molina	Provider Disputes Organization Determinations - MCAL, CALV, MOLN	Monthly	15th calendar day of the following month
Claims	Medi-Cal	Provider Dispute Summary Report - MCAL	Quarterly	30th of the month following the end of the quarter

Delegated Service	LOB Detail	Report Description	Frequency	Due Date
Claims	Medi-Cal	Claims Settlement Practice Report - MCAL	Quarterly	30th of the month following the end of the quarter
Claims	Medi-Cal	Timeliness Summary Reports - MCAL	Quarterly	30th calendar day of the following month after each quarter end.
Claims	Medi-Cal CalViva	Claims Settlement Practice Report - CALV	Quarterly	30th of the month following the end of the quarter
Claims	Medi-Cal CalViva	Provider Dispute Summary Report - CALV	Quarterly	30th of the month following the end of the quarter
Claims	Medi-Cal CalViva	Timeliness Summary Reports - CALV	Quarterly	30th calendar day of the following month after each quarter end.
Claims	Medi-Cal Molina	Claims Settlement Practice Report - MOLN	Quarterly	30th of the month following the end of the quarter
Claims	Medi-Cal Molina	Provider Dispute Summary Report - MOLN	Quarterly	30th of the month following the end of the quarter

Delegated Service	LOB Detail	Report Description	Frequency	Due Date
Claims	Medi-Cal Molina	Timeliness Summary Reports - MOLN	Quarterly	30th calendar day of the following month after each quarter end.
Claims	ALL LOBs	Notification - Change of Principal Officer	As applicable	Immediate upon change of officer
Credentialing	Medi-Cal	Credentialing Report	Quarterly	15th of the month following the end of the quarter.
Credentialing	Commercial Medicare	Credentialing Report	Semi-annual	February 15 August 15

Organization Determinations

If a participating physician groups (PPGs) or hospitals is delegated for Utilization Management (UM) they must submit monthly to the Plan (delegation oversight team) the completed Organization Determination (OD) template provided by the Plan , for each line of business, that includes all authorizations that a determination was completed in the previous month.

If a PPGs or hospitals is delegated for Claim processing they must submit monthly to the Plan (delegation oversight team) the complete OD template and for each line of business that includes all claims (received and claims in addition where a determination was made in the previous month. Additionally, quarterly a summary report should be submitted for processed claims and disputes using the MTR, PDR & STML form posted on the Health Industry Collaborative Effort (HICE).

The Plan uses the information from the PPGs to fulfill reporting requirements to the regulators such as CMS, DHCS, DMHC.

Reporting Elements & Submission

All reporting elements including instruction, data dictionary and template are included in the template workbook provided by the plan.

All reports should be submitted through the SFTP. Access has been granted to the PPG users responsible for reporting.

The Plan does delegate responsibility for complex case management to those providers with a dual-risk contract who meet the requirement as delineated by the National Committee for Quality Assurance (NCQA). With the exception of Molina, the Plan does not delegate responsibility for QI functions, all PPGs are required to participate in and cooperate with QI activities, including Healthcare Effectiveness Data and Information Set (HEDIS®), access surveys, disease management, and other quality initiatives.

To access the current year UM/QI report templates, workplans and instruction, visit the Health Industry Collaboration Effort (HICE).

Corrective Action Plan

Provider Type: Participating Physician Groups (PPG) | Hospitals

When a delegated entity is not in compliance with the Plan policies, contractual obligations or regulatory requirements, the Delegation Oversight Department may implement a corrective action process to correct the deficiencies.

- Delegate is notified of deficiency and requested to submit a corrective action plan (CAP) to address the deficiency and implement monitoring measures to avoid reoccurrence of deficiency.
    - The delegation oversight compliance auditor reviews the CAP for appropriateness and completeness and notifies the delegate of whether the CAP is approved.
    - If the Plan does not approve the CAP, the delegate is notified and asked to revise and resubmit the CAP to the Plan.
- If the delegate does not submit a CAP, or complete the actions in their CAP in a timely manner, the deficiency may be escalated to the Delegation Oversight Workgroup (DOW), Compliance and Network Management Leadership and or at a JOM to discuss deficiencies or to recommend further actions.
- If the delegate remains deficient it may be escalated to the Delegation Oversight Committee (DOC) to take formal actions up to and including de-delegation.

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.

Member Appeals and Grievances

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

Health Net does not delegate member appeals or grievances. All grievances and appeals should be forwarded immediately to the Health Net Appeals and Grievances Department.

Health Net prefers receiving appeals and grievances by fax within one business day. This enables Health Net to receive, process and resolve the member's issue quickly in accordance with state and federal timeliness requirements. Contact the Health Net Appeals and Grievances Department.

Monitoring Provider Exclusions

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

The Centers for Medicare & Medicaid Services (CMS) and the California Department of Health Care Services (DHCS) both require contractors, their subcontractors and other delegated entities to monitor federal and state exclusion lists. The parties or entities on these lists are excluded from various activities, including rendering services to Medicare, Medicaid and any other federal health care program 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 these 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), Medi-Cal Restricted Provider Database (RPD), 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.

Providers on any of these lists, except for the RPD, will be terminated from all products, federal and non-federal. Providers on the RPD will only be terminated from the Medi-Cal line of business.

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 plans. Health Net's contracted providers and their downstream subcontractors or delegated entities 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, subcontractor, or other delegated entity for Medicaid or Part C and Part D related activities. Health Net, its contracted providers, and their downstream subcontractors or delegated entities 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.

CMS Preclusion List

The CMS Preclusion List is published by the Centers for Medicare and Medicaid Services 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.

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 and 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.

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 at Healthnet.com. Registered providers can log into the provider portal to access the reports located under the regulatory section.

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.

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.

Restricted 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. The RPD data file is updated monthly and is available at Healthnet.com. Registered providers can log into the provider portal to access the report located under the regulatory section.

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 is subject to audit upon request from Health Net or CMS.

Regulatory Citations for Excluded Requirements

Medicare Advantage organizations (MAOs) and their FDRs must abide by the regulations documented in the Social Security Act 1862(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 the Medicare Manual, Volume 100-16, Chapters 9 and 21 §50.6.8.

Medicaid managed care programs, their subcontractors and other delegated entities 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), and 1001.1901, and California Welfare and Institutions Code sections 14043.6 and 14123.

Additional regulations that require sponsors to include CMS requirements in their contracts, as well as monitor their subcontractors and other delegated entities, are available in 42 CFR §422.504(i)(4)(B)(v) and 423.505(i)(3)(v).

Monitoring Provider Sanctions for the Federal Employees Health Benefit Program

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

The U.S. Office of Personnel Management (OPM) has statutory and regulatory authority to exclude health care providers from participation in the Federal Employees Health Benefit Program (FEHBP). Debarment and suspension prohibit a health care provider from receiving payment for services and supplies provided to an FEHBP member on or after the effective date of their debarment and suspension actions.

Under the authority of the Federal Employees Health Benefits Amendments Act of 1988 (5 USC §8902a) and the Government-wide Non-procurement Debarment and Suspension Common Rule (Executive Order 12549 and 5 CFR Part 970), the Administrative Sanctions Branch debars from participation in the FEHBP health care providers who have lost professional licensure, been convicted of a crime related to delivery of or payment for health care services, violated provisions of a federal program, or are debarred by another federal agency.

For non-FEHBP members, refer to Monitoring Provider Exclusions.

Monitoring for Suspended and Debarred Providers

As a contracting health plan for FEHBP, Health Net is required to monitor these providers to validate Health Net is not credentialing or paying debarred or suspended providers for services rendered to members enrolled in Health Net's FEHBP. Health Net requires its delegated participating physician groups (PPGs) to monitor this site as well, when credentialing physicians and paying claims. For non-FEHBP members, refer to Monitoring Provider Exclusions.

The OPM, under the Inspector General U.S. Department of Health and Human Services (OIG-HHS), imposes suspension and debarment actions for entities contracted with the FEHBP. The current FEHBP suspended and debarred report is available at Healthnet.com. Registered providers can log into the provider portal to access the reports located under the regulatory section.

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. FEHBP members identified through the claims review must receive notifications that they can no longer receive services from the provider.

Health Net and PPG claims departments also must check this list for non-participating providers who are suspended or debarred to ensure that they are not paid for services rendered to Health Net members while sanctioned.

Claims Payment for Suspended and Debarred Providers

Health Net must notify FEHBP members who obtain services from a debarred or suspended provider. OPM regulations prescribe a 15-day grace period after issuance of the notice, during which time services rendered by the health care provider are still covered. No payments are made for services rendered more than 15 days after the date of notice to the member.

Exceptions must be documented in the claims processing system. Exceptions include but are not limited to:

- Urgent/emergent.
- Approved member exception.
- Inpatient stays within 30 days after suspension/debarment.
- Good faith in cases where member was not aware of the sanction.
- Suspended/debarred provider or owner/administrator in a non-debarred/suspended facility.
- Services by a non-debarred/suspended provider at a debarred/suspended group or clinic.

Sub-Delegated Functions

Provider Type: Participating Physician Groups (PPG)

For delegated entities that subcontract with another entity to carry out delegated quality management (QI), utilization management (UM), member connections, and credentialing and recredentialing functions, the Delegation Oversight Department is enforcing the following National Committee for Quality Assurance (NCQA) requirements:

- QI for quality management
- UM for utilization management
- MEM for member connections
- CR for credentialing and recredentialing

The Plan performs audits and requires that delegated entities demonstrate how they ensure that the subcontractor performing delegated QI, UM, member connections, and credentialing and recredentialing functions on the delegated entities behalf is meeting NCQA standards and any additional regulatory state and/or federal requirements. More specifically, the Plan requires proof of an agreement between the provider group

and subcontractor entity that delineates the rights and responsibilities of each party and requirements for review of subdelegated activities.

Definitions

The current Health Plan Standard and Guidelines, published by NCQA, define delegation and sub delegation as follows:

- Delegation - Occurs when the organization (Health Net) gives another entity (such as a participating physician group (PPG) or independent practice association (IPA) the authority to carry out a function that the organization would otherwise perform.
- Sub delegation - Occurs when the organization's delegate (such as a PPG or IPA that contracts with Health Net to perform a specific function) gives a third entity the authority to carry out a delegated function.

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

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.

Financial Statements

Provider Type: Participating Physician Groups (PPG) | Hospitals

Health Net monitors and evaluates the financial viability of its delegated and capitated participating providers and maintains adequate procedures to ensure providers' reports and financial information confirms each provider is financially solvent (section 1300.75.4.5(a)(1) of Title 28 of the California Code of Regulations (CCR)).

All providers with a capitated Provider Participation Agreement (PPA) are required to submit their annual financial statements to Health Net 150 days after the close of the participating physician group's (PPG's) or hospital's fiscal year. PPGs and hospitals are further required to submit to Health Net quarterly financial updates, prepared by the provider organization and reflecting year-to-date activity, within 45 business days after the close of the calendar quarter or most recent quarter, if provider's fiscal year is different from calendar year.

PPGs' and hospitals' financial statement packets should include:

- Signed Health Net financial certification form (for quarterly unaudited financials only).
- DMHC quarterly and-or annual financial survey report forms as detailed in subsection 1300.75.4.2(b) and (c) of Title 28 of the California Code of Regulations (CCR) including:
  - balance sheet
  - an income statement
  - a statement of cash-flow
  - a statement of net worth
  - cash and cash equivalent
  - receivables and payables
  - risk pool and other incentives
  - claims aging
  - notes to financial statements
  - enrollment information
  - mergers, acquisitions and discontinued operations
  - the incurred but not reported (IBNR) methodology
  - administrative expenses
  - footnote disclosures (for annual audited financial survey)

For nonprofit entities, refer to subsection 1300.75.4.2(b) and (c) of the California Code of Regulations for additional requirements.

PPGs and hospitals must submit these quarterly financial updates and annual audited financial statements to the Financial Oversight Department

PPGs and hospitals must also ensure compliance with Health Net's financial solvency standard benchmarks and related contractual requirements to make sure their financial status is stable and not deteriorating over time. If the PPGs and hospitals fail to meet the financial solvency standard, and it is determined by Health Net that a corrective action plan (CAP) is needed, the PPGs and hospitals must submit a CAP within 30 days from the date of request. Below are the 14 financial solvency review standard benchmarks that must be met:

Provider Type	Category	Standard
PPG, Hospital	Working Capital	Must be positive
PPG, Hospital	Tangible Net Equity	Must be positive
PPG	Required Tangible Net Equity	Refer to 1300.76(c)(1) of Title 28 of CCR

Provider Type	Category	Standard
PPG	Cash to Claims Ratio	= or > 0.75
PPG, Hospital	Cash to Payable Ratio	= or > 0.50
PPG, Hospital	Profit Margin Ratio	> 0.00
PPG	Medical Loss Ratio	= or < 0.85
PPG, Hospital	Debt-to-Equity Ratio	= or < 1.0
PPG, Hospital	Accounts Receivable Turnover	= or > 11.81
PPG, Hospital	Average Days to Collect	= or < 30 days
PPG	Average Claims Liability	between 2.5 & 3.5 months
PPG	General and Administrative Expenses	= or < 0.15
Hospital	Total Operating Expense	= or < 1.0
PPG, Hospital	Total Z-Score	= or > 1.81

If the PPG is determined to be noncompliant, a corrective action plan (CAP) must be filed simultaneously with the financial survey to the Department of Managed Health Care (DMHC).

PPGs With Sub-Delegating Risk Arrangements

PPGs with sub-delegating risk arrangements are required to monitor and evaluate the financial viability of their delegated and capitated participating providers and maintain adequate procedures to ensure providers' reports and financial information confirms each provider is financially solvent according with section 1300.75.4.5(a)(1) of Title 28 of the California Code of Regulations (CCR) and with Health Net's financial benchmark as outlined above. When requested by Health Net, PPGs are required to provide copies of their monitoring policies and procedures within 30 days of Health Net's request.

Financial Survey Filing Requirements

Participating Physician Groups (PPG) | Hospitals

The following Department of Managed Health Care (DMHC) filing requirements are included for those participating physician groups (PPGs) that assume financial risk on a capitated or fixed periodic payment basis for the cost of health care services rendered to health plan members (sections 1300.75.4, 1300.75.4.2, 1400.75.4.7, 1300.75.4.8, and 1300.76 of Title 28 of the California Code of Regulations (CCR)).

PPGs and hospitals must submit the quarterly and annual audited financial statements to Health Net's Financial Oversight Department.

Filing Types	Requirements	Filing Period	Filing Deadline
Quarterly Financial Survey	PPGs submit an electronic quarterly financial survey report to DMHC and Health Net no later than 45 calendar days following the close of each quarter of its fiscal year. (Note: PPGs with financial statements prepared in the fiscal year submit the most recent quarter.) Hospitals submit quarterly financial surveys to Health Net directly. (Note: Hospitals with financial statements prepared in the fiscal year must submit the most recent quarter.)	Q1 Q2 Q3 Q4	May 15 August 15 November 15 February 15
Annual Financial Survey	PPGs submit an electronic annual audited financial survey including auditors notes and opinion letter to	Annual	May 31

Filing Types	Requirements	Filing Period	Filing Deadline
	DMHC and Health Net not more than 150 calendar days after the close of PPG's fiscal year determined by the DMHC, and based upon PPG's annual audited financial statement prepared in accordance with generally accepted auditing standards. Hospitals submit annual audited financial surveys including auditors notes and opinion letter to Health Net directly.		

If a PPG organization reports deficiencies in any of the six DMHC grading criteria listed below, the PPG must submit a self-initiated corrective action plan (CAP) proposal in an electronic format to DMHC and Health Net (section 1300.75.4.8 of Title 28 of the CCRs). The grading criteria are:

- tangible net equity (TNE): must be positive
- required tangible net equity: Positive TNE shall be at least equal to the greater of:
  - (A) one percent (1%) of annualized revenues; or,
  - (B) four percent (4%) of annualized non-capitated medical expenses.
- working capital: must be positive
- cash-to-claims ratio: 0.75
- claims timeliness percentage: 95%
- incurred but not reported (IBNR) methodology, both documented and used in estimation of IBNR liabilities: three months

Late Filing for Financial Survey Requirements

Health Net is required by the DMHC to follow up on late filing of the financial survey (section 1300.75.4.5 of Title 28 of the CCR). As soon as the PPG files with DMHC, the PPG must immediately submit the confirmation of the filing to the Financial Oversight Department. Late-filing PPGs can be downloaded from the DMHC website.

PPG Networking Contractual Requirements

Participating Physician Groups (PPG)

Participating physician groups (PPGs) may contract with providers to furnish necessary services to members. The California Department of Managed Health Care (DMHC) and the Centers for Medicare & Medicaid Services (CMS) require health plans to collect and review the contract and subcontract templates at least annually to ensure that they contain required elements and wording and do not contain prohibited elements or wording. Contract and subcontract templates, with a cover letter, must be submitted on request and on issuance of a new template.

PPG Network

PPGs must provide the plan with a list of names, practice locations, federal tax identification numbers, professional practice names, and the business hours for all member physicians and other participating providers who contract with the PPG. The list must be submitted in a form acceptable to the plan as stated in the Provider Participation Agreement (PPA).

Proof of Executed Contracts

DMHC requires the plan to ensure that all providers in the network have executed contracts. The plan requires that the cover page and signature page of each provider and physician contract be submitted on execution, on credentialing or re-credentialing, and on request to the provider relations and contracting specialist (formally provider network administrator (PNA)) assigned to the PPG.

Provider Education

Each PPG is responsible for having a written process that assists in timely distribution of plan policies, procedures, manuals, updates, newsletters, and reports. PPGs are required to:

- Publish and distribute provider operations manuals and updates to all providers, taking steps to ensure that new providers receive these materials promptly.
- Maintain provider and member service education programs for each primary care physician's (PCP's) office.

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.

Delegated Medical Management

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

This section contains general information on delegated medical management.

Select any subject below:

- Overview
- Delegation
- Delegated Utilization Management
- Delegation Oversight Interactive Tool
- Inpatient Denial Log Submission

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 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

Participating Physician Groups (PPG)

Health Net uses the Delegation Oversight Interactive Tool (DOIT) to evaluate structural and process elements. Refer to the Utilization Management (UM)-Delegation Agreement for more information on these elements.

Health Net may delegate responsibility for activities associated with UM and Care Management services to its PPGs. Prior to participating with Health Net, and at least annually thereafter, Health Net conducts a review of each PPG. Health Net uses DOIT and other tools to evaluate the provider's facility and ability to deliver high-quality health care consistently and perform necessary administrative functions. Based on the audit scores and findings, if certain thresholds and criteria are met, the Delegation Oversight Committee (DOC) may deem it proper to delegate certain specific functions to the PPG to perform. If approved for delegation, a delegation agreement is forwarded to the PPG for signature. The delegation agreement includes a matrix that delineates the specific responsibilities delegated to, and accepted by, the PPG.

Upon delegation, Health Net may delineate specific and certain medical management functions for performance improvement. Performance improvement plans shall be shared with PPGs at regular intervals. Health Net and PPG medical directors are required to afford and actively participate in implementation of performance improvement plans.

Health Net systematically monitors and tracks provider compliance for all delegated providers because Health Net remains accountable to state and federal regulatory agencies for provider compliance even if certain functions are delegated.

Delegation Program Monitoring and Evaluation

Health Net may delegate responsibility for activities associated with utilization management (UM) and Care Management to participating providers. The DOC determines delegation status for each of the above functions, based initially on the results of pre-delegation comprehensive evaluation.

The DOC renders delegation decisions and provides guidance regarding delegation responsibilities through reports of annual audit results, oversight and monitoring, and periodic reviews of PPG specific data as reported from the Health Net Quality Improvement (QI) staff. This data includes, but is not limited to, complaints, access audit performance, member satisfaction results, and other quality of care data. Health Net may revoke, partial or complete delegation at any time if the committee determines that the PPG is no longer capable of performing delegated functions.

The DOC communicates delegation decisions for new PPGs or additional lines of business, as well as any recommendations and requests for root cause analysis and/or corrective action plans, to the PPG in writing by a series of standardized letters. The letters describe the functions or activities for which delegation is approved or denied, a delegation agreement, a delineation of the responsibilities of the PPG and the health plan, and the time frames for responses and submission of any required corrective plans. Health Net always remains accountable for all care and service delivered to members.

Delegation agreements for existing delegates are updated and signed as needed.

Health Net and PPGs may schedule operations meetings based on PPG requests or business needs identified by Health Net. Other criteria affecting PPG performance may necessitate additional meetings as determined by representatives. The meetings are multidisciplinary and provide a forum for both parties to discuss operational issues and PPG performance measures, which may include: access audit results, accreditation updates, UM audit results, care management audit results, appeals and grievance issues, denial issues, medical management issues, claims issues, eligibility, encounter data submission, pharmacy issues, required submissions report, provider profiles, and other information relevant to the member population served. Representatives from the PPG, Health Net and participating hospitals (if any) are included in the meetings.

Screening of prospective, concurrent and retrospective quality issues is conducted by the Quality Improvement staff upon notification of potential quality of care concerns. Indicators that may be reviewed include:

- Access - delay in authorization
- Access - delay in diagnosis
- Access - delay in service
- Communication
- Continuity of care
- Denial or delay of referral or authorization
- Denial of treatment
- Emergency services
- Encounter data submission
- Financial viability
- Inadequate care
- Inappropriate care or treatment
- Inappropriate denial of treatment
- Messy or unsanitary environment
- Misdiagnosis or inability to diagnose
- PPG claims and UM timeliness
- Physician incentive plan reporting
- Provider education
- Refusal to treat or care for members
- Rude, inappropriate or insensitive behavior
- Satellite addition and deletion
- Unprofessional and unethical behavior
- Urgent issues
- Utilization, credentialing and claims delegation oversight

Transitioning Delegated Functions

Delegated providers interested in transitioning any of their delegated functions, such as utilization management, claims, care management, or credentialing, to a new or different subcontracted entity or management services organization (MSO) must request approval from Health Net a minimum of 90 calendar days in advance of the anticipated transition date.

Submit written requests to your Provider Network Management (PNM) representative at least 90 calendar days in advance of the transition with the following information:

- Name of the new entity
- Delegated functions to transition to the new entity
- Contact name with contact information at the new entity
- Date of proposed transition

Approval or denial of the delegation transition to another entity is provided by Health Net once Health Net performs a comprehensive assessment and evaluation of the new entity.

Delegated providers are prohibited from initiating any transition plans to the new entity without Health Net's prior approval. Failure to comply with adequate notification and approval can jeopardize a provider's participation in Health Net's provider network.

Revoking Delegation

The DOC may, prior to any of the steps discussed in the Corrective Action Plan topic, decide to revoke delegation or send Health Net staff to the PPG for oversight and to assist in achieving compliance. When revoking delegation, Health Net follows written policies and procedures to ensure that there is no adverse effect on members.

Program Evaluation for Delegation

Oversight of PPG

Oversight of PPG operations includes annual ongoing review and monitoring of the written description of the utilization management (UM) program and operational assessment using the Delegation Oversight Interactive Tool (DOIT). PPG oversight includes, but is not limited to:

- Monitoring of denials.
- Compliance with health care criteria.
- Compliance with Health Net's approval and denial decision timelines standards.

During the assessment, the UM compliance auditor reviews policies and procedures, including the UM program to validate adherence to compliance standards. The UM compliance auditor will provide the PPG with details on all findings and request the PPG to outline a plan for improvement, where needed. The UM compliance auditor will review this plan and verify that it is appropriate based on the failures identified prior to approval.

Additional PPG documentation may be requested to complete the evaluation. The completed evaluation, with recommendations from the UM compliance auditor, is reviewed and presented to the Delegation Oversight Workgroup (DOW) and forwarded to the Delegation Oversight Committee (DOC) PPGs with extensive improvement plans are monitored closely until the changes are effective. A non-compliant PPG may be referred to the DOC for further action. Status reports are made to the DOC. PPGs not able to maintain the required standards are referred to the DOC for possible revocation of specified delegated activities.

In the event that a PPG disagrees with audit findings or the delegation decision of the DOC, the PPG may present the issue in dispute, in writing, to the chairperson of the DOC within 10 business days of receipt of the determination.

Delegation Assessments

Health Net evaluates the PPG's UM program pre-contractually and at least annually thereafter. To guide the assessment and provide consistency, Health Net uses a standard set of evaluation criteria driven by regulatory requirements and guidelines. Criteria is applied based on the lines of business delegated to the PPG.

The UM compliance auditors will perform these evaluations. The UM compliance auditor communicates with PPGs regarding the UM and care management (CM) program and standards. The UM compliance auditors are the principal liaison for regulatory requirements between Health Net and the PPGs and play an integral role in helping PPGs maintain compliance with Health Net's expectations.

Delineation of Delegation Responsibilities

Structural elements are basic requirements that must be developed in order to maintain an effective utilization management (UM) program. These elements are developed and approved to provide a process to support UM activities. The elements of a provider's UM program are reviewed, revised and approved annually. Health Net

uses the Delegation Oversight Interactive Tool (DOIT) for evaluating structural and process elements. Refer to the Utilization Management (UM)-Delegation Agreement for more information.

Revocation of Delegated Medical Management

Health Net reserves the right to revoke delegated status when the PPG has failed to meet and maintain established standards. Capitation payments may be adjusted when revocation of medical management functions occurs.

Delegated Review Processes - Concurrent, Prospective and Retrospective

Participating physician group (PPG) utilization review (UR) staff should perform concurrent reviews daily. PPGs may be required to communicate their concurrent review findings to Health Net medical management staff daily, or as requested by the Utilization Management (UM) and Care Management (CM) staff. The objective of PPG concurrent reviews is to assess clinical information during a member's hospital stay, coordinate the discharge plan, assist in determining medical necessity at the correct level of care, and perform the quality improvement screening.

The first review occurs within 24 hours of admission to confirm that the member is in the appropriate setting and is receiving medically necessary care, and to begin discharge planning. The PPG utilization management nurses review the member's continued stay using standardized nationally recognized criteria, such as InterQual® Guidelines. If a concurrent review does not confirm the need for continued stay, alternative care or a less acute level of care must be considered.

PPGs must develop processes to identify and manage variant bed days and provide timely notification of denials to Health Net to facilitate claims adjudication.

Health Net is responsible for a concurrent review of out-of-area admissions for delegated PPGs, except for PPGs with financial responsibility for out-of-area services, according to the PPG's Provider Participation Agreement (PPA). Refer to the Out-of-Area Services discussion for more information. PPGs are responsible for working with Health Net to determine and facilitate the transfer of a member back into the network when appropriate, and the member is stable.

Prospective Review Process

A prospective review is performed to determine the medical necessity of elective referrals to specialty or ancillary care, inpatient admissions and outpatient procedures.

Requests for prior authorization of elective referrals, admissions or procedures are received by the participating physician group (PPG) from the primary care physician (PCP) or specialist. The PPG determines medical necessity through the use of standardized nationally recognized criteria and approves or denies the request. Refer to the Referrals and Prior Authorization topics for additional information.

Performance standards for turn-around times for review of, determination and decision notification for requests for prior authorization vary by line of business and the urgency of the request. Refer to the Utilization Management Timeliness Standards for Commercial, Medi-Cal and Medicare plans on the Industry Collaboration Effort (ICE) website at www.iceforhealth.org/library.asp.

The PPG is obligated to provide oversight and documented monitoring of the utilization review process for medical appropriateness whenever this process is performed by a sub-delegated review organization. The PPG may not sub-delegate a function or activity to an entity whose delegation status with Health Net is currently denied or revoked for that function or activity. PPGs must notify Health Net prior to any sub-delegation agreement.

The UM Compliance Auditor periodically educates the PPG on plan tools, provides performance data, and evaluates performance using the provider assessment tools. Failure to meet the standards results in development of an issue in the DOIT and requires the PPG to create and action plan to remediate all findings. The PPG will submit an action plan for approval by the UM compliance auditor, who will review the action plan to ensure it is appropriate to address all findings. Once approved, the PPG must update the UM compliance auditors through DOIT of the status of each action plan. Once completed, the UM compliance auditor will decide if retesting is required for the issue.

Retrospective Review Process

A retrospective review is conducted on individual cases and with aggregate decision data. An individual case review helps to identify specific matters arising from an episode of care (for example, emergency room claims are reviewed for medical necessity and coverage). Problems identified through the retrospective review process are communicated to the PPG to identify and manage variant bed days and provide timely notification of denials to Health Net to facilitate claims adjudication.

Utilization Management Responsibilities

Dual risk is restricted to participating physician groups (PPGs) with a dual-risk capitation agreement with the plan for professional and hospital services that have successfully met the plan performance standards. These groups have comprehensive administrative systems and have demonstrated an ability to perform utilization and care management activities effectively. At least annually, Health Net performs standardized program reviews of these PPGs to assess performance. 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 dual-risk relationship, PPGs are responsible for the following:

- Having an effective, comprehensive utilization management (UM) and care management (CM) program in place that includes a UM committee comprised of actively practicing providers.
- Performing prospective, concurrent and retrospective reviews of medical care consistent with Health Net's goals and objectives.
- Cooperating with Health Net on medical management of all out-of-area admissions.
- Providing valid and reliable encounter data in a timely manner as requested and complies with the UM program.
- Reporting and analysis, including, but not limited to, the following:
    - Bed days/1,000, admits/1,000, length of stay (semi-annually for commercial and quarterly for Medicare)
        - For Health Net membership
        - For all managed care membership
    - Mental health (not applicable to Medi-Cal)
        - Days/1,000

        - Admits/1,000
        - Length of stay
    - Adoption of UM criteria
    - Monitor quality and timeliness of UM decisions and notifications
    - Approval and denials
    - Communication with members
- Preparing action plans for any out-of-the-ordinary UM indicators.
- Identifying children with potential California Children's Services (CCS)-eligible conditions and making referrals to the appropriate CCS county programs (applicable to Medi-Cal only).
- Having a written UM program description and plan approved by Health Net. 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.
- Having specific written procedures for precertification, concurrent and retrospective reviews, and care management that is 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 a UM committee composed of providers that makes determinations regarding approval or denial of health care services to members.
- The PPG's UM program and policies and procedures specifically outline member and provider notification of medically necessary determinations, including for approvals and denials. The denial process is clearly outlined and includes an appeal process.
- The PPG denial policy and procedure and member letters include required regulatory statements that clearly indicate the reason for the denial, alternative treatment suggestions and how the member can appeal directly to Health Net.
- The PPG denial process includes required regulatory statements that inform participating providers (for example, physicians, inpatient facilities, and ancillary providers) that they may appeal directly to Health Net.
- The PPG uses standardized nationally recognized UM medical review criteria to ensure consistent medical necessity determinations and interrater reliability (IRR) for all individuals involved in the UM process.
- The PPG and PPG-hospital affiliates report encounter data monthly. Care management cases (shared risk only) are reported to the Medical Management staff at the point of identification. Dual-risk PPGs delegated to perform complex case management according to NCQA standards are assessed annually for compliance with those standards. Refer to the Care Management section in the Utilization Management section for additional information on criteria for referral to the care management program.
- The PPG assists in identification of coordination of benefits and third-party payer information (not applicable to Medi-Cal).
- The PPG participates with Health Net in meetings as scheduled.
- The PPG administers member coverage based on the member's Evidence of Coverage (EOC).
- Failure of the PPG to meet the under- and over-utilization standards results in development of a corrective action plan that is submitted to Health Net for review and approval.
- PPG representatives participate with Health Net medical management committees as requested.

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

Health Net Responsibilities

In a dual-risk relationship, Health Net is responsible for the following:

- Contracting with the PPG for delegated UM functions.
- 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.
- During the pre-contractual assessment with the PPG, the UM compliance auditor validates the PPG UM program adheres to the plan utilization and care management delegation criteria.
- Review and approval of the PPG UM program and conducting an annual audit of the PPG using the Delegation Oversight Interactive Tool (DOIT), including a review of denial files. If the PPG is not able to maintain the required standard of medical management, the Delegation Oversight Committee (DOC) may recommend revocation of specific delegated activities.
- A provider engagement and network specialist (formally provider network administrator) and a regional medical director (RMD) acts as a liaison with the PPG to resolve all contractual, operational and ongoing service problems.
- Oversight and monitoring when the PPG is delegated to perform complex care management for its dual-risk membership.
- PPG performance is monitored to determine if members are receiving timely medical services.

Requirements for PPGs Utilization Management Process

Health care service plans (HCSPs) and participating physician groups (PPGs) to which utilization management (UM) functions are delegated are required to employ and designate a senior medical director with an unrestricted California license to be responsible for ensuring that the UM processes are in compliance with the statute.

The name and direct telephone number (or extension) of the health care professional making the decision to delay, deny or modify a request for authorization of payment of service must be included in the notification letter to the requesting provider.

Health care service plans and PPGs to which UM functions are delegated are required to maintain telephone access for providers to request authorization for payment of health care services.

Timeliness Requirements for UM Decision Making

The health care service plan and its PPGs to which utilization review (UR) functions have been delegated are required to comply with standards established by the Centers for Medicare & Medicaid Services (CMS), the Department of Health Care Services (DHCS) and the National Committee for Quality Assurance (NCQA).

For current standards, refer to the Industry Collaboration Effort (ICE) website at www.iceforhealth.org/library.asp to locate the Approved ICE Documents for the appropriate UM Timeliness Standards.

Disclosure of UM and UR Processes

Health care service plans (HCSPs) (or delegated participating physician groups (PPGs)) and disability insurers are required to disclose the UM and UR processes and criteria the plan and its delegated PPGs use to

authorize, modify, defer, or deny health care services when requested by health care providers, members or the public.

Disclosures must be accompanied with the following text in its entirety:

"The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."

Health care service plans and PPGs may charge reasonable fees for copying and postage costs and may make the information available electronically.

Delegated Utilization Management - Behavioral Health

Provider Type: Participating Physician Groups (PPG) | Hospitals

Health Net and MHN, Health Net's behavioral health division, have written standards for centralized triage and referral functions for behavioral health services. They are intended to ensure that these functions are correctly adopted and monitored, as well as professionally managed. This is achieved by:

- Making triage and referral decisions according to protocols that define the level of urgency and care setting.
- Adopting triage and referral protocols that are based on sound clinical evidence and currently accepted practices in the industry.
    - Using protocols that specifically address mental health and substance abuse triage and referral.
    - Providing triage and referral staff with up-to-date protocols and guidelines.

  Health Net, MHN and participating physician groups (PPGs) delegated for triage and referral follow these guidelines:

- Triage and referral decisions that do not require clinical judgment are made by staff who have relevant knowledge, skills and professional experience.
- Triage and referral decisions that require clinical judgment are made by a licensed behavioral health care provider with qualified experience.
- Triage and referral staff are supervised by a licensed behavioral health care provider with a minimum of a Master's degree and five years of post-degree clinical experience.
- A licensed psychiatrist or licensed doctoral-level clinical psychologist experienced in clinical risk management oversees triage and referral decisions.

Inpatient Denial Log Submission

Provider Type: Participating Physician Groups (PPG)

Hospitals must notify Health Net of a member's inpatient admission within 24 hours. In addition, Health Net requires delegated participating physician groups (PPGs) to submit information regarding denial of member inpatient admissions on a weekly basis.

Delegated PPGs are required to submit a weekly inpatient denial log (PDF) every Wednesday by close of business for the previous week's inpatient denials. If there are no denials, then the PPG must also submit a log that states that there were no denials for this time period. Providers must use the inpatient denial log and include the following information:

- member name
- member identification (ID) number
- admission and discharge dates
- number of days denied within the current length of stay and the date(s) of denied days
- type of service (for example, obstetrics (OB), skilled nursing facility (SNF), medical/surgical, or intensive care unit (ICU))
- admitting facility name
- authorization or denial number for each level of service during the length of stay
- disposition (such as discharged to home, SNF or hospice)

Submit weekly inpatient denial logs to Health Net via encrypted email, fax or mail.

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.

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:

Overview

Participating Physician Groups (PPG) | Ancillary | Hospitals

A participating provider that expands its capacity by adding new or satellite facilities or new participating physicians or other subcontracting providers must notify Health Net in writing at least 90 days before the addition. According to the terms of the Provider Participation Agreement (PPA), the participating provider agrees that Health Net has the right to determine whether the new or satellite facilities or the new participating physicians are acceptable to Health Net.

Addition of New Physicians, Providers or Facilities

Until Health Net approves new subcontracting providers (for example, primary care physicians (PCPs), specialists and ancillary providers), the providers are not allowed to provide covered services under the Health Net PPA. Health Net must be notified in writing at least 90 days before the addition.

Health Net is free to deny participation to any new subcontracting providers and is not obligated to state a cause or explain the denial of the addition or provide the facility, provider or subcontracting providers with any right to appeal or any other due process. Health Net's decision in these cases is final and binding.

In addition, hospitals, ancillary providers and participating physician groups (PPGs) are responsible for providing Health Net with copies of the standard agreements used for their subcontractors. Health Net reviews these standard agreements to ensure compliance with regulatory requirements[1] and directs the facility to make any changes required in order to meet the requirements. Health Net requires hospitals, ancillary providers and

PPGs to send sample forms to Health Net for review if they make any changes to their standard agreements or replace them with new standard agreements.

Hospitals, ancillary providers and PPGs must provide Health Net with a copy of the signature page for each subcontractor. Physicians or other subcontractors must be credentialed before they are added to Health Net's network. Hospitals, ancillary providers and PPGs must also provide Health Net a list of the names, locations and federal tax identification numbers (TINs) of all of its participating providers.

Hospitals, ancillary providers and PPGs are also responsible for informing Health Net when they cease to use a specific subcontractor or when they add a new subcontractor. Health Net periodically sends each hospital, ancillary provider and PPG a list of the physicians or subcontractors Health Net shows as active and under contract with the participating provider. Hospitals, ancillary providers and PPGs are required to review this list and notify Health Net of any additions or deletions. At least monthly, hospitals, ancillary providers and PPGs must provide Health Net with a list of additions, deletions and address changes, as well as a complete listing annually.

For PPGs only, the Active Physicians Listing is available monthly on the Health Net provider website as an administrative report. Select Provider Reports under Welcome. This report provides PPGs a means to review and revise their records on a monthly basis and communicate physician demographic changes and terminations to Health Net. Additionally, this listing is used by the Health Net Provider Network Management Department to validate PCP and specialist information with the PPG on a quarterly basis.

Hospitals, ancillary providers and PPGs must furnish Health Net copies of any amendments to a contract with a participating provider within 20 days of execution.

[1]Medicare Managed Care Manual, Chapter 11, Section 100.4.

Closure and Termination

Provider Type: Participating Physician Groups (PPG)

Participating physician groups (PPGs) are required to notify the Health Net regional Provider Network Management Department in writing at least 90 days in advance of the date that a subcontracting provider does the following:

- closes the medical practice
- terminates the relationship with the PPG

For HMO and Medicare Advantage HMO, Health Net notifies affected members 30 days in advance, whenever possible, of a primary care physician (PCP) termination. The notification is sent by U.S. mail, and includes instructions on selecting a new PCP.

Health Net may allow a member to continue using a terminated provider when:

- A member had been receiving care for an acute or chronic condition, in which case care by the terminated provider is covered for 90 days or longer, if necessary, for a safe transfer of the member.
- A member is pregnant, in which case care by the terminated provider is covered until postpartum services related to the delivery are completed or longer, if necessary, for a safe transfer of the member.

The terminated provider is subject to the same contractual terms and conditions imposed prior to termination until medical care to the member is completed. These terms and conditions include, but are not limited to:

- credentialing
- hospital privileging
- utilization review
- peer review
- compensation

Refer to the Transition of Care topic for more information.

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.

Member Notification for Specialist Termination

Participating Physician Groups (PPG)

Delegated participating physician groups (PPGs) must have a written policy regarding member notification when a specialist terminates their contract. The written policy must include the following elements:

- PPGs must notify the plan 90 days prior to a specialist terminating (or as stated in the PPG's Provider Participation Agreement (PPA)).
- PPGs must identify members who have regularly seen the terminating specialist or have an open authorization to receive services from the terminating specialist.
- Identified members must be notified by the PPG in writing and the notification must be made immediately upon notification of termination, but no later than 30 calendar days prior to the effective date of the specialist's termination.
- PPGs must help members transition to a new specialist within the PPG's network of participating providers.

If a member with an acute care condition has questions or concerns regarding the continuation of services from the terminating specialist, advise the member to call the Health Net Member Services Department, Health Net Medi-Cal Member Services Department, Community Health Plan of Imperial Valley Member Services Department or CalViva Health Member Services Department.

Templates for Only Medicare and DSNP Member Notifications

To notify Medicare and DSNP members when a specialist terminates, PPGs must use the applicable template in the table below approved by the Centers for Medicare & Medicaid Services.

Template	H-contract	Product
Medicare Provider Termination Notification Template-MA H0562	H0562	Medicare Advantage
Medicare Provider Termination Notification Template-DSNP H3561	H3561	Dual Special Needs Plans: • Wellcare Dual Align • Wellcare CalViva Dual Align • Wellcare Dual Liberty

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: Participating Physician Groups (PPG) | Hospitals

This section includes information on requirements for adding or removing a participating provider.

Select any subject below:

- Access to Care and Availability Standards
- Open Clinical Dialogue
- Threshold Languages and Language Assistance Codes
- Claims Denials
- Claims Payment Requirements
- Authorization and Referral Timelines
- Credentialing and Recredentialing
- Eligibility and Data Entry Requirements
- Obtaining Interpreter Services
- Quality Improvement Problem Resolution

Access to Care and Availability Standards

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

Health Net's appointment accessibility and provider availability policies, procedures and guidelines for providers and health care facilities providing primary care, specialty care, behavioral health care, urgent care, ancillary services, and emergency care, are in accordance with applicable federal and state regulations, contractual requirements and accreditation standards. These access standards are regulated by the California Department of Managed Health Care (DMHC), the Centers for Medicare & Medicaid Services (CMS), the

National Committee for Quality Assurance (NCQA) and the Department of Health Care Services (DHCS). The National Committee for Quality Assurance (NCQA) monitors medical standards for access to and availability of care and sets behavioral health time-elapsed appointment access standards.

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 of Health Net's service area, a comprehensive range of primary, specialty, institutional, and ancillary care services are readily available and accessible at reasonable times. 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, practitioner/ 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 specialist office hours must be reasonable and sufficient to ensure that members are able to access care within established time-elapsed access standards, and posted in the provider's office. To meet this requirement, Health Net requires a primary care's practice to be open at least 20 hours per week and a specialist's practice to be open at least 16 hours per week for members to schedule appointments within Health Net's 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 ensure availability of services.

After-Hours Access Guidelines

As required by applicable statutes, PCPs must ensure that, when medically necessary, they have medical services available and accessible to members 24 hours a day, seven days a week. PCPs are required to have appropriate 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, the plan 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 the plan 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 Script Template

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 another answering service can use as a guide for staff answering the telephone. For PPGs or physicians who use an automated answering system/answering machine, this template can be used as a script to advise members how to access care. The script includes basic information that members need to access after-hours care, and modifications can be made according to PPGs' and physicians' needs.

Health Net makes the script available in the following threshold languages:

- Arabic (PDF)
- Armenian (PDF)
- Chinese/Cantonese (PDF)
- English (PDF)
- Farsi (PDF)
- Hmong (PDF)
- Khmer (Cambodian((PDF))
- Korean (PDF)
- Russian (PDF)
- Spanish (PDF)
- Tagalog (PDF)
- Vietnamese (PDF)

After-hours scripts are available in additional languages upon request. Contact the Provider Network Management, Access & Availability Team for more information.

Answering Services

The provider is responsible for the answering service they use. If a member calls after hours or on a weekend for a possible medical emergency, the provider 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 a member's condition 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 to 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
- 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 the 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 but 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 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 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. Triage and/or screening services are available to members, 24 hours a day, seven days a week, through the Customer Service Department telephone number displayed in the back of the member's identification (ID) card. Members can select the triage or screening option to be connected.

Facility Access for the Disabled

Health Net and its participating providers and practitioners 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 must 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.

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.

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 provider 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 behavioral 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 §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).

Appointments and Referrals

Members are instructed to call their PCP directly to schedule appointments for routine care, except in the case of a life-threatening emergency. Health Net members must seek most care through their PCP. The PCP is responsible for coordinating all referrals for specialty care if the necessary services fall outside the scope of the PCP's practice. Exceptions to this process are:

- Emergency care
- Urgent care
- Obstetrics and gynecology (OB/GYN) for preventive care, pregnancy care or gynecological complaints
    - Female members have the option to directly access a participating women's health specialist (such as an OB/GYN or certified nurse midwife) for routine and preventive covered health care services for women (such as breast exams, mammograms and Pap smears).
- Member's self-referral to a behavioral health provider, which may be covered depending on the member's benefit coverage.
- Members with chronic life-threatening, degenerative or disabling conditions or diseases that require continuing specialized medical or behavioral health care, which qualify for a standing referral to a specialist under Health Net's national policy requirements. For example a member with HIV/AIDS, renal failure, or acute leukemia may seek a standing referral to a qualified, credentialed specialist
- Female members have the option of direct access to a participating women's health specialist (such as an OB/GYN or certified nurse midwife) within the network for women's routine and preventive covered health care services (such as breast exams, mammograms and Pap tests).

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 or chart. When an appointment is missed, providers are required to attempt to contact the member a minimum of three times, via mail or phone.

Appointment Rescheduling

According to the timely access regulations (28 CCR 1300.67.2.2) and to Health Net's Medical Records Documentation Standards policies and procedures (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 extended if 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; has

determined and documented 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.

Advanced Access

The PCP may demonstrate compliance with the established primary care time-elapsed access standards through the implementation of standards, policies, processes, and systems providing same or next business day appointments with a PCP, or other qualified health care provider, such as a nurse practitioner or physician assistant from the time an appointment is requested; and offers advance scheduling of appointments for a later date if the member prefers not to accept the appointment offered within the same or next business day.

Advance Scheduling

Preventive care services and periodic follow up care appointments, including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat health conditions and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of their practice. For detailed standing referral information, refer to Operations Manuals > Referrals > Standing Referral to a Specialist > Regular Standing Referrals.

Shortage of Providers

If it is determined that there is a shortage of one or more types of participating providers (including seldom-used or unusual specialty services) in a Health Net service area, Health Net and its participating providers are responsible for ensuring members are seen within the appropriate time-elapsed appointment standards [28 CCR 1300.67.2.2(c)(7)(B)]. To comply with applicable laws and regulations, and ensure timely access to covered health care services, a provider or PPG operating in a service area that has a shortage of one or more types of providers and cannot provide an appointment within the required time frame must:

- For primary care services - Refer members to available and accessible participating providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the member's health care needs.
- For specialty services (including seldom-used or unusual specialty care) - Refer members to available and accessible participating providers in neighboring service areas. If a specialist is not available in neighboring areas within the network, the participating provider must refer the member to, and arrange for the provision of, an out-of-network specialist, when medically necessary for the member's condition for as long as the provider or PPG is unable to provide timely access within the network.
    - Member costs for medically necessary referrals to out-of-network providers must not exceed applicable copayments, coinsurance and deductibles.

  These requirements do not prohibit Health Net or its delegated PPGs from accommodating a member's preference to wait for a later appointment from a specific participating provider. If a member prefers to wait for a later appointment, document it in the relevant record.

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 originating 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. Refer to Interpreter Services for more information.

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.

Prior Authorization Processes

Health Net requires prior authorizations to be processed and completed in a manner that assures appointments for covered health care services are provided in a timely manner, appropriate to the member's condition and comply with the requirements of the time-elapsed appointment access standards. If the appointment type requires prior authorization, obtaining authorization must be completed within the time frame for that visit or service to be offered. For example, expedited utilization management (UM) review processes and appointment scheduling for urgent care appointments for services that require prior authorization, [28 CCR 1300.67.2.2(c)(5)(B)], more commonly known as urgent pre-service requests, must be conducted concurrently, or the prior authorization turnaround timeline must be shortened to allow sufficient time to communicate the outcome to the member and/or the referring provider and ensure an appointment is offered to the member within 96 hours of the request. Refer to the Prior Authorization section for more information.

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.

Health Net HMO and POS 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%

ACCESS MEASURE	STANDARD	PERFORMANCE GOAL
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 15 minutes	70%

Compliance is measured by results from the Provider Appointment Availability Survey (PAAS) and Providers 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	Appointment within 15 business days of request	70%

ACCESS MEASURE	STANDARD	PERFORMANCE GOAL
physician (psychiatrist) for routine care[3]		
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%
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).

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 below are Health Net's performance goals for geo-access and provider availability-related criteria:

Health Net HMO and POS Geo-Access Standards*

Availability Standards	Performance Threshold
One PCP within 15 miles or 30 minutes from residence or workplace (HMO/POS only)	90% or more of practitioner/provider network meet compliance rate
Two SCPs (including high-volume SCP) within 15 miles or 30 minutes from residence or workplace	90% or more of practitioner/provider network meet compliance rate
For each type of high volume specialist, 1 SCP within 15 miles or 30 minutes from residence or workplace (NCQA only)	90% or more of practitioner/provider network meet compliance rate
One behavioral health provider (BHP) within 10 miles from residence or workplace in urban areas; within 25 miles from residence or workplace in suburban areas; and 60 miles from residence or workplace in rural areas	95% or more 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 ancillary care provider (lab, radiology or pharmacy) within 15 miles or 30 minutes from residence or workplace	90% or more of practitioner/provider network meet compliance rate
One ancillary care provider (lab, radiology or pharmacy) within 15 miles or 30 minutes from PCP (DMHC reporting purposes only)	90% or more of practitioner/provider network meet compliance rate
Practitioner/Provider Availability Standards	
Member to full time equivalent (FTE) PCP ratio	2,000:1

Availability Standards	Performance Threshold
Member to FTE physician	1,200:1
Member to SCP ratio	1,200:1
Member to behavioral health physician ratio	5,000: 0.8
Member to psychologist ratio	2,300: 0.8
Member to master's level behavioral health provider ratio	1,150: 0.8
Percent PCPs open practice	85% of PCPs accepting new members
Percent SCPs open practice	85% of SCPs accepting new members
Member to hospital ratio	3,000:1
Member to emergency room ratio	3,000:1
Member to lab and radiology ratio	3,000:1
Member to pharmacy ratio	1,000:1

*Certain rural portions of the plan service area may have a standard that differs from within 15 miles/30minutes based on lack of practitioner and hospital availability. Regulatory approval is required for areas that vary from within 15 miles/30 minute standard.

Corrective Action

Health Net investigates and implements corrective action when timely access to care standards, as required by Health Net's Appointment Accessibility for commercial and SHP (Medi-Cal) 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 90% 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.

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.

Open Clinical Dialogue

Participating Physician Groups (PPG) | Hospitals

The Provider Participation Agreements (PPAs) include a statement that providers can communicate freely with members regarding their medical conditions and treatment alternatives, including medication treatment options, regardless of coverage limitations. Providers' contracts and subcontracts are required to include this provision.

Additionally, Health Net may not prohibit or otherwise restrict a health care professional, acting within the lawful scope of practice, from advising, or advocating on behalf of, an individual who is a patient and enrolled under a Health Net plan.

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.

Claims Denials

Participating Physician Groups (PPG) | Hospitals

The Delegation Oversight auditors review claim denial by delegated entities to ensure that notification letters to providers comply with accuracy and timeliness requirements. Providers may not send a denial notice to a member as they are provider denials only..

Claim Audit Check Cashing Requirement

Health Net conducts audits to ensure 70% of checks mailed by the delegated entity to their participating and non-participating providers are cleared within 14 calendar days from the date the check was mailed. Check mailing is monitored to validate that checks are being mailed timely.

Claims Payment Requirements

Provider Type: Participating Physician Groups (PPG) | Hospitals

Timely processing of claims is monitored via the participating physician group's (PPG's) self-reported monthly claims timeliness reports. Accuracy and timely processing of claims is verified by routine and targeted audits conducted by the Delegation Oversight staff.

PPGs are required to:

- Process 95 percent of commercial HMO claims within 45 business days of receipt.
- Pay 15 percent interest or $15 per year, whichever is greater, on late paid claims for emergency services rendered in the United States.
- Pay 15 percent interest on late paid claims and include an additional penalty fee of $10 if the interest is not included with the original claims payment.
- Pay 15 percent interest on late paid claims for non-emergency services rendered in the United States.
- Resolve 95 percent of provider disputes within 45 business days (if a provider dispute is in favor of the provider check, this needs to be mailed within five days of the resolution letter, including interest if applicable).

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 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.

Eligibility and Data Entry Requirements

Participating Physician Groups (PPG) | Hospitals

All participating physician groups (PPGs) and hospitals are required to enter the following into the PPG's or hospital's system:

- Eligibility and primary care physician (PCP) assignment information within two business days after receipt.
- New member information that is not yet on eligibility or capitation reports upon verification of eligibility.
- PCP changes requested by the member within two business days of receipt of requested change.

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 Problem Resolution

Participating Physician Groups (PPG) | Hospitals

Under the plan's quality improvement (QI) standards, all participating physician groups (PPGs) and hospitals are required to:

- Initiate research, on quality-of-care problems identified by clinical staff.
- Provide feedback and information on the issue so that a determination can be made.
- Participate in the QI corrective action process, as applicable.

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
- Health Education Program
- Health Management Programs
- Language Assistance Program and Cultural Competency
- Quality Improvement Program

Health Net's Health and Wellness Program

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

This section contains general information on Health Net's disease management programs.

Select any subject below:

- Health and Wellness Program Disclaimer
- Health and Wellness 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.

Health Net's Health and Wellness Program

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

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Health Net's Health and Wellness 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. The program 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 Health 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 (PDF) to:

- The Craving to Quit tobacco cessation program, available to commercial members). members only).
- The Health Coaching Program (available to Commercial 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 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.

Decision Power Program

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

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Health Net's Decision Power® 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.

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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)

Health Net encourages participating physician groups (PPGs) to provide health education and disease management programs to their members based on identified risks and Healthcare Effectiveness Data and Information Set (HEDIS®) standards.

PPGs should offer health education programs at each PPG delivery site (including satellites) with 5,000 or more Health Net members. Each PPG plans health education programs based on the recommended program criteria and protocols included in the Health Education Program subtopic.

Providing health education programs is part of the contractual agreement between Health Net and the PPG. The PPG is responsible for planning, implementing and evaluating its health education programs.

Health Education Program Offerings

All PPGs should recommend the following core topics: diabetes management, early prenatal education, baby care basics, and for Health Net Medicare Advantage (MA) members, a senior-specific health education or disease management program. Health Net encourages PPGs to provide additional program topics that reflect the breadth and depth of their members' needs. This includes efforts to identify members who smoke and to refer them to appropriate programs.

PPGs may select additional topics from the following list. PPGs are encouraged to select additional topics based on demographic and diagnostic data specific to their members.

Category	Examples
Maternal, infant and child health	VBAC, childbirth preparation, breastfeeding
Circulatory	hypertension, hypercholesterolemia
Respiratory	COPD, asthma

Category	Examples
Musculoskeletal	back care, arthritis, osteoporosis
Weight management	adults, adolescents, children

Advisory Committee and Program Coordinator

Advisory Committee

Participating physician groups (PPGs) should designate a standing health education advisory committee, including at least one physician and the health education coordinator, to be involved in program planning, evaluation, internal communication, and promotion. This committee can be the same as the PPG Quality Improvement Committee (QIC). The health education advisory committee is responsible for:

- Meeting at least once a quarter.
- Maintaining written records of the advisory committee.

Health Net recommends that PPGs:

- Select advisory committee members to achieve a wide representation of departments in the PPG or geographic locations in a PPG.
- Distribute meeting minutes widely within the PPG so that staff are kept informed about the program.
- Develop a supportive, enthusiastic advisory committee. This helps to ensure a quality program and win support from other physicians and staff.

Health Education Coordinator

PPGs should designate a health education coordinator responsible for coordination and delivery of the health education programs, including PPG staff program orientation and record keeping.

Health education coordinators should spend the following number of hours per week coordinating the health education programs based on the PPG's Health Net membership.

PPG Membership	Hours Per Week
Fewer than 5,000 members	15
5,000 to 10,000 members	15 to 25

PPG Membership	Hours Per Week
10,000 to 20,000 members	25 to 40
20,000 or more members	40 hours or more

The health education coordinator's responsibilities are to:

- Direct members into health education programs based on referrals from Health Net care managers or health risk assessment (HRA) results.
- Be accessible to Health Net members seeking information, suggestions and problem solving.
- Coordinate satellite programs (unless another coordinator is designated to do this).
- Maintain all program records and make them available for the site evaluation.

Health Net recommends that:

- Health education coordinators have one of the following credentials: masters of public health (MPH), certified health education specialist (CHES), registered nurse (RN), physician assistant (PA), family nurse practitioner (FNP), registered dietitian (RD), or a Masters or Bachelors degree in health education, nutrition or exercise physiology.
- Health education coordinators receive administrative and medical staff support.

Health Education Program Protocols

Health education program protocols are recommendations for success when providing classes on diabetes, early prenatal education and baby care basics. Program protocols also include disease-specific education programs and smoking cessation for participating physicians groups (PPGs).

Diabetes Education Program Protocols

All diabetes education programs should encourage an active partnership between the member, the member's family and the health care provider. Such partnerships can improve member adherence to treatment plans and enable families to better support efforts to control the member's diabetes.

It is also important that all diabetes education programs emphasize the concept of self-management of diabetes rather than teaching individual skills.

The following topics are required for all diabetes education programs:

- Understanding diabetes:
  - Basic definition and facts about diabetes
    - Normal and abnormal glucose metabolism
    - Classifications: Type I and Type II
  - Factors in the development of Type I and Type II diabetes
  - Signs and symptoms of diabetes

        - Chronic complications
            - Retinopathy
            - Neuropathy
            - Nephropathy
            - Cardiovascular disease
            - Sexual dysfunction/impotence
- Medications (as indicated):
    - Oral medication
    - Insulin use
        - Review of insulin's action
        - Injection techniques
        - Dosage
        - Insulin reaction (hypoglycemia)
        - Hyperglycemia
- Strategies to control diabetes:
    - Blood glucose monitoring and interpretation of results
    - Nutrition and meal planning
    - Exercise and activity
    - Routine tests to measure control
        - Annual retinal examination
        - Glycosylated hemoglobin (HbgA1c) screening every three months
        - Annual microalbumin creatinine urine screening
        - Blood pressure screening at every visit
        - Cholesterol screening once a year
        - Foot examination at every visit
- Living with diabetes:
    - Preventing, detecting and treating complications
        - Skin, eye and dental care
        - Immunizations
        - Infections
        - Foot and leg care
        - "Sick day" rules
        - Identification (such as MedicAlert)
    - Psychological adjustment
    - Lifestyle considerations (nutrition, physical activity and smoking cessation)
    - Family involvement
    - Community resources
- Patient self-care:
    - Behavior change strategies
    - Goal setting
    - Risk factor reduction
    - Problem-solving

Adapted from the Journal of Clinical and Applied Research and Education, Diabetes Care, American Diabetes Association, Volume 38: Supplement 1, January 2015.

Frequency

One-to-one counseling should be offered on an ongoing, as-needed basis. Health Net recommends that participating physician groups (PPGs) also offer seminars or classes at least monthly. The diabetes education program may also be a one-session class, multiple-session classes, one-to-one counseling, or any

combination of these modes. The recommended minimum length for group programs is three to four sessions, each two hours in length. Classes and seminars should be followed by a one-hour, one-to-one follow-up appointment to develop individualized care plans.

Participant Tracking

PPGs should give documented feedback regarding a member's program attendance to the physician for him or her to include in the member's medical chart.

Disease-Specific Program Protocols

It is important that all disease-specific education programs encourage an active partnership between the patient, the patient's family, and the health care provider. Such partnerships can improve patient adherence to treatment plans and enable families to better support the patient's efforts to manage his or her disease.

Content may be expanded and additional components incorporated as indicated by the specific disease or condition.

All disease or condition-specific education programs should cover the following topics, as applicable:

- Understanding the disease:
  - Basic definition of the disease and affected physiological processes
  - Causes of the disease
  - Signs and symptoms of the disease
- Medications (if applicable):
  - Different types of medications
  - Purpose of medications and how they work
  - Common side-effects and coping strategies
  - Importance of medication compliance
  - Methods of maintaining compliance with the medication regimen
- Living with the disease:
  - Treatment of the disease:
    - Development of treatment/care plan
    - Routine medical visits and tests
    - Avoiding, detecting and treating complications, if applicable
- Lifestyle considerations:
  - Nutrition
  - Exercise
  - Other considerations specific to the disease
  - When to call a medical professional immediately
  - Psychosocial issues
  - Importance and role of family/caregivers
- Patient self-care:
  - Importance of patient compliance with treatment/care plan
  - Self-monitoring, as appropriate
  - Behavior change strategies
  - Individual goal setting

Frequency

One-to-one counseling should be offered on an ongoing, as-needed basis and should be at least one hour in length. Health Net recommends that participating physician groups (PPGs) offer seminars or classes, which are at least two hours in length, at least monthly. Programs may be offered as a combination of quarterly group programs with one-to-one counseling available in the other two months, as long as both programs are equally available to members.

Participant Tracking

PPGs should document feedback regarding a member's program attendance to be given to the physician for him or her to include in the member's medical chart.

Patient Health Education

Patient health education is the effort to keep members fully informed about the availability and use of participating physician group (PPG) facilities and services.

PPGs must offer patient health education as a covered service to members in two main areas:

- Proper use of Health Net and PPG services.
- Health maintenance and improvement, including personal health care measures and counseling.

Health Net has developed an enrollment packet, which includes a plan overview that explains to members how to use Health Net and PPG services. This enrollment packet is distributed to members, along with identification (ID) cards and the member's Schedule of Benefits. Members are directed to contact their PPGs if they have questions.

PPG Responsibilities

PPGs must make an effort to keep members fully informed about the availability and use of PPG facilities and services. New member interviews, letters of introduction and the Health Net Member Services Department provide sources of ongoing education and information.

Health education services, including educational activities and publications that contain instructions on achieving and maintaining physical and mental health and preventing illness or injury, should be developed by the PPG.

Health Net's Pre-recorded Health Information

Health Net offers a library of pre-recorded information on a variety of health topics to all Health Net members through the AudioHealth Library®. Members may access the library by contacting the Health Net Member Services Department.

Responsibilities for Health Education Programs

Program Delivery Site

Participating physician groups (PPG) and its participating providers should dedicate and maintain a physical environment or setting conducive to the delivery of health education programs and optimal learning and ensure that is appropriate for its Health Net membership. Specifically:

- Member education must not occur in an examination or a waiting room during clinic hours.
- All programs should be conducted onsite or at an appropriate offsite location.
- The sites must be accessible to individuals who have physical limitations.

Program Evaluation and Tracking

Health Net recommends that groups evaluate all classes and seminars using a written participant evaluation form. The evaluation form should include an overall satisfaction question using a five-point rating scale, such as:

5	4	3	2	1
Extremely Satisfied	Very Satisfied	Satisfied	Not Very Satisfied	Extremely Dissatisfied

Written participant evaluation forms are not required for one-to-one counseling sessions.

PPGs should conduct follow-up telephone calls or use other means to evaluate the quality of one-to-one counseling sessions.

Program Promotion

PPGs should promote all programs to Health Net members and PPG staff. Health Net encourages PPGs to mail promotional materials to Health Net members at least once per year to promote all health education programs. Suggested promotional activities include:

- Flyers and posters in waiting areas.
- Medical group newsletters via direct mail.
- Telephone recordings.

PPGs may not use the Health Net corporate logo on material without Health Net's permission.

Record-keeping Responsibilities

PPGs should use and maintain appropriate medical and non-medical records (for example, attendance lists, evaluation forms, patient education sign-in sheets, and documentation of feedback to physicians).

Specifically, PPGs should maintain the following documentation:

- Attendance records or one-to-one education sign-in sheets identifying Health Net members.
- Written program evaluations for all programs (except one-on-one counseling).
- A system to document smoker identification and referrals to a smoking cessation program.
- Minutes from advisory committee meetings.
- A physician feedback system of participant attendance and progress in the diabetes and early prenatal programs, which provides a link between the referring physician, patient, and health education program:

- Attendance feedback is documented in the member's medical record or in a central file.
- A random sampling of medical records or copies of feedback records may be reviewed during the annual site evaluation.

PPGs may also document the member's progress, response to education and attendance in other programs and share this information with the member's physician.

Speakers Bureau

Participation in Health Net's Speakers Bureau program is optional. Participating physician groups (PPGs) are asked periodically to provide presentations or screenings to Health Net employer groups.

For more information, select any subject below:

- Baby Care Basics Protocol
- Early Prenatal Education Program Protocol
- Smoking Cessation Program

Baby Care Basics Protocol

Provider Type: Participating Physician Groups (PPG)

The following topics are recommended for all baby care basics education programs:

- Normal newborn characteristics:
  - physical characteristics
  - reflex response
  - behavior patterns
  - sleep patterns
- Newborn care:
  - bathing, including: umbilical cord care, circumcision care, skin care, and proper bathing techniques
  - diapering and changing
  - nutrition, including: breast-feeding and bottle feeding tips on technique, positions, frequency, formula storage, bottle care and cost, and signs of hunger
- Caring for a sick baby:
  - before calling the doctor
  - newborn warning signs
- Well baby checkups:
  - importance of regular checkups
  - what to expect at pediatric visits
  - immunization guidelines
- Safety tips:
  - infant car seat use
  - home environment
- Resources for baby care information

- community resources
- websites
- literature

Frequency of Program

One-to-one counseling should be offered on an ongoing, as-needed basis. Health Net recommends participating physician groups (PPGs) offer seminars or classes at least monthly. The baby care basics education program may be a one-session seminar, a multi-session class, one-to-one counseling, or any combination of these modes.

Baby care basics education programs offered as classes or seminars should be at least two hours in length. One-to-one nutrition education programs should be at least one hour in length. A multi-session class is strongly recommended.

Early Prenatal Education Program Protocol

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

The following topics, adapted from the American Congress of Obstetricians and Gynecologists and Gynecologists Guide to Planning for Pregnancy, Birth and Beyond, 1990, are recommended for all early prenatal education programs.

- Normal changes of pregnancy:
  - Physical (appropriate weight gain)
  - Emotional
  - Sexual
- Prenatal medical care:
  - Importance of regular care
  - What to expect at obstetrical (OB) visits
  - Genetic history
  - Maternal serum screening for birth defects
  - Recognizing problems
    - Warning signs
    - When to call the doctor
  - Special considerations
    - Pregnancy over age 35
    - The Rh factor
    - VBAC (vaginal birth after cesarean)
      - Recommended for most women
      - Benefits of vaginal deliveries
- Prenatal nutrition:
  - Balanced diet
  - Additional protein and calcium
  - Folic acid
  - Adequate fluid intake

- Gestational diabetes
- Prenatal exercise:
  - Benefits
  - Exercises/activities to avoid
  - Recommendations for exercising safely
- Self-care:
  - Remedies for common discomforts
  - Stress management
  - Sexually transmitted diseases
- Lifestyle considerations:
  - Avoid or minimize use of harmful substances
    - Alcohol
    - Nicotine
    - Prescription medications
    - Over-the-counter medications
    - Recreational drugs
    - Caffeine
    - Herbal medicine
  - Working during pregnancy
  - Safety
  - Protection from environmental hazards
  - Check-up after delivery
- Infant car seat use:
  - Importance
  - How to use properly
  - Required by law

Frequency

One-to-one counseling should be offered on an ongoing, as-needed basis and be at least one hour in length. Health Net recommends that participating physician groups (PPGs) offer seminars or classes at least monthly that are at least two hours in length.

The early prenatal education program can be a one-session seminar, a multi-session class, one-to-one counseling, or any combination of these modes.

Participant Tracking

Documented feedback regarding program attendance should be given to the physician to be included in the member's medical chart.

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.

Health Management Programs

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

This section contains information on Health Net's health management programs.

Select any subject below:

- Overview
- Breast Cancer Health Initiative
- Behavioral Health Services
- Health Net's Health and Wellness Program

Overview

Provider Type: Participating Physician Groups (PPG)

Health Net has developed innovative health management programs to measure and improve the health status and quality of life of members through collaborative relationships with employers, purchasing coalitions and participating physician groups (PPGs).

Management of Osteoporotic Fractures

The primary objective of the Osteoporosis Initiative is to improve the quality of care for post-menopausal women with osteoporotic fractures. Members who have not had a bone mineral density (BMD) test or an appropriate medication for osteoporosis treatment after a fracture are identified for intervention.

Member Satisfaction Survey

Member satisfaction with the quality of care and services rendered by Health Net, participating physician groups (PPGs) and physician offices is measured at least annually. Health Net participates in the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Member Satisfaction Survey. CAHPS® assesses the level of member satisfaction with components of health care delivery such as access to care (routine, urgent and specialty care), wait time in the provider office, medical services, and overall member satisfaction.

Behavioral Health Services

Provider Type: Participating Physician Groups (PPG)

Health Net has quality initiatives to improve members' physical and mental health outcomes. Health Net focuses on various psychotropic medications, including antidepressant medication management. For example, eligible members with gaps in their antidepressant medication refills, and who are diagnosed with depression, receive automated or live outreach conducted by clinical pharmacists to remind them to continue taking their medications, refill their prescriptions and report any medication problems or concerns to their providers.

Most Health Net members appropriately seek depression treatment from their primary care physicians (PCPs), which is why Health Net provides physicians and participating physician groups (PPGs) with tools, such as Provider Tip Sheets, to support the management and coordination of care for members diagnosed with behavioral health conditions.

In an effort to increase awareness of the importance of identification and management of behavioral health conditions, among both providers and members, Health Net has been developing and posting:

1. Member online news articles to educate members on behavioral health (i.e., mental health and substance use), how to recognize the need for help, the availability and types of treatments, and the importance of treatment, medication adherence, and communicating with their providers.
2. Provider online news articles on the importance of monitoring, managing, and coordinating care and information exchange between medical and behavioral health providers, and available resources for easy reference and assistance.

Breast Cancer Health Initiative

Provider Type: Physicians | Participating Physician Groups (PPG)

The Breast Cancer Health Initiative is targeted toward members ages 40 through 74. Members in this age range should have mammography screenings. Health Net may place telephone calls, contract with a vendor to conduct either live or automated calls, send email, and text or mail reminders to members who have not had a mammogram in the past two years since turning age 40 to encourage them to complete the breast cancer screenings recommended for their age group. Health Net may also reach out to members eligible for the breast cancer screening measure (compliant or non-compliant) and survey them on what helped and could help keep them up with their care, in order to plan and strategize future interventions to better address members' needs. The effectiveness of these interventions is measured through the Healthcare Effectiveness Data and Information Set (HEDIS®) Breast Cancer Screening measure.

Health Net's Health and Wellness Program

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

Health Net's member wellness portal is a central hub for all of the wellness programs and activities. The wellness programs were created to engage people in their health with personalized tools and achievable goals. Members can feel confident in their ability to make positive and lasting behavioral changes.

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)

Commercial	CalViva Health	Community Health Plan of Imperial Valley	Medi-Cal
			Non-discrimination Notice Medi-Cal (Chinese) (PDF)
			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:

- Overview
- Health Net Quality Improvement Committees
- Monitoring Access Standards Compliance
- Participation in Public Reporting of Hospital Performance
- Quality Improvement HAC Program
- Quality Improvement Program
- Quality Improvement Program and Compliance and HEDIS
- Recognition for Quality Performance
- Quality of Care Issues

Overview - Quality Improvement

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

The Health Net Quality Improvement (QI) program includes the development and implementation of standards for clinical care and service, the measurement of compliance to the standards and implementation of actions to improve performance. The scope of these activities considers the enrolled populations' demographics and health risk characteristics, as well as current national, state and regional public health goals.

Health Net's Population Health Management strategy provides usage risk stratification data compiled from a variety of data sources to help teams target the right members with the right resources to address member health and social determinants of health (needs at all stages of life. The QI program impacts the following:

1. **Health Net members** in all demographic groups and in all service areas in which Health Net is licensed.
2. **Network Providers**, including physicians, facilities, hospitals, ancillary providers, and any other contracted or subcontracted provider types.
3. **Aspects of Care**, including level of care, health promotion, wellness, chronic conditions management, care management, continuity of care, appropriateness, timeliness, and clinical effectiveness of care and services covered by Health Net.
4. **Health Disparities** by supporting activities and initiatives that improve the delivery of health care services, patient outcomes, and reduce health inequities.
5. **Communication** to meet the cultural and linguistic needs of all members.
6. **Behavioral Health Aspects of Care** integration by monitoring and evaluating the care and service provided to improve behavioral health care in coordination with other medical conditions.
7. **Provider/Provider Performance** relating to professional licensing, accessibility and availability of care, quality and safety of care and service, including practitioner and office associate behavior, medical record keeping practices, environmental safety and health, and health promotion.
8. **Services Covered by Health Net**, including preventive care; primary care; specialty care; telehealth, ancillary care; emergency services; behavioral health services; diagnostic services; pharmaceutical services; skilled nursing care; home health care; long term care (LTC), Long-Term Services and Supports (LTSS): Community Based Adult Services (CBAS) which meets the special, cultural and linguistic, complex or chronic needs of all members.
9. **Internal Administrative Processes** which are related to service and quality of care, including customer service, enrollment services, provider relations, practitioner and provider qualifications and selection, confidential handling of medical records and information, case management services, utilization review activities, preventive services, health education, information services, and quality improvement.

Except for Molina, Health Net does not delegate its QI program or oversight responsibilities to PPGs, participating providers, hospitals, or ancillary providers. PPGs, participating providers, hospitals, and ancillary providers are required to comply with the standards and requirements set forth by Health Net, included in this operations manual.

Health Net regularly communicates information about Health Net's QI program goals, processes and outcomes as they relate to member care through provider updates, committee meetings and other forums. QI program information is also available to providers by request through Health Net's Provider Services Center (Commercial, Medicare Advantage, Medi-Cal, CalViva Health, Community Health Plan of Imperial Valley).

Health Net Quality Improvement and Health Equity Committees

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

The Health Net Quality Improvement and Health Equity Committee (QIHEC) is responsible to ensure quality and safety of care and services rendered to Health Net members.

The QIHEC is led by Health Net's Chief Medical Directory and Chief Health Equity Officer and is overseen by Health Net's Governing Board. The QIHEC meets quarterly. External practitioners (Network Providers, including but not limited to hospitals, clinics, county partners, physicians, subcontractors, downstream subcontractors.

Subcontractors, downstream subcontractors, and network providers must be representative of the composition of the HNCS' provider network and include, at a minimum, network providers who deliver health care services to members affected by health disparities, limited English proficiency (LEP), children with special health care needs (CSHCN), seniors and persons with disabilities (SPDs) and persons with chronic conditions participate on this committee along with representatives from Behavioral Health, Pharmacy Department, Network Management, Medical Affairs, Customer Service Operations, Credentialing, Peer Review, and Population Health & Clinical Operations (PHCO) which includes Utilization Management (UM) and Care Management.

QIHEC functions include the following:

- Annually assess UM, QI, and Health Equity activities, including areas of success and needed improvements in services rendered within the QI and Health Equity program at the regional and/or county level; Conduct a quality review of all services rendered, the results of required performance measure reporting, and the results of efforts to reduce health disparities;
    - Address activities and priorities related to the Quality Improvement and Health Equity Transformation Program (QIHETP)
    - Analyze and evaluate the results of QI and Health Equity activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys;
    - Institute actions to address performance deficiencies, including policy recommendations;
    - Ensure follow-up of identified performance deficiencies or gaps in care;
- Support efforts to align resources, strategies, and partners by place in order to reduce identified inequities (e.g., via use of Health Equity Improvement Zones);
- Identify differences in quality of care and utilization of physical and behavioral health care services for members directly managed and delegated to providers;
- Ensure that all interventions to address differences in quality of care and utilization have an equity focus, including addressing underlying factors such as SDoH;
- Review performance measure results and address deficiencies, including results and deficiencies of all fully delegated subcontractors;
- Review progress summaries from Joint Operating Meetings
- Ensure connectedness to the findings, recommendations and actions from the Quality Improvement Committee, Community Advisory Committees (CAC), and Public Policy Committee to drive universal decisions and programming;
- Ensure member confidentiality is maintained in QI discussions and avoid conflict of interest among the QIHEC members;
- The QIHEC shall provide input and advice on the following non-exclusive list of topics:
    - Population Health Management;
    - Health Delivery Systems Reforms to improve health outcomes;
    - Coordination of Care;
    - Clinical quality of physical and behavioral health care;
    - Access to primary and specialty health care Providers and services;
    - Member experience with respect to clinical quality, access, and availability, culturally and linguistically competent health care and services, and continuity and coordination of care
    - Non-Specialty Mental Health Services (NSMHS) Member and PCP Outreach & Education Plan
- QIHEC is responsible for adequately addressing recommendations put forth by the CAC and providing feedback through a dashboard that outlines progress and decisions on recommendations

- For recommendations that the QIHEC is unable to reasonably address, a CAC may opt to escalate their recommendation to the HNCS Board of Directors for further review and consideration.
- Form and delegate authority to subcommittees when appropriate; and
- Review and reassess the adequacy of the charter annually and recommend any proposed changes to the Board for approval. The Committee shall annually review its own performance.

Subcommittees

Community Advisory Committee

- Refer to Community Advisory Committee section.

Utilization Management:

- Review and approve the annual Medi-Cal and dual-eligible Utilization and Care Management (CM) Programs, including the UM and CM Program Description, Work Plan, and Work Plan Evaluation;
- Monitor and support the activities for UM an CM programs, review the effectiveness of the programs, and make recommendations for improvement; and
- Oversee UM activities performed by delegated subcontractors and the shared services teams.

Quality Management

- Review and approve the annual Medi-Cal, dual-eligible QI Program Description, Work Plan, and Work Plan Evaluation;
- Monitor and support the activities for the QI program, evaluate the effectiveness of the Work Plan, and make recommendations for improvement; and
- Review and approve the annual Health Education Program Description, Work Plan, and Work Plan Evaluation.

Health Equity

- Review HNCS QI and QIHETP findings and required actions at the regional and/or county level;
- Review and approve the annual Health Equity Description, Work Plan, and Work Plan Evaluation;
- Monitor, support, and evaluate the activities for the QI and QIHETP programs, and make recommendations for improvements;
- Conduct an annual evaluation of the effectiveness of the language assistance services offered to support members with limited English proficiency and to mitigate potential cultural or linguistic barriers to accessing care in compliance with requirements from Centers for Medicare and Medicaid Services (CMS), Department of Health Care Services (DHCS), and Department of Managed Health Care (DMHC);
- Concentrate on eliminating identified health disparities including, structural racism and social risk, SDoH, and community needs; make recommendations to improve individual and community health outcomes.

- Review and provide status on formal recommendations presented by the HNCS CAC.

Credentialing/Peer Review Committee

The Credentialing/Peer Review Committee verifies and reviews practitioners and organizational providers who contract to render professional services to Health Net members for training, licensure, competency, and qualifications that meet established standards for credentialing and recredentialing. The Credentialing Committee ensures Health Net's credentialing and recredentialing criteria for participation in the Health Net network are met and maintained for all lines of business, as defined by the regional health plans. The QIHEC delegates authority and responsibility for credentialing and recredentialing peer reviews to this committee. This committee is also responsible for peer review activities and decisions regarding quality improvement follow-up on service and clinical matters, including quality of care cases. The committee provides a forum for instituting corrective action as necessary and assesses the effectiveness of these interventions through systematic follow-up for all lines of business for both inpatient and outpatient care and services.

This committee reports quarterly to the QIHEC and provides a summary of activities to the Health Net board of directors. Membership includes practicing medical directors or practitioners (representing primary and specialty disciplines) from PPGs representing each region (northern, central and southern California).

Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics (P&T) Committee ensures appropriate and cost-effective delivery of pharmaceutical agents to Health Net membership. Committee responsibilities include the review and approval of policies that outline pharmaceutical restrictions, preferences, management procedures, explanation of limits or quotas, the delineation of Recommended Drug List (RDL) exceptions, substitution and interchange, step-therapy protocols, and the adoption of prescription safety procedures.

The P&T Committee includes a Health Net medical director, practitioners from PPGs that represent primary care and specialty disciplines, and clinical pharmacists.

A Pharmacy and Therapeutics (P&T) Committee is comprised of actively practicing physicians, medical directors and clinical pharmacists who review the efficacy and safety data of medications using an evidence-based process in order to make clinically appropriate utilization management recommendations to health plans and pharmacy benefit managers. P&T Committee members also consider the potential for medication misuse or abuse, experimental or off-label use, and required level of laboratory or safety monitoring. P&T Committee utilization management tools include prior authorization criteria, quantity limits and step therapy.

Delegation Oversight Committee

Health Net may delegate responsibility for activities associated with utilization management (UM) and administrative services to its PPGs.

The Health Net Delegation Oversight Committee (DOC):

- Provides systematic oversight and regularly evaluates Health Net's PPGs or contracting vendors to assure compliance with delegated duties.
- Oversees PPG compliance with health plan and regulatory requirements pertaining to the delivery of care and services to members.

- Assesses and determines delegation for each component of the delegated responsibilities, including UM, claims, credentialing, and administrative services.
- Communicates in writing all delegation decisions, recommendations and requests for corrective action plans (CAPs) to the PPGs.
- Reports quarterly to the QIHEC.

Specialty Network Committee

The Specialty Network Committee sets standards for the Health Net participating transplant performance centers and bariatric performance centers, guiding members to specialty network providers, monitoring performance, issuing requests for CAPs, and reporting to HNQIC. This committee meets at least six times per year and reports annually to HNQIC.

Monitoring Access Standards Compliance

Provider Type: Participating Physician Groups (PPG)

Health Net measures participating physician group (PPG) performance with timely access standards through the Provider Appointment Access survey and the Provider After-Hours Access survey. Overall member satisfaction is measured through the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey process.

Providers not meeting these standards are required to submit and follow a corrective action plan (CAP), which the Provider Network Management Department monitors. Refer to the Service and Quality Requirements discussion under the Provider Oversight topic for detailed information on access standards.

Health Net analyzes results in order to identify issues within its system of care that require improvement to promote appropriate utilization of both LTSS and emergency room services, appropriate and timely access to care, and Americans with Disabilities Act (ADA) and language assistance program compliance. Health Net reports results as required to the Centers for Medicare and Medicaid Services (CMS) and DHCS.

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 Improvement and Health Equity Transformation Program

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

The Quality Improvement and Health Equity Transformation Program (QIHETP) is designed to monitor, evaluate, and take effective action to address any needed improvements in the quality and health equity of care of all Covered Services delivered to Health Net members, regardless of whether those services were delegated to a subcontractor, downstream subcontractor, or network provider. The QIHETP is continuous.

As a part of the QIHETP, Health Net is responsible for delivering quality care that enables all members to maintain health and improve or manage a chronic illness or disability. Health Net must ensure quality care in the following areas:

1) clinical quality of physical health care;

2) clinical quality of behavioral health care focusing on prevention, recovery, resiliency and rehabilitation;

3) access to primary and specialty health care providers and services;

4) availability and regular engagement with PCP;

5) continuity of care and care coordination across settings and at all levels of care, and

6) member experience with respect to clinical quality, access and availability, culturally and linguistically competent health care and services, continuity of care and care coordination.

Health Net must apply the principles of continuous quality improvement (CQI) to all aspects of its service delivery system through analysis, evaluation, and systematic enhancements of the quantitative and qualitative data collection and data-driven decision-making, up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources, feedback from members, community partners, network providers, and any other identified issues.

The purposes and goals of the QIHETP are to:

- Support Health Net's strategic business plan to promote safe, equitable and high quality care and services while maintaining full compliance with regulations and standards established by federal and state regulatory and accreditation agencies.
- Objectively and systematically monitor and evaluate services provided to Health Net members to ensure conformity to professionally recognized standards of practice and codes of ethics.
- Provide an integrative structure that links knowledge and processes together throughout the organization to assess and improve the quality and safety of clinical care with quality service provided to members.
- Develop and implement a Quality Improvement and Health Equity Annual Plan and continually evaluate the effectiveness of plan activities at increasing and maintaining performance of target measures, and act, as needed, to enhance performance.
- Support a partnership among members, practitioners, providers, regulators, and employers to provide effective health management, health education, disease prevention and management and facilitate appropriate use of health care resources and services.

- Design, implement and measure organization-wide programs that improve member, practitioner and provider satisfaction with Health Net's clinical delivery system. These programs are population-based ongoing clinical assessments and are evaluated to determine the effectiveness of clinical practice guidelines, preventive health guidelines and care management programs.
- Monitor and increase Health Net's performance in promoting quality of service to improve member, practitioner and provider satisfaction through the use of satisfaction surveys, focused studies, and analysis of data (e.g., administrative, primary care, high-volume specialists and specialty services, and behavioral health and chemical dependency services).
- Promote systems and business operations that provide and protect the confidentiality, privacy and security of member, practitioner and provider information while ensuring the integrity of data collection and reporting systems. This is done in accordance with state and federal requirements and accreditation guidelines.
- Anticipate, understand and respond to customer needs, be customer-driven and dedicated to a standard of excellence in all customer relationships.
- Provide a means by which members may seek resolution of perceived failure by practitioners and providers or Health Net personnel to provide appropriate services, access to care and quality of care. Identify, review and investigate potential quality of care issues and take corrective action, when appropriate.

Health Net utilizes several methods to measure access to care, including telephone-based surveys and member experience surveys. Provider satisfaction with the timeliness and usefulness of information received from other physicians and various care settings is also assessed on a regular basis to measure the coordination of care in the network. Opportunities for improvement are identified by examining provider ratings of key elements in the following functional areas: access and availability, case management, prior authorization, cultural and linguistic services, concurrent review, and discharge planning.

The QIHETP includes a written program description and a Quality Improvement and Health Equity Annual Plan that defines the activities and planned improvements for the year. The annual work plan is developed following an evaluation of the previous year's activities and accomplishments. The Health Net Quality Improvement and Health Equity Committees (QIHECs) and the Health Net board of directors (BOD) approve and monitor the annual Health Net QI and HE programs and the QI and HE work plans. A written summary of QIHEC activities, findings, recommendations, and actions are prepared after every meeting and are submitted to the board of directors.

Quality Improvement Program and Compliance and HEDIS

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

Health Net tracks and monitors quality of care and service in a number of ways, including through the Healthcare Effectiveness Data and Information Set (HEDIS®). HEDIS was developed and is maintained by the National Committee for Quality Assurance (NCQA), a not-for-profit organization committed to assessing, reporting on and improving the quality of service and quality of care provided by organized delivery systems. It is the most widely used set of performance measures in the managed care industry. Participation in this effort allows health care purchasers and providers to compare Health Net's performance relative to other health plans and to identify opportunities for improvement.

In addition, Health Net participates in various quality improvement collaboratives, including:

- California Quality Collaborative (CQC), a program that seeks to improve clinical care and service for all Californians by providing strategies at the point of care. Various programs are available to providers to improve chronic disease care, patient satisfaction and efficiency. For a listing of educational programs and patient satisfaction and condition management resources, providers can visit www.calquality.org.
- The Leapfrog Group: Health Net works closely with The Leapfrog Group, purchases their data, and promotes their ratings and standards to network hospitals, members and the community.
- Cal Hospital Compare: Health Net collaborates with Cal Hospital Compare on a range of issues and contracts with them to obtain Poor Performer and Honor Roll reports and associated data files to inform hospital quality initiatives. .

Recognition for Quality Performance

Provider Type: Physicians | Participating Physician Groups (PPG)

Participating physician groups (PPGs) and directly contracted primary care physicians (PCPs) participating in the Ambetter HMO and Ambetter PPO may participate in a financial incentive program for improving quality of care as quantified by Healthcare Effectiveness Data and Information Set (HEDIS®) measures.

Incentives will be based on the following 4 HEDIS measures for care gap closure:

CODE	HEDIS MEASURE DESCRIPTION	SUB-MEASURE
CBP	Controlling High Blood Pressure	
HBD	Hemoglobin A1c Control for Patients with Diabetes	HbA1c Control (< 8.0%)
COL	Colorectal Cancer Screening	
CIS	Childhood immunization status	Combination 10

Incentives are calculated and paid out in November of the calendar year and a final payment for the full calendar year by the following August. The incentive program is not part of the compensation under the Health Net Provider Participation Agreement (PPA); it is supplemental compensation in addition to, but separate from, contracting rates. As such, Health Net reserves the right to alter the incentive program on an annual basis or to terminate it at any time by notifying the provider in writing of such termination.

Providers may contact their provider relations liaison or your provider network director for additional information about the incentive program.

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 | Hospital | Participating Physician Groups (PPG) | Ancillary

This section contains general information on referrals.

Select any subject below:

- Direct Network Referral Process
- Investigational and Experimental Treatment
- OB/GYN Self-Referrals
- Out-of-Network Referrals
- Post-Stabilization Care
- Referrals for Specialty Consultation
- Standing Referrals to a Specialist

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.

Out-of-Network Referrals

Provider Type: Participating Physician Groups (PPG)

A participating physician group (PPG) must refer members to participating providers except in emergencies or as otherwise required by law. PPGs are to use the following process when referring members to an out-of-network provider:

- Determine whether an out-of-network referral is necessary and request prior authorization.
- Have the PPG coordinator make an appointment for referral. When Health Net authorizes the referral request, the PPG coordinator arranges an appointment with the referred physician or specialist. When arrangements have been completed for the member's referral, the PPG coordinator makes a notation in the member's medical chart and completes the approrpriate form 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)
- Enter all pertinent information and obtaining all required signatures. Verify that the referral services are covered by the member's plan, as, once Health Net authorizes a referral, the authorization cannot be withdrawn and payment is required for services rendered.
- Inform member of copayments before services are performed. Some referral services require copayments. If the PPG fails to notify the member of a required copayment before the services are performed, no copayment can be charged.
- Specify what services are being authorized. The PPG physician must specify at the time of the referral what services or treatments are being requested. Some PPGs find it useful to have the participating physician initially request an evaluation or consultation. After the results are returned, a treatment plan is reviewed and an extension of the authorization is requested.
- Confirm referral services. Before referral services are performed, the referred physician must be aware that authorization is necessary for payment by the PPG. Health Net suggests that the PPG develop a standard letter to accompany the referral, explaining to the referred physician that only authorized services are reimbursed and that a member may not be charged for services.
- Make a member aware of what services are being authorized and any limitations to the authorization. No reimbursement is provided for unauthorized follow-up visits.
- Report member encounter information relating to referral services.
- Provide assistance during the process to member as needed. The member cannot be expected to know all the steps in the referral process; the PPG must provide this information.

The PPG must inform referred physicians that they may not refer the member to, or otherwise obtain the services of, another physician or medical professional without authorization from the PPG.

Post-Stabilization Care

Provider Type: Participating Physician Groups (PPG)

A participating physician group (PPG) must immediately contact or refer requests regarding authorization for post-stabilization services to the Health Net Hospital Notification Unit.

Referrals for Specialty Consultation

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

Listed below are examples of services that are referred for specialty consultation. This list provides guidelines and is not intended to be all-inclusive.

Allergy

- Chronic rhinitis if the allergic cause is indicated by IgE or nasal eosinophils or if mechanical obstruction, such as adenoids or tonsils, is obvious
- Hives if urticaria becomes chronic (six to 10 weeks or recurrent)
- Consultation if hospitalized, severe respiratory failure or member is steroid-dependent
- Asthma if difficult diagnostic dilemma, not well controlled with routine therapy, hospitalization or if severe respiratory failure has occurred or if the member has become steroid-dependent
- Significant reactions to stinging insects, chronic eczema, chronic sinusitis, and medication allergies
- Systemic allergic reactions, anaphylaxis

Cardiology - Adult

- Candidates for thrombolysis, stress testing, catheterization, angioplasty, or surgery, and life-threatening arrhythmias, or hemodynamic complications requiring invasive monitoring
- Unstable angina
- Hemodynamically complicated murmur
- Constrictive pericarditis
- Complicated hypertension (failure to respond or adverse response to conventional therapy)
- Angina despite maximal pharmacological therapy with maximally tolerated doses of nitrates, beta-blockers, and calcium channel blockers
- Intractable heart failure and arrhythmias
- Pericardial effusion
- Congenital or valvular disease for non-invasive studies and to define appropriate follow-up
- Evaluate and treat recurrent syncope (cardiac)
- Initial consultation for acute and chronic heart failure management

Cardiology - Pediatric

- Evaluate and treat any non-soft, non-systolic cardiac murmur
- Evaluate cyanosis that does not clear with crying
- Evaluate tachypnea
- Evaluate diminished pulses in any extremity
- Consultation for any member with a syndrome known to have cardiac complications (Down's, Marfan's, etc.)

Dermatology

- Acne that has not resolved or improved after three months
- Severe cystic acne
- Suspicious lesion suggesting melanoma
- Basal or squamous cell carcinomas
- Biopsy of suspicious lesions

Endocrinology

- Coma not rapidly reversible by glucose
- Instability in an established management program
- Brittle diabetes
- Diabetic complications, including retinopathy and nephropathy
- Exophthalmos, moderately severe or symptomatic
- Fine-needle aspiration of thyroid nodules
- Suspected disorders of calcium metabolism, adrenal, gonadal, or pituitary dysfunction
- Growth retardation (non-familial)
- Hyperlipidemia (no response to diet and medication, including two different medications, within one year)
- Radioactive iodine therapy

Gastroenterology

- Bowel obstruction diagnosed
- Polyps or other abnormalities
- Chronic bleeding, acute GI hemorrhage
- Undiagnosed hepatocellular disease or biliary obstruction
- Jaundice complicated by fever
- Severe acute and chronic hepatitis
- Ascites when peritoneal fluid is an exudate, chylous or intractable or if fever persists
- Severely symptomatic hemorrhoids refractory to treatment, may be referred for additional nonsurgical treatment
- Complex inflammatory bowel disease
- Chemotherapy for carcinoma

General Surgery

- Gallbladder disease, if significantly symptomatic
- Recurrent cysts, lumps or suspicious mammograms

Neurology/Neurosurgery

- Myofascial pain syndromes if there is no improvement and an uncertain diagnosis after six to eight weeks of conservative treatment or a progressive neurological deficit
- Seizures that are recurrent or refractory to treatment
- Degenerative neurological disorders
- Confirmation of diagnoses and/or intermittent consultation
- Ischemic attack that is associated with a carotid lesion
- CNS malignancies
- Persistent cervical or lumbosacral herniated nucleus pulposa resistant to conservative management

Obstetrics/Gynecology

- Ectopic pregnancy
- Uncertain clinical diagnosis
- Higher risk members (for example, over-age)
- Menometrorrhagia

Ophthalmology

- High index of suspicion for herpes
- Metallic foreign bodies
- Sudden visual change or loss
- Visual change accompanied by pain
- Sudden onset of flashing lights and floaters
- Any eye symptom not responding to treatment
- Unexplained abnormality on fundoscopic exam
- Sudden visual change or loss
- Pediatric members with dysconjugate gaze
- Lens opacification if associated with intolerable visual impairment

Orthopedics

- Fracture
- Locked knee
- Unstable knee
- Foot problems (deep abscess, gangrene, osteomyelitis)
- Any diabetic foot
- Obvious or apparent ligament tear
- Progressive disability of the knee despite conservative treatment and X-ray showing joint narrowing or gross destruction of the articular surface

Otolaryngology

- Tonsillectomy if three documented episodes within four months or six documented episodes within one year
- Tonsillar obstruction or recurrent peritonsillar abscess
- Acute otitis media, member toxic for 48 hours despite treatment
- Persistent middle ear effusion lasting more than three months with continuous treatment, or persistent infection after three courses of different antibiotics
- Persistent hearing loss or delayed speech and articulation in children under the age of 3
- Persistent retraction of tympanic membranes
- Recurrent epistaxis
- Acute and chronic sinusitis after treatment with antibiotics for 20 days or if infection not responsive in 72 hours
- Nasal obstruction after three months of treatment
- Parotid masses
- Acute or persistent hearing loss not attributable to fluid or wax
- Hoarseness that persists for more than three weeks

Psychiatry

- Diagnose, treat, and recommend medication regimen in difficult/complex cases, for example:
  - Depressions that does not respond to 60-day trial of selective serotonin re-uptake inhibitor (SSRI) medications or other antidepressants
  - Members who report feeling suicidal or homicidal
  - Panic disorders
- For example, continued:
  - Severe anxiety states
  - Clear somatoform disorders
  - Schizophrenic disorders where clozapine or risperidone are being considered
  - Bipolar disorder where lithium, carbamazepine or chlorpromazine may be needed

Psychologist

- Diagnosis, treatment and consultation regarding management of clearly emotional issues for which the member or PCP feels the need for consultation
- Psychological testing for clarification of diagnosis to establish a treatment plan

Pulmonology

- Respiratory failure
- Percutaneous lung biopsies
- Pleural biopsies
- Supraclavicular node biopsies
- Pleural effusions not due to heart failure or acute pneumonia
- Unresolved pneumonia
- Neonatal lung disease
- Cystic fibrosis
- Lung masses

- Hemoptysis
- Interstitial disease
- Sarcoidosis
- Tuberculosis
- Unusual infections
- Dyspnea of uncertain etiology
- Sleep disorders
- Complicated asthma, advanced COPD, pulmonary vascular disease, including pulmonary hypertension vasculitis and pulmonary embolism

Rheumatology

- Osteoarthritis, if no response to treatment after three months
- Rheumatoid arthritis if manifestations are not controlled on the treatment program or treatment plan to include surgery
- Collagen vascular diseases depending on the extent and severity of manifestations or complications

Social Workers/Other Credentialed Providers

- Brief psychotherapy, including post-traumatic stress disorder (PTSD), grief, recent losses

Urology/Nephrology

- Scrotal mass, testicular, or does not transilluminate
- Undescended tests
- Prostate suspicious for malignancy or obstructive symptoms that may lead to surgical treatment
- Urinary stones that do not pass in a week (4 mm or less)
- Larger or proximal stones for consideration of removal, stenting or lithotripsy
- Male infertility
- Erectile dysfunction not obviously psychogenic
- Acute renal failure
- Obstructive uropathy
- 50 percent reduction in creatinine clearance
- Nephrotic syndrome
- Circumcision with recurrent balanitis or foreskin problems

Vascular Surgery

- Arterial problems, such as gangrene, ischemic ulcers or ischemic rest pain
- Venous insufficiency with stasis ulcers
- Abdominal aortic aneurysms that are symptomatic, enlarging, or greater than 5 cm in diameter

Infectious Disease

- Human immunodeficiency virus (HIV)
- AIDS

Standing Referrals to a Specialist

Provider Type: Physicians | Participating Physician Groups (PPG)

Health Net and its participating physician groups (PPGs) are required to have procedures for members to receive a standing referral to a specialist or specialty care center, including, but not limited to, HIV or AIDS specialists.

Definitions

Standing referral is a referral by the primary care physician (PCP) to a specialist for more than one visit to the specialist, as indicated in a treatment plan, if any, without the PCP having to provide a specific referral for each visit.

Specialty care center is defined as a center that is accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

Standing Referral to a Specialist

Health Net and its delegated PPGs provide for a standing referral to a specialist if the member's PCP determines in consultation with the specialist, if appropriate, and medical director (associated with PPG or Health Net) that the member needs continuing care from the specialist as follows:

- If a treatment plan is deemed necessary in the course of care and is approved by Health Net (or the PPG), in consultation with the PCP, specialist and member, the referral is made subject to the terms of the treatment plan.
- A treatment plan may not be necessary if Health Net (or the PPG) approved a current standing referral to a specialist.
- The treatment plan may limit the number of visits to the specialist, limit the period of time that the visits are authorized, or require that the specialist provide the PCP with regular reports on the health care provided to the member.

Prolonged Standing Referral

Health Net and its delegated PPGs provide members with standing referrals for specialized medical care over a prolonged period of time specifically for members who have conditions or diseases that are life-threatening, degenerative or disabling. These members may receive a referral to a specialist or specialty care center with expertise in treating the condition or disease for the purpose of having the specialist coordinate the member's health care as follows:

- If a treatment plan is deemed necessary in the course of care and is approved by Health Net (or the PPG), in consultation with the PCP, specialist, specialty care center, and member, the referral is made, subject to the terms of the treatment plan.
- A treatment plan may not be necessary if Health Net (or the PPG) approves the appropriate referral to a specialist or specialty care center.
- The referral is made if the PCP, in consultation with the member's specialist or specialty care center, and the PPG, determines specialized care is medically necessary for the member.

Time Limits

The determination of a standing referral request is made within three business days from receipt of request by the member or the member's PCP, and all appropriate medical records, and other information necessary is submitted.

Once Health Net or its delegated PPG make the determination, the referral authorization is issued within four business days of the date the proposed treatment plan, if any, is submitted.

Ordinarily PCPs or PPGs do not refer the member to a specialist that is not participating with the PPG or Health Net, unless there is no specialist within the PPG or Health Net's networks that are appropriate to provide treatment to the member, as determined by the member's PCP in consultation with PPG or Health Net's medical director, and documented in the treatment plan. If an out-of-network referral is necessary, benefits are provided at the in-network cost-share.

The PCP and PPG must track and monitor referrals requiring prior authorization. The tracking system must include authorized, denied, deferred, or modified referrals, the timeliness of the referrals, and referrals made to non-participating providers.

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.

Urgent Care

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

Coverage for urgent care varies depending on whether it is received inside or outside the participating physician group's (PPG's) service area. It is covered if it is:

- Performed or referred by the member's selected primary care physician (PCP) or PPG at the office visit copayment.
- Performed by an out-of-network provider inside the PPG's service area, but only if the services are authorized at the listed urgent care copayment.
- Performed outside the PPG's service area when a member's circumstances require it at the listed urgent care copayment. Services provided by other providers are covered if the diagnosis demonstrates that the member requires urgently needed care. The PPG's service area is within a 30-mile radius of the member's PCP's office.

Follow-up care is covered only when performed by a provider affiliated with or authorized by the selected PPG.

HMO Physician or Practitioner only

The following document applies only to Physicians.

Coverage for urgent care varies depending on whether it is received inside or outside the member's service area, as defined in the member's Evidence of Coverage (EOC) or Certificate of Insurance (COI). It is covered if it is:

- Performed or referred by the member's primary care physician (PCP) at the office visit copayment.
- Performed by an out-of-network provider inside the member's service area, but only if the services are authorized and at the listed urgent care copayment.
- Performed outside the member's service area when a member's circumstances require it at the listed urgent care copayment. Services provided by other providers are covered if the diagnosis demonstrates that the member requires urgently needed care.

Follow-up care is covered only when performed by the member's PCP or authorized by the plan.

Utilization Management

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

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

The care manager acts in support of providers, members and families to improve health, assist with health care decisions and assist in obtaining other services that can improve the member's health and functional status.

The care manager is responsible for monitoring and managing effective and efficient use of health care services for Health Net members by identifying, coordinating, and managing members who require care management.

The care manager identifies candidates for care management from either internal or external referral sources. High-risk and high-volume cases are managed for the duration of the member's health care needs or until a care plan is no longer required.

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.

Palliative Care Services

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

Eligible members (including Dual Special Needs Plans (D-SNPs)) at any age may receive covered benefits and services while receiving palliative care. The member must be diagnosed with advanced cancer, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), or liver disease. Life expectancy is 12 months or less, health status continues to worsen and the emergency department (ED) or hospital is used to manage the illness.

Members receiving palliative care may move to hospice care if they meet the hospice eligibility criteria. For members ages 21 and older, palliative care benefits and curative care are not available once the patient moves to hospice. For members under age 21, curative care is available with hospice care.

Referrals

Palliative care services provide extra support to current benefits.

Providers can refer an eligible member to palliative care. Send a Care Management Referral Form (PDF) and related medical records by email or fax to the Care Management Department. To process the request correctly, the following information must be included on the request:

- Diagnosis code – Z51.5
- Procedure code – S0311
- Units – 6 (equals 6 months)
- Select the contracted provider of choice from the Health Net Contracted Palliative Care Providers list (PDF).

Eligibility Criteria

Members of any age are eligible to receive palliative care services if they meet all of the criteria outlined in section A. below, and at least one of the four requirements outlined in section B.

Members under age 21 who do not qualify for services based on the above criteria may become eligible for palliative care services according to the broader criteria outlined in section C. below, consistent with the provision of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.

A. General Eligibility Criteria:

1. The member is likely to, or has started to, use the hospital or emergency department as a means to manage the member's advanced disease; this refers to unanticipated decompensation and does not include elective procedures.
2. The member has an advanced illness, as defined in section B below, with appropriate documentation of continued decline in health status, and is not eligible for or declines hospice enrollment.
3. The member's death within a year would not be unexpected based on clinical status.
4. The member has either received appropriate patient-desired medical therapy or is an individual for whom patient-desired medical therapy is no longer effective. The member is not in reversible acute decompensation.
5. The member and, if applicable, the family/member-designated support person, agrees to:
    - a. Attempt, as medically/clinically appropriate, in-home, residential-based, or outpatient disease management/palliative care instead of first going to the emergency department; and
    - b.Participate in advance care planning discussions.

B. Disease-Specific Eligibility Criteria:

1. Congestive heart failure (CHF): Must meet (a) and (b)

- a. The member is hospitalized due to CHF as the primary diagnosis with no further invasive interventions planned or meets criteria for the New York Heart Association's (NYHA) heart failure classification III or higher; and
- b. The member has an ejection fraction of less than 30 percent for systolic failure or significant co-morbidities.

2. Chronic obstructive pulmonary disease (COPD): Must meet (a) or (b)
   - a. The member has a forced expiratory volume (FEV) of one less than 35 percent of predicted and a 24-hour oxygen requirement of less than three liters per minute; or
   - b. The member has a 24-hour oxygen requirement of greater than or equal to three liters per minute.
3. Advanced cancer: Must meet (a) and (b)
   - a. The member has a stage III or IV solid organ cancer, lymphoma, or leukemia; and
   - b. The member has a Karnofsky Performance Scale score less than or equal to 70 or has failure of two lines of standard of care therapy (chemotherapy or radiation therapy).
4. Liver disease: Must meet (a) and (b) combined or (c) alone
   - a.The member has evidence of irreversible liver damage, serum albumin less than 3.0, and international normalized ratio greater than 1.3, and
   - b. The member has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or
   - c. The member has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score greater than 19.

C. Pediatric Palliative Care Eligibility Criteria:

Must meet 1. and 2. listed below. Members under age 21 may be eligible for palliative care and hospice services concurrently with curative care.

1. The family and/or legal guardian agree to the provision of pediatric palliative care services; and
2. There is documentation of a life-threatening diagnosis. This can include, but is not limited to:
   - a. Conditions for which curative treatment is possible, but may fail (e.g., advanced or progressive cancer or complex and severe congenital or acquired heart disease); or
   - b. Conditions requiring intensive long-term treatment aimed at maintaining quality of life (e.g., human immunodeficiency virus infection, cystic fibrosis, or muscular dystrophy); or
   - c. Progressive conditions for which treatment is exclusively palliative after diagnosis (e.g., progressive metabolic disorders or severe forms of osteogenesis imperfecta); or
   - d. Conditions involving severe, non-progressive disability, or causing extreme vulnerability to health complications (e.g., extreme prematurity, severe neurologic sequelae of infectious disease or trauma, severe cerebral palsy with recurrent infection or difficult-to-control symptoms).

If the member continues to meet the above minimum eligibility criteria or pediatric palliative care eligibility criteria, the member may continue to access both palliative care and curative care until the condition improves, stabilizes, or results in death.

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.

Concurrent and Retrospective Review

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

Concurrent Review

Concurrent review is the process of monitoring delivery of medical services at the time the care is being rendered (inpatient admissions). Concurrent review consists of pre-admission review, continued-stay review and discharge planning.

Concurrent review is initiated at the time prior authorization is requested for an inpatient admission or on notification to the Health Net Medical Management Department that a member has been admitted (in the case of an urgent or emergency admission). Concurrent review includes an evaluation of:

- Quality of care
- Plan of treatment
- Severity of illness
- Intensity of treatment
- Length of stay
- Level of care
- Discharge plan

Based on the concurrent review process, the hospital stay is approved or denied. If the stay is approved, the hospital receives a prior authorization number. The authorization number must be indicated on the hospital claim to Health Net.

All potentially non-approved services identified by the Health Net care manager (registered nurse (RN) reviewer) are reviewed with a Health Net medical director or a specialty advisor. Physicians and members have the right of appeal all un-approved services. Care cannot be discontinued until the treating provider has been notified and agreed to an appropriate discharge or transition of care plan.

Retrospective Review

Retrospective review is review of the quality and necessity of medical services after care has been rendered. Retrospective professional review involves an evaluation of services that fall outside Health Net's established guidelines for coverage. These claims are reviewed by Health Net's professional review specialists (RN reviewers) and a Health Net medical director or a specialty advisor where the initial reviewer recommends that a claim be denied for lack of medical necessity.

Continuity of Care

Provider Type: Physicians | Participating Physician Groups (PPG) | 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) | 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 within 24 hours (or one business day when an admission occurs on a weekend or holiday), 7 days a week to the Hospital Notification Unit. Failure to notify according to the 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 it to the reporting party. The tracking number is not, by itself, 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 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, a hospital face sheet may be submitted. If a hospital face sheet is not submitted, the following information must be provided:

- 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 (if applicable).
- 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 hospitals to notify the 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.

Electronic medical records or administrative system (Medi-Cal providers only)

In accordance with the Provider Participation 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)

Requests for Authorization for Post-Stabilization Care

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 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 call the Hospital Notification Unit to request authorization for members' post-stabilization care once they are deemed stable but require facility-based care.
- **Medi-Cal members:** For post-stabilization care related to behavioral health for Medi-Cal members, Health Net oversees medical evaluation, stabilization and initial care. However, ongoing care in a facility following a behavioral health emergency falls under the responsibility of County Mental Health Plans. To ensure continuity of care, please contact your County Mental Health Plan for

authorization of all facility-based services. They will coordinate and manage continued care once the member has been stabilized and is ready for transition.

County Mental Health Plan information is available through the Department of Health Care Services. Health Net will coordinate with the County Mental Health Plan to transition the member once appropriate.

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.

CCS-eligible conditions (Medi-Cal members)

If a patient's Health Net identification (ID) card indicates enrollment through Medi-Cal, the member is under age 21, and services are related to a California Children's Services (CCS)-eligible condition, the hospital should still request post-stabilization authorization from Health Net's HNU using the procedure described above.

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

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) UM vendors 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, delegates 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 delegate 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 medical directors and provider engagement account executives are the principal liaisons between Health Net medical management and PPGs. Health Net UM and quality improvement (QI) staff support these directors and account executives. They play an integral part in helping PPGs and delegates meet the expectations of Health Net and its members. They play an important role in improving provider performance, provider satisfaction and clinical outcomes for our members through monthly engagement with providers and timely issue resolution.

Contacts

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
- Centene Vision Services
- Connect Hearing, Inc
- Coram
- Custom Rehab Network

D

Department of Managed Health Care

E

- Electronic Claims Clearinghouse Information
- EviCore Healthcare
- Evolent Specialty Services, Inc.
- EyeMed Vision Care

F

Financial Oversight Department

G

H

- Health Net Care Management Department
- Health Net Claims Submission
- Health Net Continuity and Coordination of Care Department
- Health Net Credentialing Department
- Health Net Delegation Oversight Department
- Health Net EDI Claims Department
- Health Net Elect Claims
- Health Net Encounter Department
- Health Net Fraud Hotline
- Health Net's Health and Wellness Referral Fax
- 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 Overpayment Recovery Department
- Health Net - Prior Authorization
- Health Net Program Accreditation Department
- Health Net Provider Services Center
- Health Net Quality Improvement Department
- Health Net's Regional Medical Directors
- Health Net Transfer/Termination Request Unity
- Health Net Transplant Care Manager
- Health Net Utilization Management Department
- Health Net Wellness and Prevention Department
- HNI Corporate Address
- Hoveround, Inc

I

J

K

Kick It California

L

- LabCorp
- Linkia, LLC

M

- Mahmee
- Matria Health Care, Inc
- MiniMed Distribution Corp, Inc
- Modivcare

N

- National Seating and Mobility
- Nurse Advice Line

O

P

- Peer-to-Peer Review Request Line
- Pharmacy Services
- Provider Disputes and Appeals - Commercial
- Provider Network Management Department
- Pumping Essentials

Q

Quest Diagnostics

R

- Reinsurance Claims Unit
- Roche

S

Smiths Medical, Inc

T

- Transitional Care Services
- Transplant Team

U

V

W

X

Y

Z

Contacts

This section contains general contact information for providers.

AcariaHealth

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

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AcariaHealth (preferred hemophilia provider):
844-538-4661
Fax: 844-750-0827

Access2Care

Non-emergency standard transportation services are arranged through Access2Care™.

844-515-6876

Available 24 hours a day, 7 days a week. For more information, visit the Access2Care website.

Scheduling Non-Emergency Standard Transportation Services Through Access2Care

Providers should refer to the table below and contact Access2Care to arrange for medically necessary or covered transportation services.

Access2Care Transportation Services

TRANSPORTATION NEED	HOURS AND SERVICE REQUIREMENTS
Standard days and hours of customer service center operation for routine reservations	Monday through Friday, 8 a.m. to 8 p.m. Pacific time (PT)
Weekend and holiday schedule	Closed Saturday and Sunday Closed on the following national holidays: New Year's Day, Memorial Day, Independence Day

TRANSPORTATION NEED	HOURS AND SERVICE REQUIREMENTS
	(July 4), Labor Day, Thanksgiving, and Christmas
Routine transportation requests	Requires a 72-hour notification
Urgent trip and hospital discharge requests	Advance notice is not required and transportation can be scheduled for same day of service.
Hours of operation for urgent and same-day reservations	Transportation assistance and after-hours hospital discharges is available 24 hours a day, 7 days a week
Hours of operation for ride assistance and hospital discharges	Transportation assistance and after-hours hospital discharges is available 24 hours a day, 7 days a week
Toll-free phone numbers	Reservations: 844-515-6876

Access to Interpreter Services

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

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Health Net offers language assistance services to its participating providers. Participating providers may request no-cost translation and interpreter support for a Health Net member at to the provider or member.

Medi-Cal

Interpreter support is available 24 hours a day, seven days a week. The California Department of Management Health Care (DMHC) requires that interpreter services, according to Section 1367.04 of the Health and Safety Code and Section 1300.67.04 of Title 28 of the California Code of Regulations, are coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment. To allow sufficient time for scheduling, providers must request interpreter services a least five business days prior to the member's appointment. For sign language requests, please request this at least 10 business days prior to the member's appointment.

If an appointment is rescheduled, it is very important to reschedule the interpreter services for the time of the new appointment to ensure the member is provided with these services.

Interpreter support may also assist in identifying the member's language need. This service is provided at no cost to Health Net participating providers.

Participating providers may request interpreter services by using the following numbers:

Medi-Cal Interpreter Services

Member Plan	Hours of Availability	Contact Number	Required Information
Medi-Cal (Amador, Calaveras, Kern, Inyo, Los Angeles, Mono, Sacramento, San Diego, San Joaquin, Stanislaus, Tulare and Tuolumne)	24 hours a day, 7 days a week	800-675-6110	Member name and Health Net ID number, appointment date and time
Medi-Cal/CalViva (Fresno, Kings and Madera)	24 hours a day, 7 days a week	888-893-1569	Member name and the Plan ID number, appointment date and time
Medi-Cal/Community Health Plan of Imperial Valley	24 hours a day, 7 days a week	833-236-4141	Member name and the Plan ID number, appointment date and time
Behavioral Health	Monday through Friday, 8 a.m. to 5 p.m., Pacific time (not available for after hours)	800-647-7526	Member name and the Plan ID number, appointment date and time

HMO, Medicare Advantage HMO, PPO

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 also reschedule the interpreter services for the time of the new appointment to ensure the member is provided with these services.

Interpreter support may assist in identifying the member's language need. This service is provided at no cost to Health Net participating providers.

Participating providers may request interpreter services by using the following numbers:

Commercial Interpreter Services

Line of Business	Phone Number	Hours of Availability
Individual & Family Plans (Ambetter PPO)	844-463-8188	Monday through Friday, 8 a.m. to 6 p.m. Pacific time (see below for after hours)
Individual & Family Plans (Ambetter HMO)	888-926-2164	Monday through Friday, 8 a.m. to 6 p.m. Pacific time (see below for after hours)
Employer Group HMO, POS and PPO	800-641-7761	Monday through Friday, 8 a.m. to 6 p.m. Pacific time (see below for after hours)
After-hours language assistance line for commercial	800-546-4570	Monday through Friday, 5 p.m. to 8 a.m. Pacific time; weekends and holidays
Behavioral Health	800-647-7526	Monday through Friday, 8 a.m. to 5 p.m., Pacific time (not available for after hours)

Medicare Interpreter Services

Line of Business	Telephone Number	Hours of Availability
Medicare Advantage	800-929-9224	Monday through Friday, 8 a.m. to 5 p.m. Pacific time

AIDS Waiver Program

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

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The AIDS Waiver Program provides home and community-based services as an alternative to institutionalized care for those with AIDS or symptomatic HIV.

Kern

Department of Health Services Chronic Disease Prevention Program 1800 Flower Avenue Bakersfield, CA 93306 661-321-3000 (referrals and education)

Kings

Kings County Department of Public Health, Division of Nursing and Community Services 330 Campus Drive Hanford, CA 93230 559-584-1401
Fax: 559-589-0652

Los Angeles

AIDS Project Los Angeles 3550 Wilshire Blvd., Suite 300 Los Angeles, CA 90010-2404 213-201-1600

ALTAMED Health Services Corp HIV Services Division 5427 East Whitter Boulevard Los Angeles, CA 90022-4101 323-869-5449

Minority AIDS Project 5149 West Jefferson Boulevard Los Angeles, CA 90016 323-936-4949

St. Mary Medical Center Care Program 1045 Atlantic Avenue, Suite #1016 Long Beach, CA 90813 562-624-4900

Tarzana Treatment Center 18646 Oxnard Street Tarzana, CA 91356-1486 818-342-5897
Fax: 818-345-6256

Madera

Madera County Department of Public Health 14215 Road 28 Madera, CA 93638 559-675-7893

Riverside

1695 North Sunrise Way Palm Springs, CA 92262 760-323-4197

Sacramento

RX Staffing and Home Care, Inc. 4640 Marconi Avenue, Suite 1 Sacramento, CA 95821 916-979-7300

Sacramento County CCS Program 9616 Micron Avenue, Suite 640 Sacramento, CA 95827 916-875-9900 Fax: 916-854-9500

San Bernardino

1695 North Sunrise Way Palm Springs, CA 92262 760-323-4197

San Diego

North County Health Services AIDS Case Management 150 Valpreda Road, Suite 101B San Marcos, CA 92069 760-736-6725
Fax: 760-736-3210

San Joaquin

San Joaquin County Public Health Services - AIDS/Communicable Diseases Program 1601 E. Hazelton Ave. Stockton, CA 95205 209-468-3822
Fax (209) 468-8222

Stanislaus

Stanislaus County Community Health Services 830 Scenic Drive, Bldg. 3 Modesto, CA 95350 209-558-4800
Fax 209-558-4905

Alcohol and Drug Treatment Services

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

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Drug/Medi-Cal (D/MC) Alcohol and Drug treatment services are excluded from Health Net's coverage responsibilities under Health Net's Medi-Cal managed care contract. The state of California Alcohol and Drug Programs oversee the alcohol and drug programs. Health Net, its affiliated health plans, and subcontracting providers are available to coordinate referrals for members requiring substance abuse treatment and services. Members receiving services under the D/MC program remain enrolled in Health Net. Participating primary care physicians (PCPs) are responsible for maintaining continuity of care for the member.

Amador

Amador County Alcohol & Drug 10877 Conductor Blvd, Sutter Creek, CA 95685 209-223-6412

Calaveras

Calaveras County Substance Abuse 891 Mountain Ranch Rd Bldg L, San Andreas, CA 95249 209-754-6555

Fresno

Fresno County Alcohol and Drug Program 559-493-2185

Inyo

Inyo County Alcohol & Drug 162 Grove St J, Bishop, CA 93514 760-873-5888

Kern

Kern County Mental Health 2151 College Avenue Bakersfield, CA 93305 661-868-8111

Kings

Kings County Department of Public Health 330 Campus Drive Hanford, CA 93230 559-584-1401

Los Angeles

Los Angeles County Office of Alcohol and Drug Programs 714 West Olympic Boulevard Los Angeles, CA 90015 323-948-0444

Madera

Madera County Behavioral Health Services 14227 Road 28 Madera, CA 93639 559-673-3508

Mono

Mono County Alcohol & Drug Services 452 Old Mammoth Rd, Mammoth Lakes, CA 93546 760-924-1740

Sacramento

Alcohol and Drug System of Care Sacramento County Department of Health and Human Services 3321 Power Inn Road, Suite #120 Sacramento, CA 95826 916-874-9754

San Diego

Office of Alcohol and Drug Programs 888-724-7240

San Joaquin

San Joaquin County Behavioral Health Services - Substance Abuse Services 620 N Aurora ST., Suite #1
Stockton, CA 95205 209-468-3800
Fax (209) 468-3723

Stanislaus

Stanislaus County Behavioral Health and Recovery Services Stanislaus Recovery Center 1904 Richland Avenue Ceres, CA 95307 888-376-6246
209-541-2121

Tulare

Alcohol and Drug Treatment 559-636-4000

American Specialty Health Plans

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

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HMO, Medicare Advantage HMO, and PPO

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

Health Net contracts with American Specialty Health Plans, Inc. (ASH Plans) to administer and arrange chiropractic, acupuncture and massage therapy services for Health Net members in accordance with the member's applicable benefit plan.

HMO members 800-972-4226
Medicare Advantage members: 800-678-9133

April–September

Monday through Friday, 5 a.m. – 8 p.m. Pacific time (PT)

October–March

7 days a week, 8 a.m. – 8 p.m. PT

For more information, visit the American Specialty Health website.

Medi-Cal

Health Net contracts with American Specialty Health Plans, Inc. (ASH Plans) to administer and arrange acupuncture services for Health Net members.

800-972-4226, option 2.

Animas Diabetes Care LLC

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

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Provider of insulin pumps and supplies.
877-937-7867

Apria Healthcare Inc

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

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Provider of durable medical equipment (DME) services, excluding orthotics.

800-277-4288

ATG Rehab Specialists Inc

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

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Provider of rehabilitation equipment services.

877-489-3651

Byram Healthcare Centers, Inc.

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

Byram Healthcare Centers, Inc.

877-902-9726
Fax: 866-992-6331

Byram Healthcare website

Behavioral Health Provider Services

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

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If there is any indication during a medical evaluation that a psychiatric or substance abuse problem is present, the primary care physician (PCP) or his or her staff may contact Health Net for a referral to a behavioral health provider. Health Net also assist with member eligibility, benefits and general questions behavioral health services.

844-966-0298

California Department of Health Care Services Subacute Contracting Unit

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

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Facilities can contact the California Department of Health Care Services (DHCS) Subacute Contracting Unit (SCU) to request an application to be contracted for subacute care and receive Medi-Cal subacute care reimbursement.

California Children's Services Paneling Inquiries

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

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Paneling Inquiries:

Visit the Department of Health Care Services website or contact the Integrated Systems of Care Division, Provider Enrollment Unit at 916-552-9105. Select option 5, then option 2.

California Department of Social Services State Fair Hearing

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

California Department of Social Services State Hearings Division
P.O. Box 944243, MS 19-17-37 Sacramento, California 94244-2430

Fax: 916-651-2789 Phone: 800-743-8525 (voice) and 800-952-8349 (TTY)

California Children's Services Program

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

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The California Children's Services (CCS) program provides specialized medical care, rehabilitation services, and case management to children with medical or surgical conditions who meet program eligibility requirements. It is essential that physicians identify children with CCS-eligible conditions and arrange for their timely referral to the county CCS program.

Amador

County Department of Health 10877 Conductor Blvd., Ste. 400 Sutter Creek, CA 95685

209-223-6630
Fax: 209-223-3524

Calaveras

County Department of Health Mail: 891 Mountain Ranch Road San Andreas, CA 95249-9713 700 Mountain Ranch Road, Suite C2 San Andreas, CA 95249

209-754-6460
Fax: 209-754-1710

Fresno

1221 Fulton Mall, Room #101 P.O. Box 11867 Fresno, CA 93721

209-754-6460
Fax: 559-455-4789

Imperial

935 Broadway Street El Centro, CA 92243-2396

442-265-1455
Fax: 442-265-1481

Inyo

County Department of Health 1360 N. Main Street, Suite 203-C Bishop, CA 93514 760-873-7868
Fax: 760-873-7800

Kern

1800 Mt. Vernon Avenue Bakersfield, CA 93306

661-321-3000
Fax: 661-868-0268

Kings

Kings County Department of Public Health, Division of Nursing and Community Services 330 Campus Drive Hanford, CA 93230-4375 559-852-4693
Fax: 559-582-6803

Los Angeles

9320 Telstar Avenue, Suite #226 El Monte, CA 91731-2849 800-288-4584
Fax: (855) 481-6821

Madera

Madera County Department of Public Health 14215 Road 28 Madera, CA 93638-5715 559-675-4945
Fax: 559-675-7803

Mono

County Department of Health Mail: P.O. Box 3329, Mammoth Lakes, CA 93546 1290 Tavern Road, Suite 246 Mammoth Lakes, CA 93546 760-924-1848
Fax: 760-924-1831

Riverside

Riverside County Department of Health 10769 Hole Ave, #220 Riverside, CA 92505-2869 951-358-5401
Fax: 951-358-5198

Sacramento

9616 Micron Avenue, Suite #640 Sacramento, CA 95827 916-875-9900
TTY 800-735-2929
Fax: 916-854-9500

San Bernardino

San Bernardino County Department of Health 150 E Holt Blvd, 3rd Floor Ontario, CA 91762 909-458-1637
Fax: 909-986-2970

San Diego

Department of Health 6160 Mission Gorge Road, Suite 400 San Diego, CA 92120 619-528-4000
Fax: 619-528-4087

San Joaquin

San Joaquin County Public Health Services 420 South Wilson Way Stockton, CA 95205

209-468-3900
Fax 209-953-3632

Stanislaus

830 Scenic Drive, Bldg. 3 PO Box 3088 Modesto, CA 95353-3088 209-558-7515
Fax: 209-558-7862

Tulare

1062 South K Street Tulare, CA 93274 559-687-6915
Fax: 559-713-3740

Tuolumne

County Department of Health 20111 Cedar Road North Sonora, CA 95370-5939 209-533-7404
Fax: 209-533-7406

CalViva Health Medi-Cal Member Services Department

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

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To ensure appropriate coverage of medical services for Medi-Cal members, CalViva Health requires the provision of timely responses and accurate information. If prompt and accurate information is not provided, a member may misuse the program, resulting in medical services not being covered. To avoid these problems, CalViva Health directs inquiries from members to CalViva Health's Medi-Cal Member Services Department. Provider inquiries are directed to the CalViva Health liaison Provider Engagement Network Specialists when applicable.

The CalViva Health Medi-Cal Member Services Department ensures that translation services are available for members when they call. In addition, the CalViva Health Member Handbook and other member-informing materials are translated into the required threshold languages.

CalViva Health's Medi-Cal Member Services Department handles incoming calls and correspondence from members. This department is responsible for:

- Medi-Cal questions and explanation of coverage.

- Information about access to and delivery of care.
- Professional and hospital services, bills, and claims.
- Member problems and inquiries.
- Address changes.
- Identification card requests.
- Primary care physician (PCP) selection and transfer requests

The CalViva Health toll-free number is printed on the back of the member's identification card 888-893-1569 (TTY 711). CalViva Health is here 24 hours a day, 7 days a week. While telephone assistance is the PCP's responsibility, the CalViva Health Medi-Cal Member Services Department can assist members in reaching their PCP when needed. It is the responsibility of the servicing provider to confirm eligibility at the time of service. CalViva Health's Medi-Cal Member Services representatives can provide the telephone number for the member's PCP, or the call can be routed to the CalViva Health Nurse Advice Line (N24) when applicable.

CalViva Health Member Services Department; Open 24/7 phone number:888-893-1569
Fax: 844-837-5947 or 800-281-2999

CalViva Health Medi-Cal Provider Services Department

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

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As a prepaid health care delivery system, CalViva Health has some unique characteristics that make timely response and accurate information necessary. If prompt and accurate information is not provided, a member may misuse the program, resulting in medical services not being covered. To avoid this, CalViva Health directs inquiries from providers to CalViva Health's Medi-Cal Provider Services Department or to CalViva Health's Provider Engagement Network Specialists, where available. Members are directed to the Medi-Cal Member Services Department.

CalViva Health's Medi-Cal Provider Services Department Customer Service Advocates are available 24 hours a day, 7 days a week, to assist providers with:

- Member eligibility, effective dates, and eligibility research
- Primary care physician (PCP) selection and transfer requests for members
- Questions about the CalViva Health Medi-Cal Recommended Drug List (RDL)
- Benefit information
- Professional and hospital billing
- Claims
- Questions regarding claims status
- Exceptions and administrative decisions
- Complaints and grievances regarding provider care, delivery of care or participating physician group (PPG) staff
- Requests for removal/ PCP/PPG reassignment for non-compliant members

The CalViva Health Medi-Cal Provider Services Department phone number 888-893-1569, option 2.

Fax: 844-837-5947 or 800-281-2999

Eligibility and claims status available online.

Provider's may use the Medi-Cal Claims Inquiry email box for claim status only if the provider portal is down or not working. This box is only for claim status and denial inquiries.

CalViva Health Nurse Advice Line

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

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The CalViva Health Nurse Advice Line was developed to assist members in obtaining primary care. Information is available 24 hours a day. The program is a service offered in conjunction with the primary care physician (PCP) and does not replace the PCP. According to Health Net's access-to-care standards, all PCPs must provide 24-hour telephone service for instructions, medical condition assessment and advice. The CalViva Health Medi-Cal Member Services Department coordinates member access to the CalViva Health Nurse Advice Line.

On receipt of a call, the program nurse addresses emergencies immediately by directing the member to the emergency department and assists the member in securing an ambulance, if necessary. Members needing urgent care are referred to an urgent care center if the PCP is not available. The referral record can be faxed to the emergency department or urgent care center to inform the facility of the member's condition and pending arrival.

The program nurse educates the member on the role of the PCP, assists the member in scheduling an appointment with the PCP, and gives the member information on procedures to follow until care is received from the PCP. A copy of the encounter is faxed to the PCP immediately at the close of the call.

All interaction with hospital staff, urgent care center staff and the PCP is documented. In addition, incident reports are completed when a member does not accept the program nurse's recommendations. The nurse uses a tracking mechanism to follow up on the disposition of the member and notifies the PCP and the plan of any members who require follow-up coordination.

888-893-1569

Cancer Information Services

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

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If a participating physician group (PPG), hospital, ancillary provider, or physician is not affiliated with a mammography center, a list of certified centers is available from Cancer Information Services or the Food and Drug Administration's (FDA's) website at www.fda.gov

800-422-6237

Care Ride Unit

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

Phone: 833-236-9695

Fax: 833-701-0051

Case Management Department

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

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Contact the Case Management Department at:

Commercial

Email: Case.Management.Referrals@healthnet.com
Fax: 800-745-6955

Medi-Cal

Email: CASHP.ACM.CMA@healthnet.com
Fax: 866-581-0540

Case Management for Health Net, CalViva Health or Community Health Plan of Imperial Valley (CHPIV) Medi-Cal members with Adverse Childhood Experiences (ACEs):

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

- 866-801-6294 if the member has a Health Net or CHPIV plan.
- 888-893-1569 if the member has a CalViva Health Medi-Cal plan.

Centers for Medicare & Medicaid Services

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

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The Centers for Medicare & Medicaid Services (CMS) is a federal agency within the Department of Health and Human Services that governs the Medicare, Medicaid, Clinical Laboratories (under CLIA program), and Children's Health Insurance programs to help ensure that eligible beneficiaries in these programs are able to get high-quality health care.

Health Net has entered into an agreement with CMS to administer health care services to eligible Medicare beneficiaries. Participating providers are required to adhere to all legislative and regulatory requirement issued by CMS.

To obtain additional information regarding CMS, refer to the CMS website.

Centene Vision Services

Contact Centene Vision Services to locate a participating optometrist or optician from whom Medi-Cal member may receive covered services (routine vision examination/refraction, lenses and frames) when medically necessary.

- Fresno, Kings and Madera Counties: 844-876-7123
- Amador, Calaveras, Imperial, Inyo, Kern, Los Angeles, Mono, Sacramento, San Diego, San Joaquin, Stanislaus, Tulare and Tuolumne counties: 844-820-8600

WELLCARE BY HEALTH NET (MEDICARE ADVANTAGE) Contact Centene Vision Services to locate a participating optometrist or optician from whom Wellcare By Health Net member may receive covered services (routine vision examination/refraction, lenses and frames) when medically necessary. Provider Services for Wellcare By Health Net: 866-392-6058

Centralized Transplant Unit

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

Fax numbers for organ transplant reviews and authorizations:

- For individual Medicare plan members: 833-769-1143
- For employer group Medicare members: 833-769-1142

Children's Medical Services

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

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The Children's Medical Services (CMS) Branch of the California Department of Health Services (DHS) oversees state-funded public health programs for children, including California Children's Services (CCS).

Children's Medical Services Branch Office MS 8100 P.O. Box 997413 Sacramento, CA 95899-7413

Communicable Disease Reporting

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

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To protect the public from the spread of infectious, contagious, and communicable disease, health care providers are required by law to report communicable diseases to the local health officer. 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, must notify the local health department (LHD).

Reports must be made using the Confidential Morbidity Report. A completed copy of the report must be sent to the Communicable Disease Control division of the county health department.

Amador

10877 Conductor Blvd Sutter Creek, CA 95685 209-223-6407
Fax: 209-223-1562

Calaveras

700 Mountain Ranch Road, Suite C-2 San Andreas, CA 95249 209-754-6460
Fax: 209-754-1709

Fresno

Communicable Disease Control County of Fresno 1221 Fulton Mall P.O. Box 11867 Fresno, CA 93775
559-445-3324

Fax: 559-445-3535

Imperial

935 Broadway Street El Centro, CA 92243 442-265-1444
Fax: 442-265-1440

Inyo

1360 N. Main Street Bishop, California 93514 760-873-7868
Fax: 760-873-7800

Kern

Department of Public Health Services Chronic Disease Prevention Program 1800 Mt. Vernon Avenue Bakersfield, CA 93306 Fax: 661-321-3000

Kings

Kings County Department of Public Health, Communicable Disease Services 330 Campus Drive Hanford, CA 93230 559-584-1401
Fax: 559-584-5672

Los Angeles

Acute Communicable Disease 313 North Figueroa Street, Room #117 Los Angeles, CA 90012 888-397-3993 888-397-3778 or 213-482-5508

HIV Epidemiology Program 600 South Commonwealth, Room #805 Los Angeles, CA 90005 213-351-8196

Long Beach Health Department 562-570-4000

Pasadena Health Department 626-744-6005

Pediatric HIV and AIDS Reporting Program 313 North Figueroa Street, Room #203 Los Angeles, CA 90012 213-250-8666

Sexually Transmitted Disease Program 2615 South Grand, Room #500 Los Angeles, CA 90007 213-744-3251 > Fax: 213-749-9602

Tuberculosis Control Program 2615 South Grand, Room #507 Los Angeles, CA 90007 213-744-6160
Fax: 213-749-0926

Madera

Madera County Department of Public Health, Communicable Disease Control Program 14215 Road 28
Madera, CA 93638 559-675-7893
Fax: 559-674-7262

Mono

1290 Tavern Road, Suite 246 PO Box 3329 Mammoth Lakes, CA 93546 760-965-9897
Fax: 760-924-1831

Sacramento

Sacramento County Public Health 7001-A East Parkway, Suite 600A Sacramento, CA 95823 916-875-5881 (online reporting and set-up assistance)
Fax: 916-854-9708

San Diego

San Diego Department of Community Epidemiology Health & Human Services Agency 3851 Rosecrans Street
San Diego, CA 92110 619-692-8499
Fax: 858-715-6458

San Joaquin

San Joaquin County Public Health Services 1601 E. Hazelton Ave. Stockton, CA 95205 209-468-3822
Fax: 209-468-8222

Stanislaus

Stanislaus County Health Services Agency Communicable Disease Program 820 Scenic Drive Modesto, CA 95350 209-558-5678 (Reporting Line)
209-664-6032 (After hours emergency/weekend - confidential phone number for reporting purposes only)
Fax: 209-558-7531

Tulare

Tulare County Department of Health Services 115 East Tulare Avenue Tulare, CA 93274 559-685-5720
Fax: 559-685-4835

health net

Tuolumne

20111 Cedar Road N. Sonora, CA 95370 209-533-7401
Fax: 209-533-7406

Community-Based Adult Services Centers

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

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Community-based adult services (CBAS), formerly Adult Day Health Care (ADHC), provides an alternative to institutionalization for eligible Medi-Cal members ages 18 and older.

Fresno

Adult Day Health Care of Fresno and Clovis 5757 North First Street Fresno, CA 93710 559-227-8600
Fax: 559-227-8200

Clovis Adult Day Health Care Inc. 50 West Bullard, Suite 113 Clovis, CA 93612 559-298-3996
Fax: 559-298-2074

Heritage Adult Day Health Care Center 5377 N. Fresno Street Fresno, CA 93710 559-222-0304
Fax: 559-222-2132

Heritage West 3677 W. Beechwood Avenue Fresno, CA 93711 559-261-0707
Fax: 559-261-9995

Valley Adult Day Health Care Center 4835 E. McKinley Avenue Fresno, CA 93703 559-454-0386
Fax: 559-454-0387

Imperial

Imperial County Area Agency on Aging 778 West State Street, El Centro CA 92243 442-265-7030 Fax: 442-265-7030

Alegria Adult Day Health Care Center 1101 C.N. Perry Avenue, Calexico, Imperial County CA 92231 760-768-8419

DayOut ADHC – Brawley 616 Main Street, Brawley, Imperial County CA 92227 760-344-5665

DayOut ADHC – El Centro 757 Main Street, El Centro, Imperial County CA 92243 760-337-8393

Kern

Aging and Adult Services 5357 Truxtun Avenue, Bakersfield, CA 93309 661-868-1000
Fax: 661-868-1001

Alzheimer's Disease Association of Kern County 5500 Olive Drive, Bakersfield, CA 93308 661-393-8871
Fax: 661-393-9973

Chateau Bakersfield Adult Day Health Care Center 824 18th Street, Bakersfield, CA 93301 661-322-4085
Fax: 661-323-1059

Delano Adult Day Health Care Center 1457 Glenwood Street, Delano, CA 93215 661-725-7070
> 661-725-9300

Los Angeles

A Plus Adult Day Health Care 3321 Tyler Avenue El Monte, CA 91731 626-579-6588
Fax: 626-579-6586

Antelope Valley Adult Day Health Care Center 42212 10th Street, Suite 8 Lancaster, CA 93534 661-949-6278
Fax: 661-949-6768

Ararat Adult Day Health Care Center 721 South Glendale Avenue Glendale, CA 91205 818-240-1721
Fax: 818-240-2160

Arcadia Adult Day Health Care Center 15 Las Tunas Drive Arcadia, CA 91007 626-447-9700
Fax: 626-446-5405

Arcadia of Hollywood Adult Day Health Care Center 860 North Highland Avenue Los Angeles, CA 90038
323-466-4122
Fax: 323-466-2340

Babylon Adult Day Health Care Center 5955 Lindley Avenue Tarzana, CA 91356 818-996-9300
Fax: 818-996-9173

Sacramento

AltaMedix 4234 North Freeway Blvd, Suite 500 Sacramento, CA 95834 916-648-3999
Fax: 916-648-1919

California Association for Adult Day Services 1107 9th Street, Suite 701
Sacramento, CA 95814 916-552-7400
Fax: 916-552-7404

Eskaton Adult Day Health Care Center - Carmichael 5105 Manzanita Avenue, Suite D Carmichael, CA 95608
916-334-0296
Fax: 916-348-6715

Health for All Adult Day Health Center - Meadowview 2730 Florin Road Sacramento, CA 95822 916-391-5591

Fax: 916-391-0264

Help to Recovery - Easter Seals Superior California 3205 Hurley Way Sacramento, CA 95864 916-485-6711
TTY: 916-485-9632
Fax: 916-485-2653

Rancho Cordova Adult Day Health Care Center 10086 Mills Station Road, Sacramento, CA 95827
916-369-1113
Fax: 916-369-1138

San Diego

AmeriCare Adult Day Health Care Center 340 Rancheros Drive, Suite 196 San Marcos, CA 92069
760-682-2424
Fax: 760-471-5104

Casa Pacifica ADHC Center 1424 30th Street, Suite C
San Diego, CA 92154 619-424-8181
Fax: 619-424-8151

Clairemont Villa Adult Day Health Center 10174 Old Grove Road San Diego, CA 92131 858-576-8575
Fax: 858-576-8424

Elm Adult Health Center 1220 Elm Avenue Imperial Beach, CA 91932 619-827-0573
Fax: 619-271-1284

George G. Glenner Alzheimer's Family Centers, Inc. 335 Saxony Road Encinitas, CA 92024 760-635-1895
Fax: 760-436-0949

280 Saylor Drive Chula Vista, CA 91910 760-420-1703
Fax: 760-420-0196

Hope Adult Day Health Care Center 11239-A Camino Ruiz San Diego, CA 92126 858-653-5916
Fax: 858-653-5295

Horizons Adult Day Health Care Center 14154 E. 8th Street, Suite 5
National City, CA 91950 619-474-1822
Fax: 619-474-1826

Loving Care Adult Day Health Care Center 2565 Camino Del Rio South, Suite 201 San Diego, CA 92108
619-718-9777
Fax: 619-718-9772

Neighborhood House Adult Day Health Care Center 851 South 35th Street
San Diego, CA 92113 619-233-6691
Fax: 619-233-6693

Poway Adult Day Health Care Center 12250 Crosthwaite Circle Poway, CA 92113 858-748-5044
Fax: 858-748-5405

San Ysidro Adult Day Health Care Center 3364 Beyer Boulevard San Ysidro, CA 92173 619-205-1373
Fax: 619-600-4867

Western Adult Day Health Care Center 240 Magnolia Avenue El Cajon, CA 92020 619-631-7222
Fax: 619-631-9228

Stanislaus

Stanislaus County Health Services Agency 830 Scenic Drive Modesto, CA 95350 209-558-7000

Tulare

To obtain information on the nearest CBAS center, call 855-689-7396.

Community-Based Adult Services Face-To-Face Request Line

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

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Providers must submit all Community-Based Adult Services (CBAS) requests, including requests for a face-to-face assessment, on the Health Net provider portal. Once logged in, go to the member's profile and select *Assessments* . Select *Fill Out Now!* next to CBAS Treatment Request.

Comprehensive Perinatal Services Program

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

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All pregnant members must have access to Comprehensive Perinatal Services Program (CPSP) services, which integrate health education, nutrition and psychosocial services with obstetrical care.

Amador

Amador County Public Health 10877 Conductor Blvd. 400 Sutter Creek, CA 95642 209-223-6407
Fax: 209-223-3524

Calaveras

Calaveras Public Health Department
891 Mountain Ranch Road San Andreas, CA 95249 209-754-6464
Fax: 209-754-6459

Fresno

1221 Fulton Mall P.O. Box 11867 Fresno, CA 93721 559-445-3234

Imperial

935 Broadway Street El Centro, CA 92243 800-675-2229

Inyo

Inyo County Health Department
207 A West South Street Bishop, CA 93514 760-873-7868
Fax: 760-873-7800

Kern

Department of Public Health Services Comprehensive Perinatal Services Program 1800 Mt. Vernon Avenue Bakersfield, CA 93306 661-868-0523

Kings

Kings County Department of Public Health 330 Campus Drive Hanford, CA 93230 559-584-1401
Fax: 559-584-5672

Los Angeles

Los Angeles 213-639-6419

Long Beach 562-570-4060

Madera

Madera County Department of Public Health 14215 Road 28 Madera, CA 93638 559-675-7893
Fax: 559-674-7262

Mono

Mono County Health Department P.O. Box 3329 Mammoth Lakes, CA 93546 760-924-1842
Fax: 760-924-1831

Riverside

951-358-5438

Sacramento

Sacramento County Department of Health and Human Services 7001-A East Parkway, Suite 600 Sacramento, CA 95823 916-875-5437
Fax: 916-875-5888

San Bernardino

800-227-3034

San Diego

3851 Rosecrans Street San Diego, CA 92110 619-542-4053

San Joaquin

San Joaquin County Public Health Services - CPSP 1601 E. Hazelton Ave Stockton, CA 95205 209-468-3004
Fax 209-468-2072

Stanislaus

Stanislaus County Health Services Agency

Maternal and Child Health Branch 830 Scenic Drive Modesto, CA 95350 209-558-6819

Tulare

559-685-2275

health net

Tuolumne

Tuolumne County Health Department
20111 Cedar Rd. N. Sonora, CA 95370 209-533-7401
Fax: 209-533-7406

Connect Hearing Inc

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

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888-608-7462

Connect Hearing website

County Mental Health Plan

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

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Services available under the Medi-Cal specialty mental health program are excluded from Health Net's coverage responsibilities. Primary care physicians (PCPs) provide outpatient mental health services, within the scope of their practice and coordinate referrals for members requiring specialty or inpatient mental health services.

County Mental Health Plan Contact Information

COUNTY	PHONE NUMBER
Amador	888-310-6555 or 209-223-6412
Calaveras	800-499-3030 or 209-754-6525
Fresno	559-253-9180
Imperial	760-482-2939

COUNTY	PHONE NUMBER
Inyo	800-841-5011
Kern	800-991-5272 or 661-868-8000
Kings	800-655-2553
Los Angeles	800-854-7771
Madera	888-275-9779
Mono	800-687-1101 or 760-924-1740
Riverside	800-706-7500
Sacramento	Sacramento County Mental Health Treatment Center 2150 Stockton Blvd. Sacramento, CA 95817 Adult Access team 916-875-1055 Fax: 916-875-1190 TTY: 916-874-8070 Child and Family Access team 916-875-9980 Fax: 916-875-9970 TTY: 916-876-8892 Psychiatric emergencies 916-732-3637 Toll-free 24-hour information line 888-881-4881
San Bernardino	888-743-1478
San Diego	888-724-7240
San Joaquin	209-468-8700 Crisis intervention line 209-468-8686
Stanislaus	888-376-6246
Tulare	559-624-7445 Emergency or crisis line: 800-320-1616
Tuolumne	800-630-1130 or 209-533-6245

County Relations/Service Coordination

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

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Public programs specialists interact with public health departments and programs and work with participating providers and Department of Health Care Services (DHCS) in administering public programs and services.

800-526-1898
Fax: 866-208-2240

Coram

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

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Health Net's preferred infusion provider

- Phone: 866-899-1661
- Fax: 866-843-3221

Custom Rehab Network

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

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Provider of custom rehabilitation equipment services.

800-276-6557

Community Health Plan of Imperial Valley Member Services Department

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

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To ensure appropriate coverage of medical services for Medi-Cal members, Community Health Plan of Imperial Valley requires the provision of timely responses and accurate information. If prompt and accurate information is not provided, a member may misuse the program, resulting in medical services not being covered. To avoid these problems, Community Health Plan of Imperial Valley directs inquiries from members to Community Health Plan of Imperial Valley's Medi-Cal Member Services Department. Provider inquiries are directed to the Community Health Plan of Imperial Valley liaison Provider Engagement Network Specialists when applicable

The Community Health Plan of Imperial Valley Medi-Cal Member Services Department ensures that translation services are available for members when they call. In addition, the Community Health Plan of Imperial Valley Member Handbook and other member-informing materials are translated into the required threshold languages.

Community Health Plan of Imperial Valley's Medi-Cal Member Services Department handles incoming calls and correspondence from members. This department is responsible for:

- Medi-Cal questions and explanation of coverage.
- Information about access to and delivery of care.
- Professional and hospital services, bills, and claims.
- Member problems and inquiries.
- Address changes.
- Identification card requests.
- Primary care physician (PCP) selection and transfer requests.
- Handling complaints about Community Health Plan of Imperial Valley programs or staff

The Community Health Plan of Imperial Valley’s toll-free number is printed on the back of the member’s identification card: 833-236-4141 (TTY 711). Community Health Plan of Imperial Valley is available 24 hours a day, 7 days a week. While telephone assistance is the PCP's responsibility, the Community Health Plan of Imperial Valley Medi-Cal Member Services Department can assist members in reaching their PCP when needed. It is the responsibility of the servicing provider to confirm eligibility at the time of service. Community Health Plan of Imperial Valley's Medi-Cal Member Services representatives can provide the telephone number for the member's PCP, or the call can be routed to the Community Health Plan of Imperial Valley Nurse Advice Line (N24) when applicable.

Community Health Plan of Imperial Valley Provider Services Center Opened 24/7 Phone Number 833-236-4141

Fax: 844-837-5947 or 800-281-2999

Community Health Plan of Imperial Valley Provider Services Department

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

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As a prepaid health care delivery system, Community Health Plan of Imperial Valley has some unique characteristics that make timely response and accurate information necessary. If prompt and accurate information is not provided, a member may misuse the program, resulting in medical services not being covered. To avoid this, Community Health Plan of Imperial Valley directs inquiries from providers to Community Health Plan of Imperial Valley 's Medi-Cal Provider Services Department or to CHPIV's Provider Engagement Network Specialists, where available. Members are directed to the Medi-Cal Member Services Department.

Community Health Plan of Imperial Valley s Medi-Cal Provider Services Department Customer Service Advocates are available 24 hours a day, 7 days a week, to assist providers with:

- Member eligibility, effective dates, and eligibility research
- Primary care physician (PCP) selection and transfer requests for members
- Questions about the CHPIV Medi-Cal Recommended Drug List (RDL)
- Benefit information
- Professional and hospital billing
- Claims
- Questions regarding claims status
- Exceptions and administrative decisions
- Complaints and grievances regarding provider care, delivery of care or participating physician group (PPG) staff
- Requests for removal/ PCP/PPG reassignment for non-compliant members

The Community Health Plan of Imperial Valley Medi-Cal Provider Services Department toll-free telephone number is printed on the back of the member's identification card. The servicing provider is responsible for confirming the member(s) eligibility at the time of service.

Community Health Plan of Imperial Valley Provider Services Department Phone Number: 833-236-4141

Fax: 844-837-5947 or 800-281-2999

Eligibility and claims status available online.

Provider’s may use the Medi-Cal Claims Inquiry email box for claim status only if the provider portal is down or not working. This box is only for claim status and denial inquiries.

Community Health Plan of Imperial Valley Nurse Advice Line

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

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The Community Health Plan of Imperial Valley Nurse Advice Line was developed to assist members in obtaining primary care. Information is available 24 hours a day. The program is a service offered in conjunction with the primary care physician (PCP) and does not replace the PCP. According to Health Net's access-to-care standards, all PCPs must provide 24-hour phone service for instructions, medical condition assessment and advice. The Community Health Plan of Imperial Valley Medi-Cal Member Services Center coordinates member access to the Community Health Plan of Imperial Valley Nurse Advice Line.

On receipt of a call, the program nurse addresses emergencies immediately by directing the member to the emergency department and assists the member in securing an ambulance, if necessary. Members needing urgent care are referred to an urgent care center if the PCP is not available. The referral record can be faxed to the emergency department or urgent care center to inform the facility of the member's condition and pending arrival.

The program nurse educates the member on the role of the PCP, assists the member in scheduling an appointment with the PCP, and gives the member information on procedures to follow until care is received from the PCP. A copy of the encounter is faxed to the PCP immediately at the close of the call.

All interaction with hospital staff, urgent care center staff and the PCP is documented. In addition, incident reports are completed when a member does not accept the program nurse's recommendations. The nurse uses a tracking mechanism to follow up on the disposition of the member and notifies the PCP and the plan of any members who require follow-up coordination.

833-236-4141

Delta Dental

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

855-643-8515

April–September
Monday through Friday
8 a.m. – 8 p.m. Pacific time (PT)

October–March
7 days a week
8 a.m. – 8 p.m. PT

Dental Benefit Providers

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

866-249-2382

April–September
Monday through Friday
5 a.m.– 8 p.m. Pacific time (PT)

October–March
7 days a week
5 a.m. – 8 p.m. PT

Denti-Cal

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

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Medi-Cal members are entitled to annual dental screenings, as described in the periodic health exam schedules. Primary care physicians (PCPs) refer members for dental services to Medi-Cal dental providers.

800-322-6384

Department Of Health Care Services

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

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The sterilization informational brochures are available online for downloading and printing. California Department of Health Care Services (DHCS)

Department of Insurance

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

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The Department of Insurance (DOI) maintains a program to assist consumers with resolution of complaints involving HMOs. Members are expected to use Health Net's grievance procedures first to attempt to resolve any dissatisfaction. If the grievance has been pending for at least 30 days or was not satisfactorily resolved by Health Net, the member may seek assistance from the DOI. Providers, including participating physicians, may assist the member in submitting a complaint to the DOI for resolution and may advocate the member's position before the DOI. No provider can be sanctioned in any way by Health Net or by a participating physician group (PPG) for providing such assistance or advocacy.

800-927-4357
213-897-8921

Department Of Managed Health Care

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

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The Department of Managed Health Care (DMHC) maintains a program to assist consumers with resolution of complaints involving HMOs. Members are expected to use the grievance procedures first to attempt to resolve any dissatisfaction. If the grievance has been pending for at least 30 days or was not satisfactorily resolved by Health Net, the member may seek assistance from the DMHC. Providers, including participating physicians, may assist the member in submitting a complaint to the DMHC for resolution and may advocate the member's position before the DMHC. No provider can be sanctioned in any way by Health Net or by a participating physician group (PPG) for providing such assistance or advocacy.

888-466-2219
800-400-0815
TTY: 877-688-9891

Contact DMHC

Department Of Social Services (DSS)

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

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The Department of Social Services (DSS) Public Inquiry and Response Unit handles inquiries from Medi-Cal beneficiaries regarding fair hearings and grievances.

PO Box 944243 Mail Stop 19-37 Sacramento, CA 94244-2430

800-952-5253
TTY: 800-952-8349

Fax: 916-229-4110

Electronic Claims Clearinghouse Information

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

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Submit electronic claims for Health Net members to the appropriate clearinghouse:

Clearinghouse Information

CLEARINGHOUSE	PHONE NUMBER	WEBSITE	HEALTH NET PAYER ID NUMBER
Change Healthcare (fee-for-service only)	877-469-3263 or 800-792-5256	client-support.changehealthcare.com	68069 (Medicare and Individual Family Plans including Covered California) 95567 (Medi-Cal and Commercial)
Transunion (capitated encounters only)	Your account manager or 310-337-8530	www.transunion.com	95568 and 95570

The payer ID must be included with every claim.

Health Net encourages participating providers to review all electronic claim submission acknowledgment reports regularly and carefully. Questions regarding accessing these reports should be directed to the vendor or clearinghouse.

EviCore Healthcare

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

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eviCore healthcare is responsible for prior authorization for select sleep and radiation therapy services.

Sleep

Online requests: eviCore healthcare

Phone: 888-693-3211

Fax: 866-999-3510

Radiation therapy

Online requests: eviCore healthcare

Phone: 888-693-3211

Fax: Radiation Therapy: 800-540-2406

Evolent Specialty Services, Inc.

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Evolent Specialty Services, Inc. (Evolent), formerly known as National Imaging Associates, Inc. (NIA), is responsible for prior authorization for advanced imaging services and cardiac imaging.

Prior authorization requests must be submitted to Evolent online or by phone as follows. Evolent does not accept fax submissions.

www.RadMD.com (24 hours a day, seven days a week, except when maintenance is performed once every other week after business hours)

Evolent Specialty Services Contact Information

PRODUCT	HOURS OF OPERATION	PHONE NUMBER
Commercial	Monday through Friday, from 8 a.m. to 8 p.m.	800-424-4802
Medi-Cal	Monday through Friday, from 8 a.m. to 8 p.m.	800-424-4809

EyeMed Vision Care

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Health Net is contracted with Centene Vision Services to provide vision benefits to Health Net members for some plans. Centene Vision Services sub-delegates benefit administration to EyeMed. EyeMed provides

benefits for routine vision exams and eyewear through their network of optometrists, dispensing opticians and optometric laboratories.

Benefit administration for the routine vision examination varies by plan/product. Please verify coverage to determine if an appointment for a vision examination is covered through the participating physician group (PPG) or through EyeMed.

EyeMed Vision Care
Health Net Vision
4000 Luxottica Place
Mason, OH 45040

866-392-6058

Financial Oversight Department

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

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The Financial Oversight Department is responsible for tracking and monitoring the financial solvency of delegated providers. Contact them for assistance to submit quarterly financial updates or statements and for questions.

email: financeoversight-pa@healthnet.com

FitOn Health

FitOn Health gives Medicare members access to the best digital fitness and wellness content, fitness studios, and gyms. This benefit is covered under member's Medicare health plan at no additional cost. Members will be able to continue their current fitness routine while having access to a variety of new activities.

At the beginning of each month, credits are added to member's FitOn Health account. Members can use the credits at any fitness facility in the FitOn Health network.

For more information about this benefit, contact FitOn Health.

855-378-6683, select option 1

Have questions?

Email: move@fitonhealth.com

For more information, visit fitonhealth.com/help or fitonhealth.com/members.

Health Care Options (HCO)

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

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The Health Care Options (HCO) contractor processes Medi-Cal managed care enrollments and disenrollments. Refer members to the appropriate toll-free number for assistance.

Arabic 800-576-6881

Armenian 800-840-5032
Cambodian 800-430-5005

Cantonese 800-430-6006

English and other languages 800-430-4263

Farsi 800-840-5034

Hmong 800-430-2022

Korean 800-576-6883

Laotian 800-430-4091

Mandarin 800-576-6885

Russian 800-430-7007

Spanish 800-430-3003

Tagalog 800-576-6890

Telephonic device for the deaf and hearing impaired 800-430-7077

Vietnamese 800-430-8008

Health Net Care Management Department

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

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Health Net offers transition of care assistance that allows members who are receiving care to continue with their established non-participating provider. Approval decisions are based on individual review of member's care needs in relation to benefits and regulatory requirements.

- Medicare Case Management: 800-977-7915
- Commercial Case Management: 888-732-2730

Health Net Claims Submission

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

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Claims address for EPO, HSP and HMO products.

Health Net of California, Inc. (and/or)
Health Net Life Insurance Company
Commercial Claims
PO Box 9040
Farmington, MO 63640-9040

Health Net Continuity and Coordination of Care Department

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

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Participating physician groups (PPGs) must immediately forward all pertinent documentation for investigational or experimental treatment for a terminal illness via fax or by overnight mail.

Fax: 866-295-4780

Health Net of California, Inc.
Continuity and Coordination of Care
Medical Management Department
21281 Burbank Blvd.
Woodland Hills, CA 91367

Health Net Credentialing Department

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

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The Health Net Credentialing Department is responsible for credentialing and recredentialing directly contracting providers and all providers affiliated with participating physician groups (PPGs) to which credentialing responsibilities have not been delegated. The Health Net Credentialing Department also oversees delegated and subcontracting credentialing activity.

20151 Nordhoff
Chatsworth, CA 91311
Fax: 800-655-4128

Health Net's Health and Wellness Referral Fax

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

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To refer a Health Net member to one of the programs for disease management, case management or complex case management, fax a referral to 800-745-6955 or 678-355-4018 for pregnancy notification only.

You can also email a referral fax.

Delegation Oversight Department

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

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The Health Net Delegation Oversight Department (previously Provider Oversight Department) oversees participating providers in all Health Net lines of business and assists them in understanding and complying with Health Net's requirements and those of state and federal regulatory agencies. The department conducts on-site due diligence evaluations prior to Health Net agreeing to contract with a provider and through on-site evaluations at least annually thereafter. Based on these evaluations, the Health Net Delegation Oversight Committee (DOC) determines which functions are to be delegated to the participating physician group (PPG). The Health Net DOC measures, monitors and oversees compliance of providers and requires corrective actions when deficiencies are discovered. The DOC is a multi-disciplinary committee comprised of, but not limited to, members from Health Net's Delegation Oversight, Health Care Services, Network Management, Medical Management, Finance Departments, and State Health Programs. If the prescribed three-step corrective action process with progressive sanctions does not resolve the deficiency, delegation may be revoked and the provider's contract terminated.

Coalition Reports

Program Accreditation Department
21281 Burbank Blvd., 5th Floor

Woodland Hills, CA 91367

Fax: 866-476-0311 provider.oversight@healthnet.com

Email the Delegation Oversight Group at Delegation_Oversight_Group@CENTENE.COM for any questions about access, users, or use of the Delegation Oversight Interactive Tool.

Health Net EDI Claims Department

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

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For questions on electronic claims or electronic remittance advice for Individual Family Plan (IFP), Medicare Advantage (MA) HMO member claims, contact:

Centene EDI Department

800-225-2573, extension 6075525

Or by email at EDIBA@centene.com

The following providers can continue to contact Health Net EDI department by phone at 800-977-3568 or by email at edi.support@healthnet.com

- California, MA HMO employer group, HMO, PPO (including EnhancedCare PPO for small business group), POS, and Medi-Cal (including CalViva Health)

Health Net Elect Claims

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

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Claims address for the Health Net Elect Point-of-Service (POS) product.

Health Net of California, Inc. (and/or)
Health Net Life Insurance Company
Commercial Claims
PO Box 9040
Farmington, MO 63640-9040

Health Net Encounter Department

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

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Contact the Health Net Encounter Department via email for encounter data questions.

Enc_Group@healthnet.com

Health Net Enrollment Services Department

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

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For general questions regarding eligibility and enrollment, contact the Health Net Enrollment Services Department Monday through Friday, from 7:30 a.m. to 7 p.m. at:

800-327-0502

Health Net Facility Site Review Compliance Department

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

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The Health Net Facility Site Review (FSR) Compliance Department improves the health of Health Net members through one-on-one education and support of providers.

The Health Net FSR Compliance Department develops materials that simplify the work of providers with respect to legal and accreditation requirements, medical record criteria, documentation of preventive care services, health education, continuity of care, and other clinical interventions, public health programs, and disease management.

Health Net's FSR Compliance nurses educate and assist physicians and their staffs in complying with legal and accreditation requirements and are aware of the effect of added expectations on standards of practice.

21281 Burbank Blvd., Woodland Hills, CA 91367 209-943-4803
Email: Facility.site.review@healtlhnet.com

Health Net Fraud Hotline

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

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Health Net is serious about finding and reporting fraud, waste or abuse (FWA). To report suspected FWA, please contact the Special Investigations Unit at one of the following:

Phone: 866-685-8664. The toll-free Fraud, Waste & Abuse Hotline is answered by an independent third party and is available 24 hours a day, 7 days a week.

Email: Special_Investigations_Unit@centene.com

Mail: Centene Special Investigations Unit7700 Forsyth Blvd 5th floor, Room 519Clayton, MO 63105

Reports of suspected fraud may be made anonymously.

Health Net Health Education

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

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Medi-Cal Counties

Fresno, Kings, Madera

The Health Education System promotes resources and programs to educate members on how to improve their health and the importance of preventive screenings, recognizing potential health risks and minimizing existing health problems.

CalViva Health education programs, services and resources are available at no cost to CalViva Health Medi-Cal members through self-referral or a referral from their primary care physician (PCP). Members and providers may obtain more information by contacting the Member Services at 888-893-1569. Members are directed to the appropriate service or resource based on their needs. Telephonic and website-based services are available 24/7.

7625 N. Palm Suite #107 Fresno, CA 93721 888-893-1569
Fax: 800-628-2704

Amador, Calaveras, Imperial, Inyo, Los Angeles, Mono, Sacramento, San Joaquin, Stanislaus, Tulare and Tuolumne

The Health Net Health Education educate members on how to improve their health and the importance of preventive screenings, recognizing potential health risks and minimizing existing health problems.

Health education programs, services and resources are available at no cost to the Plan's Medi-Cal members through self-referral or a referral from their primary care physician (PCP). Members and providers may obtain more information by contacting Member Services at 800-675-6110. Members are directed to the appropriate service or resource based on their needs. Telephonic and website-based services are available 24/7.

21281 Burbank Boulevard Woodland Hills, CA 91367 800-675-6110
Fax: 800-628-2704

Health Education programs and services include:

- Member Services Line. Members or the parents of youth members may order health education materials on a wide range of topics, such as asthma, healthy eating, diabetes, immunizations, baby bottle-induced tooth decay, prenatal care, and exercise. These materials are available in several threshold languages. Direct members to call their respective Member Services line.
- Tobacco Cessation Program. Kick It California is a no-cost, statewide quit smoking and vaping program for members ages 13 years and older. The program is based on clinical research and proven to help you quit. Kick It California offers:
    - **Telephonic Quit Coaching**:
        - Customized one-on-one coaching with a quit coach over the phone in six languages (English, Spanish, Cantonese, Mandarin, Korean and Vietnamese).
        - Tailored quit plan to member's unique circumstances.
        - Available Monday – Friday 7 a.m. – 9 p.m., Saturday 9 a.m. – 5 p.m.
        - To enroll, members may use the online web form, or call directly at 800-300-8086 (English) or 800-600-8191 (Spanish).

        - **Automated Texting Program:**
            - Receive helpful tips at critical points during your quit journey. Quit coaches respond to questions within two business days.
            - Text "Quit Smoking" or "Quit Vaping" to 66819.
            - Texto "Deje de Fumar" o " No Vepear" al 66819.
        - **Chat with a Quit Coach**
            - Kickitca.org/chat
            - Alternative option for both members and health care providers.
            - Platform allows members quick responses to inquiries such as available services and free nicotine patch evaluation.
            - Health care providers may use the chat to find answers to cessation-related questions.
            - Available in English only, Monday – Friday, 7 a.m. – 9 p.m., and Saturday 9 a.m. – 5 p.m.
        - Mobile App:
            - Kick It Quit Smoking/Vaping app designed to help people quit smoking and vaping.
            - Features tools such as a personal log of smoking triggers, motivational reminders and links to helpful resources.
            - Available for download on the App Store® and Google Play®
            - Visit Kick It California for more details

- Digital Health Education - members have access to online and digital resources for health education through our Krames Staywell health library – Resource library to help you learn about your health and how to stay healthy.
  - Health and Medications – Easy access to more than 4,000 health sheets.
  - Wellness and Lifestyle Improvements – We have a set of assessments and tools to help you.
- myStrength™ website and mobile application offers clinically-proven mental health resources to help members manage depression, anxiety, stress, substance use, and pain management.
- Health Education Classes. Members may access health education classes on a variety of health topics, such as diabetes, asthma, healthy eating, oral health, heart health, fitness, and prenatal care. Members can request a schedule of upcoming health education classes by calling their respective Member Services phone line.
- Member Incentive Programs - Incentive programs for members allow eligible individuals to engage in activities aimed at promoting behavioral change, such as health screenings, preventive health appointments, and health education initiatives, in exchange for rewards. Health Net will notify members who are eligible to participate.
- Provider Resources. Physicians may order health education materials online by using the Health Education Material Order Form.

21281 Burbank Boulevard Woodland Hills, CA 91367
Fax: 800-628-2704

Health Net Health Equity Department

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

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The Health Net Health Equity Department promotes access to care for members who speak a primary language other than English. The department is responsible for developing, implementing and monitoring processes to meet regulatory requirements. The department assesses the cultural and language needs of members and encourages provider, community advocate, and member input through ongoing communication and by participation in county-specific Community Advisory Committees. This helps ensure that materials and interpreter services are available in the member's language, while taking into consideration the member's cultural background in the development of member materials.

The Health Net Health Equity Department has a number of internal processes to enhance services to Health Net's non-English speaking members, including:

- Tracking the interpretation needs of members.
- Monitoring population and membership language distribution for trends.
- Monitoring the availability of materials translated into threshold languages.
- Assessment of language capabilities of the existing provider network and recommendations to the Health Net Provider Network Management staff for network development.
- Review of translations of member materials, such as the Evidence of Coverage (EOC), provider directories, marketing materials, form letters, health reminders, member surveys, newsletters, and health education materials.
- Providing in-service trainings, workshops and educational opportunities to Health Net staff on the linguistic needs and cultural background of Health Net members.

- Supporting Health Net participating providers with information and material on the cultural background, linguistic needs and health care concerns of Health Net members.
- Gathering feedback from providers, the community and members using surveys and focus group studies on cultural and linguistic needs.
- Monitoring and tracking cultural or linguistic related member grievances to gain an understanding of issues impeding member access to care.

Contact the Health Net Health Equity Department for more information at
Cultural.and.Linguistic.services@healthnet.com
Commercial: 800-977-6750
Medicare: 800-546-4570

Fax: 818-543-9188

For written translation assistance services, contact the appropriate Provider Services Center:

Line of Business	Phone Number	Hours of Availability
Large Employer Group	800-641-7761	Monday through Friday, 8 a.m. to 6 p.m. Pacific time (see below for after hours)
Small Employer Group (off exchange)	800-361-3366	Monday through Friday, 8 a.m. to 6 p.m. Pacific time (see below for after hours)
Small Employer Group (on exchange)	888-926-5133	Monday through Friday, 8 a.m. to 6 p.m. Pacific time (see below for after hours)
Individual Family Plan (off exchange)	877-857-0701	Monday through Friday, 8 a.m. to 6 p.m. Pacific time (see below for after hours)
Individual Family Plan (on exchange)	888-926-2164	Monday through Friday, 8 a.m. to 6 p.m. Pacific time (see below for after hours)
After-hours language assistance line for commercial	800-546-4570	Monday through Friday, 5 p.m. to 8 a.m. Pacific time; weekends and holidays

Line of Business	Phone Number	Hours of Availability
Medicare Advantage	800-929-9224	Monday through Friday, 8 a.m. to 5 p.m. Pacific time
Medi-Cal (Amador, Calaveras, Inyo, Kern, Los Angeles, Mono, Sacramento, San Diego, Stanislaus, Tulare and Tuolumne)	800-675-6110	Monday through Friday, 8 a.m. to 6 p.m. Pacific time
After hours Medi-Cal (Amador, Calaveras, Inyo, Kern, Los Angeles, Mono, Sacramento, San Diego, Stanislaus, Tulare and Tuolumne)	800-675-6110, select the member option	6 p.m. to 8 a.m. Pacific time, weekends and holidays
Medi-Cal/CalViva Health (Fresno, Kings and Madera)	888-893-1569	24 hours a day, 7 days a week
Medi-Cal/Community Health Plan of Imperial Valley	833-236-4141	24 hours a day, 7 days a week

Health Net Hospital Notification Unit

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

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Hospitals are required to contact the Health Net Hospital Notification Unit (HNU) within 24 hours of an admission (or one business day when an admission occurs on a weekend or holiday) for a Health Net member via phone, fax or website.

Hospital Notification Unit

LINES OF BUSINESS	FAX NUMBER	PROVIDER PORTAL WEBSITES
• Employer group Medicare Advantage (MA) HMO • Employer group HMO, POS, PPO, (includes EnhancedCare PPO Small Business Group (SBG)) • Medi-Cal	Fax: 800-676-7969	provider.healthnetcalifornia.com
• Individual MA HMO and Special Needs Plan (SNP) (does not apply to MA HMO employer groups)	Fax: 844-825-8045	provider.healthnetcalifornia.com

For Individual & Family Plans (IFP) members (Ambetter HMO and Ambetter PPO), hospitals are required to contact the HNU within 24 hours or one business day, via fax or by web, when an admission occurs on a weekend.

IFP Hospital Notification Unit

LINES OF BUSINESS	FAX NUMBER	PROVIDER PORTAL WEBSITE
• IFP Ambetter HMO • IFP Ambetter PPO	Fax: 844-760-8992	provider.healthnetcalifornia.com

Health Net
Attention: Hospital Notification Unit
21281 Burbank Blvd.
Woodland Hills, CA 91367

Post-stabilization authorization request: call 800-995-7890 to provide notification.

Health Net Long-Term Care Intake Line

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

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Providers should contact the Health Net Long-Term Care Intake line via fax to notify Health Net of its Medi-Cal members' admissions to long-term nursing facilities.

Fax: 855-851-4563

800-453-3033 - to check the status of your request

Health Net Mail Order Prescription Drug Program

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

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HMO and PPO

For commercial [non-Individual and Family Plan (IFP)] plans, use **CVS:**

New prescription medication requests may be mailed by the member or faxed to CVS by the prescribing physician. The member's identification number, date of birth, telephone number including area code, and Health Net affiliation should be listed on the prescription request to ensure it is processed correctly.

CVS Caremark
PO Box 94467
Palatine IL 60094-4467
Fax: 800-378-0323

For on/off-exchange Ambetter HMO/PPO plans, use **Express Scripts® Pharmacy:**

The prescribing physician can send requests for new prescriptions to Express Scripts Pharmacy via **fax to 800-837-0959** or e-prescribe the request 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.

Medicare Advantage HMO

The prescribing physician can send requests for new prescriptions to **Express Scripts Pharmacy** via **fax to 800-837-0959** or e-prescribe the request 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 identification number, date of birth, phone number including area code, and Health Net affiliation should be listed on the prescription request to ensure it is processed correctly.

Note: For Employer Group Retiree Drug Subsidy (RDS) members, use CVS Caremark mail order service.

Health Net Marketing Department

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

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Prior to using, distributing or displaying marketing materials directed to Medicare-eligible beneficiaries, participating providers are required to send these materials for approval to the Health Net Marketing Department, Attention: Medicare Marketing Director.

MedicareMktgReview@healthnet.com

Health Net Medi-Cal Claims

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

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Address for written correspondence regarding claims, tracers, adjustment requests, or denial reconsideration. Health Net Community Solutions, Inc. Medi-Cal Claims PO Box 9020 Farmington, MO 63640-9020

Health Net Medi-Cal Facility Site Review Compliance Department

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

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The Health Net Medi-Cal Facility Site Review (FSR) Compliance Department improves the health of Health Net members through one-to-one provider education and support.

The Health Net Medi-Cal FSR Compliance Department develops materials that simplify the work of providers with respect to legal and accreditation requirements, medical record criteria, documentation of preventive care services, health education, continuity of care, and other clinical interventions, public health programs, and disease management.

Health Net's FSR Compliance nurses educate and assist physicians and their staffs in complying with legal and accreditation requirements and are aware of the effect of added expectations on standards of practice.

Fresno, Kings and Madera

7625 N Palm Ave., Ste. 101 Fresno, CA 93711 559-447-6114
Fax 877-779-0753

Amador, Calaveras, Imperial, Inyo, Kern, Los Angeles, Mono, Riverside, San Bernardino, Sacramento, San Joaquin, Stanislaus, Tulare and Tuolumne

21281 Burbank Boulevard, 3rd Floor Woodland Hills, CA 91367 818-676-7860
Fax: 877-779-0753

Health Net Medi-Cal Medical Management Department

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

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The Health Net Medical Management Department conducts concurrent review of inpatient cases and coordinates care for members under the care management program. Contact the Prior Authorization Department to request prior authorization or assistance with referrals. Participating physician groups (PPGs) may contact the Medical Management Department for assistance with member case management. Providers affiliated with a delegated PPG must follow their PPG's instructions for referrals and requests for prior authorization. All participating providers must inform Health Net immediately when investigational or experimental treatment is requested.

Phone number for status of request: 800-421-8578
Fax: 800-743-1655

Medi-Cal Member Appeals and Grievances Department

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

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- By phone: Contact Health Net 24 hours a day, 7 days a week by calling 800-675-6110 or 833-236-4141(Imperial County). If you cannot hear or speak well, please call TTY: 711.
- In writing: Fill out an appeal form or write a letter and send it to:

Health Net Medi-Cal Member Appeals and Grievances Department P.O. Box 10348 Van Nuys, CA 91410-0348
Fax: 877-713-6189

Your doctor's office will have appeal forms available. Your health plan can also send a form to you.

- Electronically

OR

CalViva Health Member Appeals and Grievances Department PO Box 10348 Van Nuys, CA 91410-0348

Fax: 877-831-6019

Health Net Medi-Cal Member Services Department

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

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To ensure appropriate coverage of medical services for Medi-Cal members, Health Net requires the provision of timely responses and accurate information. If prompt and accurate information is not provided, a member may misuse the program, resulting in medical services not being covered. To avoid these problems, Health Net directs inquiries from members to Health Net's Medi-Cal Member Services Department. Provider inquiries are directed to the Provider Engagement Network Specialists when applicable.

The Health Net Medi-Cal Member Services Department ensures that translation services are available for members when they call. In addition, the Health Net Member Handbook and other member-informing materials are translated into the required threshold languages.

Health Net's Medi-Cal Member Services Department handles incoming calls and correspondence from members. This department is responsible for:

- Medi-Cal questions and explanation of coverage.
- Information about access to and delivery of care.
- Professional and hospital services, bills, and claims.
- Member problems and inquiries.
- Address changes.
- Identification card requests.
- Primary care physician (PCP) selection and transfer requests.
- Handling complaints about Health Net programs or staff.

The Health Net toll-free number is printed on the back of the member's identification card 800-675-6110 (TTY 711). Health Net is here 24 hours a day, 7 days a week. While telephone assistance is the PCP's responsibility, the Health Net Medi-Cal Member Services Department can assist members in reaching their PCP when needed. It is the responsibility of the servicing provider to confirm eligibility at the time of service. Health Net's Medi-Cal Member Services representatives can provide the telephone number for the member's PCP, or the call can be routed to the Health Net Nurse Advice Line (N24) when applicable.

Health Net Member Services Department Open 24/7

Phone Number: 800-675-6110

You can also visit Member Services online at any time at www.healthnet.com.

Fax: 844-837-5947 or 800-281-2999

Medi-Cal Provider Appeals and Grievances - Health Net Medi-Cal and CalViva Health

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

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Address for provider disputes and grievances:

Medi-Cal Provider Appeals Unit PO Box 989881 West Sacramento, CA 95798-9881

OR

CalViva Health Provider Disputes and Appeals Unit PO Box 989881 West Sacramento, CA 95798-9881

Health Net Medi-Cal Provider Services Department

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

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As a State Health Program, Health Net has some unique characteristics that make timely response and accurate information necessary. If prompt and accurate information is not provided, a member may misuse the program, resulting in medical services not being covered. To avoid this, Health Net directs inquiries from providers to Health Net's Medi-Cal Provider Services Department or to Health Net's Provider Engagement Network Specialists, where available. Members are directed to the Medi-Cal Member Services Department.

Health Net's Medi-Cal Provider Services Department Customer Service Advocates are available 24 hours a day, seven days a week, to assist providers with:

- Member eligibility, effective dates and eligibility research
- Primary care physician (PCP) selection and transfer requests for members
- Questions about the Plan’s Medi-Cal Rx Contract Drug List (CDL)
- Benefit information
- Professional and hospital billing
- Claims
- Questions regarding claims status
- Exceptions and administrative decisions
- Complaints and grievances regarding provider care, delivery of care or participating physician group (PPG) staff
- Requests for removal/PCP/PPG reassignment for non-compliant members

The Health Net Medi-Cal Provider Services Department toll-free telephone number is printed on the back of the member's identification card. The servicing provider is responsible for confirming the member(s) eligibility at the time of service.

Health Net Provider Services Department Phone Number: 800-675-6110, option 2
Fax: 844-837-5947 or 800-281-2999 Provider website

Providers may use HNMedi-cal.ClaimsInquiry@healthnet.com for claim status only if the provider portal is down or not working. This email is only for claim status and denial inquiries.

To disenroll a non-compliant member refer to Disenrollment section.

Fax or mail the formal letter and all supporting document’s to:

Attn: Non-Compliance Unit

Fax: (844) 837-5947

Address: PO BOX 10303, Van Nuys, CA 91410-0303

Health Net Medicare Advantage Claims Department

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

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Address for Health Net Medicare Advantage (MA) claims.

Health Net of California, Inc.
Medicare Claims
PO Box 9030
Farmington, MO 63640-9030

Health Net Medicare Advantage Provider Disputes

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

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Address for Medicare Advantage provider disputes.

Health Net Provider Appeals Unit
PO Box 9030
Farmington, MO 63640-9030

Health Net Medicare Appeals and Grievances Department

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

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Although there is a specific post office box for submission of Health Net Medicare member appeals for denied services or other grievance correspondence, Health Net prefers to receive appeals and grievances by fax. This

enables Health Net to receive, process and resolve the member's issues quickly in accordance with state and federal timeliness requirements. Member appeal requests must be submitted in writing.

Health Net Medicare Appeals and Grievances Department

Fax: 844-273-2671

PO Box 10450
Van Nuys, CA 91410-0450

800-275-4737

For non-contracted providers, submit your dispute request in writing, along with complete documentation (such as a remittance advice from a Medicare carrier), to support your payment dispute to:

Wellcare By Health Net – Appeals
P.O. Box 3060
Farmington, MO 63640-3822

Health Net Medicare Programs Provider Services Department

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

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To ensure appropriate coverage of medical services for Medicare members, Health Net requires the provision of timely responses and accurate information an absolute necessity. If prompt and accurate information is not provided, a member may misuse the program, resulting in medical services not being covered. To avoid this issue, Health Net directs inquiries from members and employer groups to the Medicare Programs Member Services Department. Inquiries from participating physician groups (PPGs), hospitals, ancillary providers, and physicians are directed to the Provider Services Department, or the provider relations and contracting specialist (previously known as regional network administrators), where available.

The Provider Services Department telephone number is to be used exclusively by PPGs, hospitals and providers and should not be given to members.

During business hours (Monday through Friday, 8 a.m. to 5 p.m.), Health Net Provider Services Department representatives are available to assist providers with:

- Member eligibility and effective dates, and eligibility research.
- Questions about the Health Net prescription drug program.
- Conflict resolution regarding benefit interpretation.
- Exceptions and administrative decisions.
- Complaints regarding health care services, delivery of health care services or PPG staff.
- Request for removal of members for disciplinary actions.

- PPG transfer requests, other than address change or open enrollment.
- Questions regarding claim status.

Claims address:

Health Net of California, Inc.
Medicare Claims
PO Box 9030
Farmington, MO 63640-9030

800-929-9224 for all Medicare individual and Medicare employer group plans

800-641-7761 for all Medicare Supplement plans

Health Net Member Appeals and Grievances Department

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

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Address and telephone numbers for member appeals for denied services or other grievance correspondence.

PO Box 10348

Van Nuys, CA 91410-0348

800-522-0088 for commercial members in Northern California

800-638-3889 for commercial members in Southern California

Fax: 877-831-6019

Health Net Member Services Department

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

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To ensure appropriate coverage of medical services for members, Health Net requires the provision of timely responses and accurate information. If prompt and accurate information is not provided, a member may unintentionally misuse the program, resulting in medical services not being covered. To avoid these problems, member and employer group inquiries are directed to an expert team of associates via the Health Net Member Services Department. This team is responsible for resolving member and employer group issues that have

been routed to them via a telephone call, written correspondence or the Internet. The Health Net Member Services Department is responsible for resolving issues pertaining to the following:

- Health Net benefit questions and explanations.
- Education on the access of the health care delivery system.
- Professional and hospital services, bills and claims.
- ChiroNet benefits and eligibility.
- Health Net prescription drug program questions, eligibility and claims.
- EyeMed Vision Care program questions about eyewear benefits, eligibility and claims.
- Membership problems and inquiries.
- Member updates (includes adding and deleting members, address changes, PCP/PPG changes).
- Contract cancellation requests.
- Conversion.
- Identification card requests.

Health Net Member Services Department
PO Box 9103
Van Nuys, CA 91409-9103
800-522-0088

Health Net Provider Communications Department

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

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The Health Net National Provider Communications Department informs Health Net participating providers of Health Net's policies and procedures, changes in contractual, legislative and regulatory requirements through provider operations manuals, updates, letters, and newsletters. To access the most current information, log on to the provider portal.

4191 East Commerce Way
Sacramento, CA 95834
Mailstop: CA4191-04-167

provider.communications@healthnet.com

Health Net Nurse Advice Line

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

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The Health Net Nurse Advice Line was developed to assist members in obtaining primary care. Information is available 24 hours a day. The program is a service offered in conjunction with the primary care physician (PCP) and does not replace the PCP. According to Health Net's access-to-care standards, all PCPs must provide 24-hour telephone service for instructions, medical condition assessment and advice. The Health Net Medi-Cal Member Services Department coordinates member access to the Health Net Nurse Advice Line.

On receipt of a call, the program nurse addresses emergencies immediately by directing the member to the emergency department and assists the member in securing an ambulance, if necessary. Members needing urgent care are referred to an urgent care center if the PCP is not available. The referral record can be faxed to the emergency department or urgent care center to inform the facility of the member's condition and pending arrival.

The program nurse educates the member on the role of the PCP, assists the member in scheduling an appointment with the PCP, and gives the member information on procedures to follow until care is received from the PCP. A copy of the encounter is faxed to the PCP immediately at the close of the call.

All interaction with hospital staff, urgent care center staff and the PCP is documented. In addition, incident reports are completed when a member does not accept the program nurse's recommendations. The nurse uses a tracking mechanism to follow up on the disposition of the member and notifies the PCP and the plan of any members who require follow-up coordination.

800-675-6110

Health Net Overpayment Recovery Department

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

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Address for overpayment refunds and applicable information.

Health Net of California, Inc.
Attention: Claims Recover Team
PO Box 396027
San Francisco, CA 94139-6027

Health Net PPO Claims Submission

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

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Health Net Commercial Claims

PO Box 9040
Farmington, MO 63640-9040

Health Net – Prior Authorization Department

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

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Health Net accepts prior authorization requests for elective and urgent services by fax, phone and online. All participating providers must immediately inform Health Net when there is a request for investigational or experimental treatment.

Prior Auth Contacts

Lines of Business	Contact Numbers	Provider Portal Websites
• IFP Ambetter HMO	Fax: 844-694-9165 Phone: 888-926-2164 Transplant fax: 833-769-1142	provider.healthnetcalifornia.com
• IFP Ambetter PPO	Fax: 844-694-9165 Phone: 844-463-8188 Transplant fax: 833-769-1142	provider.healthnetcalifornia.com
• Employer Group HMO, Point of Service (POS), PPO	Fax: 844-694-9165 Phone: 800-641-7761 Transplant fax: 833-769-1142	provider.healthnetcalifornia.com
• Health Net Medi-Cal • CalViva Health • Community Health Plan of Imperial Valley	Fax: 800-743-1655 • Health Net: 800-675-6110 • CalViva Health: 888-893-1569 • CHPIV: 833-236-4141 Transplant fax: 833-769-1141	provider.healthnetcalifornia.com

Lines of Business	Contact Numbers	Provider Portal Websites
• Medicare (Individual and Employer Group) and Special Needs Plan (SNP)	Fax: 844-501-5713 Phone: 800-929-9224 Transplant fax: 833-769-1143	provider.healthnetcalifornia.com
• Medicare Supplement	Fax: 844-501-5713 Phone: 800-641-7761 Transplant fax: 833-769-1143	provider.healthnetcalifornia.com

Mailing Address

Health Net
Attention: Prior Authorization Department
21281 Burbank Blvd.
Woodland Hills, CA 91367

Health Net Program Accreditation Department

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

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The Health Net Program Accreditation Department supports and promotes activities to assess and monitor organization-wide and provider compliance with regulatory and oversight bodies, including the California Department of Managed Health Care (DMHC), the National Committee for Quality Assurance (NCQA), the Centers for Medicare and Medicaid Services (CMS), the Department of Health Care Services (DHCS), and the California Managed Risk Medical Insurance Board (MRMIB). The department is also responsible for preparation and implementation of any identified actions based on the findings of DMHC, NCQA and CMS audits.

The Program Accreditation Department collects, reviews and assesses various required submissions from delegated participating physician groups (PPGs), including financial statements and utilization management reports.

Address to submit expedited organization determination (EOD), Notice of Medicare Non-Coverage (NOMNC) tracking logs, utilization management and financial reports:

Program Accreditation Department Compliance Analyst
21281 Burbank Blvd.
Woodland Hills, CA 91367

818-676-6704

Provider Oversight efax: 877-890-4105

UMQIMR@healthnet.com

Health Net Provider Services Center

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

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The Health Net Provider Services Center is available to physicians, participating physician groups (PPGs), hospitals, and other providers, and features live customer service representatives, an interactive voice response (IVR) system and the provider portal websites. Customer service representatives are available via telephone and online during business hours (Monday through Friday, 8:00 a.m. to 6:00 p.m.). Services provided include the following:

- Member eligibility and effective dates information.
- Health Net's prescription drug program information.
- Claims status information.
- Instructions on how to submit disputes and appeals.
- Instructions on how to submit a complaint regarding the provision of care by a provider or express concerns about provider office staff.
- Instructions on how to request the removal of members for disciplinary actions.
- Information about the provider portal websites.

IVR for Employer Group HMO and PPO members

The Health Net Provider Services Center IVR system is a quick and accurate way to verify member eligibility and claim information without waiting to speak with a Provider Services Center representative. For employer group HMO and PPO members, providers may contact 800-641-7761. The IVR includes:

- Current and past eligibility status.
- Benefits information.
- Single or multiple claims status.
- Claims submission addresses.
- Automated fax back of member eligibility and claim status information.

IVR for Covered California and Individual Family Plan (IFP) members

The Health Net Provider Services Center IVR system is a quick and accurate way to verify member The following IVRs are available for Covered California and IFP members, which include CommunityCare HMO and

PPO Individual and Family members (EnhancedCare PPO members are excluded). Providers may verify or check eligibility status by member name and plan, claims status and copayment information.

IFP IVR Phone Numbers

If...	Then contact Health Net at...	And...
Covered California appears on the member identification (ID) card	888-926-2164 for Covered California Health Net members	Follow the prompts
Covered California does not appear on the member (ID) card	877-857-0701for Health Net IFP members	Follow the prompts

Provider Services Center Contact Information

Line of Business	Phone Number	Provider Portal Website
• EnhancedCare PPO (IFP)	844-463-8188	provider.healthnetcalifornia.com
• EnhancedCare PPO (SBG)	844-463-8188	provider.healthnetcalifornia.com
Health Net Employer Group HMO, POS, and PPO	800-641-7761	provider.healthnetcalifornia.com
• Individual Family Plan (includes CommunityCare HMO and PPO Individual and Family)	888-926-2164	provider.healthnetcalifornia.com

Claims Address

Health Net Commercial Claims
PO Box 9040
Farmington, MO 63640-9040

Email Address

provider_services@healthnet.com

The information provided is the most up-to-date as of the date of this publication. For the most up-to-date information, visit providerlibrary.healthnetcalifornia.com

Health Net Quality Improvement Department

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

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Contact Health Net's Quality Improvement Department for questions regarding quality improvement projects (QIPs).

For commercial providers email:
cqi_dsm@healthnet.com

For Medicare providers email:
cqi_medicare@healthnet.com

Health Net's Regional Medical Directors

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

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To provide better service to participating physician groups (PPGs), hospitals, employer groups, and members, Health Net's regional medical directors are located in the Irvine, Oakland, Rancho Cordova, San Diego, Woodland Hills, and other regional offices. Health Net's regional medical directors are directly responsible for any clinical matters related to Health Net policies and procedures. They also serve as professional consultants to the PPGs and hospitals.

Health Net's regional medical directors work closely with PPGs and hospitals to monitor, manage and achieve greater efficiency in the following areas:

- Utilization management (UM), including care management
- Quality management
- Pharmaceutical management
- Case review or member complaints relating to quality of care and access
- Introduction of new products

Health Net Third-Party Liability Department

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

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Medi-Cal

Providers must notify Health Net or the participating physician group (PPG) in writing of all potential and confirmed third-party tort liability cases involving a Health Net Medi-Cal member. Notify Health Net if a provider receives any subpoenas from attorneys, insurers or beneficiaries for copies of bills. Supply Health Net with copies of the request and copies of documents released as a result of the request, and provide the name, address and telephone number of the requesting party. The notification must be submitted via email to or mail notifications to:

Health Net TPL Recovery TPL Department Mailstop: CA-4191-04-108 4191 East Commerce Way Sacramento, CA 95834

Health Net Transfer/Termination Request Unit

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

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Participating physician groups (PPGs) considering the termination of a Health Net member must submit a Transfer/Termination (T/T) Incident Report to the Health Net Transfer/Termination Request Unit.

HMO

T/T Requests
P.O. Box 10348
Van Nuys, CA 91410
Fax: 877-831-6019

Medicare Advantage HMO

T/T Requests

Medicare Services:
Health Net Appeals and Grievances Department
P.O. Box 10344
Van Nuys, CA 91410-0344
Fax: 877-713-6189

Health Net Transplant Care Manager

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

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Submit transplant information to Health Net. Health Net reviews the request and may advise the participating physician group (PPG) or provider to refer the member to a transplant performance center for evaluation. Health Net's designated transplant performance centers are Medicare-certified. On completion of any evaluation, the transplant performance center must fax the evaluation directly to the Health Net transplant care manager.
888-732-2730
Fax: 866-292-5294

Health Net Transportation Vendors

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

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- Medi-Cal: ModivCare – Members can call Where's My Ride? at 855-253-6863, TTY: 711.
- Medicare: Access2Care – Medicare members can call 844-515-6876.

Health Net Utilization Management Department

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

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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 the elements of the UM process.

Health Net Utilization Management Department
PO Box 10198
Van Nuys, CA 91410

Health Net Wellness and Prevention Department

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

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Contact the Health Net Wellness and Prevention Department at:

916-935-1263

Hearing Care Solutions

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

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866-344-7756
Monday through Friday
5 a.m.-5 p.m. PT

For more information, visit the Hearing Care Solutions website.

Hearing Healthcare Providers

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

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Hearing Healthcare Providers (HHP)

www.hhpca.org

HNI Corporate Address

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

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If a participating physician group (PPG) needs to request a change to the information currently in their Provider Participation Agreement (PPA), the request must be made in writing and sent to:

Health Net of California, Inc.
Attention: Vice President, Provider Contracting/Provider Network Management
21281 Burbank Blvd
Woodland Hills, CA 91367

Hoveround Inc

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

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Provider of custom rehabilitation equipment services.

800-701-5781

In-Home Operations

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

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Medical management of chronically ill Medi-Cal members, including those with catastrophic illnesses, those who are dependent on life-sustaining equipment, and those at risk of life-threatening occurrences, requires close coordination between Health Net and the Home and Community-Based Services (HCBS) Waiver program administered by In-Home Operations (IHO). This program seeks to ensure that the medical needs of physically and mentally disabled Medi-Cal members are met by providing in-home care. 916-552-9105 in Northern California
213-897-6774 in Southern California
email: IHOwaiver@dhcs.ca.gov

J&B Medical Supply Company Inc

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

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J&B Medical Supply Company, Inc. Address: 50496 W. Pontiac Trail, Wixom, MI 48393-2088 Phone: 800-737-0045
Fax: 800-737-0012 Website: www.jandbmedicalinsurance.com

Kick It California

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

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800-300-8086 (English)

800-600-8191 (Spanish)

kickitca.org

LabCorp

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

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To find a LabCorp center near you or request a pick-up, visit www.LabCorp.com or call 800-244-9698.

Linkia LLC

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

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Linkia, LLC is Health Net's preferred provider for orthotics and prosthetics.

877-754-6542

Livante (California Quality Improvement Organization (QIO)

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

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Livante
BFCC-QIO Program
9090 Junction Drive, Suite 10
Annapolise Junction, MD 20701

Phone: 877-588-1123 or TTY: 855-887-6668
Appeals fax: 855-694-2929
All other reviews fax: 844-420-6672

Los Angeles Department Of Public Social Services

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

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Providers may call the Los Angeles Department of Public Social Services (DPSS) for assistance with the In-Home Supportive Services (IHSS) program.

The IHSS program provides services to seniors and persons with disabilities allowing them to remain safely in their homes.

888-944-4477 213-744-4477

Mahmee

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

Mahmee offers virtual doula services via the Mahmee mobile app that is designed to better connect new moms with health care and support. Mahmee can be contacted at the number listed below:

818-431-1118

Monday through Friday from 6 a.m. to 8 p.m. PT.

Saturday and Sunday from 8 a.m. to 6 p.m. PT.

Managed Care Ombudsman

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

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The Department of Health Care Services (DHCS) Managed Care Ombudsman investigates and attempts to resolve complaints about managed care plans that members have been unable to resolve through their health plans. 888-452-8609

March Vision Care

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

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Health Net members assigned to Molina Healthcare may contact March Vision Care to locate a participating optometrist and optician from whom to order and receive lenses and frames.

888-493-4070

Matria Health Care Inc

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

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Matria Health Care, Inc. provides home health and infusion services to high-risk obstetric members.

800-289-7744

Medical Board Of California

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

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A standardized summary discussing alternative breast cancer treatments and their risks and benefits must be given to members. For a no-cost brochure, contact the Medical Board of California, Breast Cancer Treatment Options. Breast Cancer Treatment Options 1426 Howe Avenue, Suite #54 Sacramento, CA 95825 Fax: 916-263-2479

Medi-Cal Provider Contested Claims

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

Address for provider contested claims:

Health Net Medi-Cal Contested Claims Department PO Box 989736 West Sacramento, CA 95798

OR

CalViva Health Contested Claims Department PO Box 989736 West Sacramento, CA 95798

Medi-Cal Rx CSC

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

Medi-Cal Rx

Phone: 800-977-2273 Fax 800-869-4325

Appeals
Medi-Cal CSC, Provider Claims Appeals Unit P.O. Box 730 Rancho Cordova, CA, 95741-0730

Prior authorization
Medi-Cal Rx Customer Service Center Attn: PA Request PO Box 730 Sacramento, CA 95741-0730 Phone: 800-977-2273

Medicare Appeals Council

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

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Health Net Medicare Advantage (MA) and MA members may request that the Medicare Appeals Council (MAC) review an administrative law judge (ALJ) decision. The review request must be made within 60 days from the date Health Net receives the ALJ hearing decision or dismissal. The request for appeal may be submitted directly to the MAC.

Department of Health and Human Services
Department Appeals Board, MS 6127
Medicare Appeals Council
330 Independence Avenue, S.W.
Cohen Building, Room G-644
Washington, DC 20201

Member Rights Information

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

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This insert must be customized with the health plan and/or participating physician group (PPG)-specific phone number and applicable couty-specific phone number for the applicable legal services office.

Legal Services Offices for Assistance for Medi-Cal Managed Care Enrollees

COUNTY	LEGAL SERVICES OFFICE
Fresno	Central California Legal Services - 800-675-8001
Kern	Greater Bakersfield Legal Aid - 661-321-3982
Kings	Central California Legal Services - 800-675-8001
Los Angeles	Neighborhood Legal Services - 800-896-3203
Madera	Central California Legal Services - 800-675-8001
Orange	Legal Aid Society of Orange County - 800-834-5001

COUNTY	LEGAL SERVICES OFFICE
Riverside	Inland Counties Legal Services Indio Office - 800-226-4257 Riverside Office - 888-455-4257
Sacramento	Legal Services of Northern California - 888-354-4474
San Bernardino	Inland Counties Legal Services San Bernardino - 800-677-4257 Rancho Cucamonga - 800-977-4257
San Joaquin	Legal Services of Northern California - 888-354-4474
San Diego	Legal Aid Society of San Diego - 877-734-3258
Stanislaus	Central California Legal Assistance - 800-675-8001
Tulare	Central California Legal Services, Visalia Office - 800-350-3654

MHN Customer Service Department

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

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If there is any indication during a medical evaluation that a psychiatric or substance abuse problem is present, the primary care physician (PCP) or his or her staff may contact the MHN Customer Service Department for a referral to an MHN provider. Customer service specialists may also assist with member eligibility, benefits and general questions about MHN.

888-935-5966

Providers treating CalViva Health members: 888-327-0010

MiniMed Distribution Corp Inc

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

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MiniMed Distribution Corp, Inc. provides insulin pumps and supplies to members with diabetes.

800-795-0618
Fax: 800-611-1716

Modivcare

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

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HMO

Non-emergency transportation services are arranged through Modivcare™ 24 hours a day, 7 days a week.

For HMO:

866-842-0675
Fax: 800-762-1777

HMO

Modivcare Transportation Services

TRANSPORTATION NEED	HOURS AND SERVICE REQUIREMENTS
Urgent trip and hospital discharge requests	Advance notice is not required and transportation can be scheduled for same day of service. For hospital discharge, it may take a transportation provider 1 to 4 hours to pick up a member, depending on provider availability

TRANSPORTATION NEED	HOURS AND SERVICE REQUIREMENTS
Hours of operation for urgent and same-day reservations	Transportation assistance for trip recovery and after-hours hospital discharges is available 24 hours a day, 7 days a week

Medi-Cal

Refer to the table below to arrange for transportation services through Modivcare. Modivcare uses language-line interpreter services for all interpretation needs during reservations.

Modivcare Transportation Services

TRANSPORTATION NEED	HOURS AND SERVICE REQUIREMENTS
Standard days and hours of customer service center operation for routine reservations.	Monday through Friday, 7 a.m. to 7 p.m. Pacific time.
Weekend and holiday schedule	Closed Saturday and Sunday Closed on the following national holidays: New Year's Day, Memorial Day, Independence Day (July 4th), Labor Day, Thanksgiving, and Christmas
Routine transportation requests	- Rideshare curb-to-curb in “real time”. (For avoidance of doubt, “real time” is defined as within 1 hour of member request.) - Non-rideshare curb-to-curb 24 hours in advance (sedan, taxi) - 48-hour notice for any mode of transportation higher than sedan (wheelchair [including ambulatory door-to-door], stretcher, non-emergent ambulance)
Urgent trip and hospital discharge requests	Advance notice is not required and transportation can be scheduled for the same day of service for hospital discharges and urgent treatment types. For hospital discharge, it may take a transportation provider 1 to 4 hours to pick up a member, depending on provider availability

TRANSPORTATION NEED	HOURS AND SERVICE REQUIREMENTS
Hours of operation for urgent and same-day reservations	Transportation assistance for trip recovery, urgent treatment types and after-hours hospital discharges is available 24 hours a day, 7 days a week
Hours of operation for ride assistance (Where's my Ride? line) and hospital discharges	Transportation assistance for trip recovery, urgent treatment types and after-hours hospital discharges is available 24 hours a day, 7 days a week

Modivcare Contact Information

FORM OF CONTACT	CONTACT INFORMATION
Toll-free telephone numbers	**Submit a Physician Certification Statement (PCS) form to the Health Net Care Ride Unit to obtain authorization before contacting Modivcare for scheduling.** Reservations and ride assistance (Where's My Ride? line) for Medi-Cal members: 855-253-6863 Ride assistance (Where's My Ride? line) for CalViva Health members: 855-253-6864 Ride assistance (Where's My Ride? line) for CHPIV members: 855-251-7097 Hearing impaired (TTY) line: 866-288-3133 For providers: Facility line: 866-529-2128 Facility fax: 877-601-0535
Website	Modivcare.com Providers may use the Modivcare website to schedule only routine transports with an advance notice of 5 business days. Print an enrollment form from the Modivcare website to sign up for this HIPAA-compliant service and return it by fax to 877-601-0535.

Molina Behavioral Health Services

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

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Behavioral Health Services assists providers with mental health services for Molina members.

1-888-665-4621
Fax: 1-866-472-0596

Molina Claims Department

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

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Submit written correspondence or claims, tracers, appeals, or adjustments to the Molina Healthcare Claims Department.

Molina Healthcare Claims PO Box 22702 Long Beach, CA 90801 1-888-665-4621, press 1 for provider

Molina Credentialing And Facility Site Review Department

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

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The Molina Healthcare Credentialing Department verifies all information about each Molina provider and evaluates the applicant's qualifications to be credentialed or recredentialed. Recredentialing of providers is conducted at least every three years. Credentialing: 1-800-526-8196 ext. 120117
Fax: 1-888-665-4629

Facility Site Review 1-800-526-8196 ext. 120118
Fax: (562) 499-6185

Molina Encounter Department

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

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The Molina Encounter Department handles all claims for capitated services.

P.O. Box 22807 Long Beach, CA 90801 MHCEncounterDepartment@MolinaHealthCare.com

Molina Healthcare Education Department

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

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The Molina Healthcare Education Department improves the health outcomes of Medi-Cal members through member and provider education and facilitating provider access to member education resources and information.

1-866-472-9483

Molina Healthcare Provider Resolution Department

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

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The Molina Healthcare Provider Resolution Department handles written inquiries from providers regarding claim disputes. Written inquiries should be sent to the following address.

Molina Healthcare Attn: Provider Dispute Unit PO Box 22722 Long Beach, CA 90801 Fax: (562) 499-0633

Molina Interactive Voice Response

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

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Contact the Molina Interactive Voice Response system if a member arrives at a primary care physician (PCP) office to receive care and does not appear on the current month's eligibility listing. 1-800-357-0172

Molina Member Services

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

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Molina Healthcare offers telephonic services via telephone. 1-888-665-4621

Molina Nurse Advice Line

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

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Molina&s nurse advice line is staffed 24 hours a day, seven days a week by highly trained nurses for member assistance and referrals. 1-888-275-8750 (English)
1-866-648-3537 (Spanish)

Molina Pharmacy Department

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

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The Molina Healthcare Pharmacy Authorization Desk is responsible for Molina's medication prior authorization requests.

1-888-665-4621, press 1 for provider
Fax: 1-866-508-6445

Molina PM160 INF Forms

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

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Send completed PM160 Information Only (INF) forms to Molina Healthcare via the fax below. (562) 435-3666, ext. 127350
Fax: (562) 499-6193

Molina Provider Services Department

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

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For Los Angeles County only: Molina Healthcare is Health Net's subcontracting health plan for the Medi-Cal managed care program in Los Angeles County. The Molina Healthcare Provider Services Department is the provider liaison to the health plan's administrative programs. This department handles telephone and written inquiries from providers regarding contracting, capitation verification, scheduling of in-service training, site audit status, and credentialing information.

200 Oceangate, Ste. 100 Long Beach, CA 90802 1-855-322-4075
Fax: 1-855-278-0312 www.molinahealthcare.com

Molina Quality Improvement Department

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

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The Molina Quality Improvement Department reviews member medical records, population-based studies on preventive care, clinical practice guidelines, focused studies, member and provider satisfaction studies, complaints and grievances, and monitors continuing quality improvement. 1-800-526-8196, ext. 126137
Fax: (562) 499-6185

Molina Utilization Management Department

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

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The Molina Healthcare Utilization Management Department handles referrals and prior authorization requests, conducts concurrent review on inpatient cases, and coordinates care for members under the case management program, including California Children's Services (CCS).

Outpatient and urgent referral requests: 1-800-526-8196, option3, then option 4

Inpatient referral requests: 1-800-526-8196, option3, then option 4

CCS referral requests: 1-888-562-5442, ext. 126586

Case management referral requests: 1-800-526-8196, ext. 127604
Fax: (562) 499-6105

Outpatient and prior authorization requests: Fax: 1-800-811-4804

Notification of inpatient admissions: Fax: 1-866-553-9262

Notification of concurrent review: Fax: 1-866-553-9263

Multipurpose Senior Services

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

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The Multipurpose Senior Services Program (MSSP) Waiver Program assists frail members ages 65 and older in remaining safe in their homes. The program is administered by the Department of Aging and provides a cost-effective alternative to institutionalization while assisting seniors in maintaining important ties to family, friends and the community. A Health Net member who meets the criteria for MSSP services and is approved and accepted into the waiver program is disenrolled from Health Net and becomes eligible for the Medi-Cal fee-for-service (FFS) program.

Amador, Calaveras, Tuolumne

Area 12 Agency on Aging
19074 Standard Road Sonora, CA 95370 209-532-6272
Fax: 209-532-6501

Fresno, Madera

Fresno and Madera Agency on Aging 3837 N. Clark Street Fresno, CA 93726 (559) 453-4405

Imperial

Imperial County Work Training Center, Inc. 210 Wake Avenue El Centro, CA 92243 760-352-6181
Fax: 760-352-6332

Inyo, Mono

Eastern Sierra Area Agency on Aging
1360 North Main Street, Suite 201 Bishop, CA 93514-2709 760-873-3305
Fax: 760-878-0266

Kings, Tulare

Kings and Tulare Area Agency on Aging 5957 S. Mooney Boulevard Visalia, CA 93277 (559) 737-4660
(800) 321-2462

San Joaquin

San Joaquin County Human Services Agency - Aging & Community Services Bureau 102 S. San Joaquin Street Stockton, CA 95202 (209) 468-1104
Fax (209) 932-2613

Stanislaus

Stanislaus County Community Services Agency 251 East Hackett Road Modesto, CA 95353 (209) 558-2346
Fax: (209) 558-2681

National Seating And Mobility

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

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Provider of custom rehabilitation equipment services.

800-404-6676

Nurse Advice Line

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

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HMO and PPO

Health Net's Nurse Advice Line is a telephonic support program that empowers members to better manage their health. The Nurse Advice Line offers support for members coping with chronic and acute illness, episodic or injury-related events and other health care issues. Highly trained registered nurses (health information managers) are available 24 hours a day, seven days a week.

The Nurse Advice Line provides real time health care assessments to help the member determine the level of care needed at the moment. Nurses provide one-on-one consultation, answers to health questions and symptom management support that empower members to make confident and appropriate decisions about their care and treatment. Members can access the nurse advice line by calling the member services number on the back of their identification (ID) card.

The Nurse Advice Line is available to physicians to discuss concerns or make referrals at 800-893-5597; select the physician/provider options.

Medicare Advantage HMO

Contact the Nurse Advice Line at 800-893-5597

Peer-to-Peer Review Request Line

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To request a peer-to-peer review, call the applicable Peer-to-Peer Review Request Line below with the necessary information available.

If you reach a voicemail, please leave a message with the required information and a callback phone number. The medical director's team will contact you to schedule a peer-to-peer review.

Plan or product	Phone number	Required information

Individual & Family Plans (Ambetter HMO and PPO) Employer Group (HMO/POS, PPO) Medicare Advantage HMO and PPO	818-676-7371	• Member name • Member date of birth • Case number • Medical director name • Name of the nurse who worked the case • Member identification number
Medi-Cal	818-676-5503	
CalViva Health		
Community Health Plan of Imperial Valley		

Pharmacy Services

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

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HMO and PPO

Providers must contact Pharmacy Services by telephone, fax or mail to request prior authorization for certain prescription medications before medications are dispensed.

800-548-5524, option 3
Fax: 866-399-0929

MedPharm
Attention: Prior Authorization
4191 East Commerce Way
Sacramento, CA 95834-9679
Mailstop: CA4151-04-530

Medi-Cal

Pharmacy Services is responsible for review of requests for medical benefit medication prior authorization for Health Net Medi-Cal members.

MedPharm
Attention: Prior Authorization
4191 East Commerce Way Sacramento, CA 95834-9679
Mailstop: CA4151-04-530 800-867-6564

Fax: 833-953-3436

Medicare Advantage HMO

Providers must contact Pharmacy Services by telephone, fax or mail to request prior authorization for certain prescription medications before medications are dispensed.

800-867-6564
Fax: 800-977-8226

MedPharm
Prior Authorization
4191 East Commerce Way
Sacramento, CA 95834-9679
Mailstop: CA4151-04-530

Premier Eye Care

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

Premier Eye Care

833-883-2339

Monday – Friday, 8 a.m. – 8 p.m. Pacific time

Email: info@premiereyecare.net

Provider Disputes and Appeals - Commercial

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

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Address for provider disputes and appeals:
Health Net Commercial Provider Disputes

PO Box 9040
Farmington, MO 63640-9040

Provider Network Management Department

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

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The Provider Network Management (PNM) Department is the provider liaison to the health plan's administrative programs, including contracting, claims resolution, and on-site education and training.

HMO, Medicare Advantage HMO, Medicare Supplement, and PPO

If you need additional information, contact the Provider Services Department (HMO, PPO, and Medicare Advantage HMO, and Medicare Supplement) for assistance. The Provider Services Department assists participating providers by obtaining and coordinating information with the PNM Department.

For hospitals and PPGs, if you need further assistance you may contact your regional provider network manager or provider network administrator.

Medi-Cal

If you need additional information, contact the Provider Services Department (Health Net, CalViva Health or Community Health Plan of Imperial Valley) for assistance. The Provider Services Department assists participating providers by obtaining and coordinating information with the PNM Department.

For hospitals and PPGs, if you need further assistance you may contact your regional provider network manager or provider network administrator.

Provider Network Management, Access and Availability Team

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

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Email: Provider Network Management, Access and Availability Team for more information.

Provider Relations Department

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

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The Provider Relations Department provides support, education and training to Health Net's Medi-Cal provider network.

Email: The Provider Relations Department

Pumping Essentials

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

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Health Net's preferred breast pump provider.

866-688-4203

Quest Diagnostics

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

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For information about Quest Diagnostics laboratory testing solutions and services or to set up an account, call 866-697-8378.

To locate a Quest Diagnostics Patient Service Center (PSC), or schedule a PSC appointment for a Health Net member, log on to the Quest Diagnostics website or call 888-277-8772.

Regional Centers

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

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Regional centers are private, non-profit corporations under contract with the California Department of Developmental Services (DDS). Their purpose is to enable people with developmental disabilities to lead as independent and productive lives as possible, to protect the legal rights of people with developmental disabilities and their families, and to reduce the incidence of developmental disabilities. Below are the regional centers as indicated for each county:

Amador, Calaveras and Tuolumne

Valley Mountain Regional Center
702 North Aurora Street Stockton, CA 95202 209-473-0951
Fax: 209-473-0256

Fresno, Kings, Madera, and Tulare

Central Valley Regional Center 4615 North Marty Ave. Fresno, CA 93722 559-276-4300
Fax: (559) 276-4360

Imperial

San Diego Regional Center 4355 Ruffin Road, Suite 200 San Diego, CA 92123-1648 858-576-2996
Fax: 858-576-2873

Inyo, Kern and Mono

Kern Regional Center 3200 North Sillect Ave. Bakersfield, Ca 93308 661-327-8531
Fax: 661-324-5060

Kern

Kern Regional Center 3200 North Sillect Ave. Bakersfield, Ca 93305 661-327-8531

Los Angeles

Eastern Los Angeles Regional Center 1000 South Fremont Ave., PO Box 7916, Alhambra, CA 91802-4700 626-299-4700

Frank D. Lanterman Regional Center 3303 Wilshire Blvd., Ste. 700, Los Angeles, CA 90010-2197 213-383-1300

Harbor Regional Center 21231 Hawthorne Blvd., Torrance, CA 90503 310-540-1711

North Los Angeles Regional Center 15400 Sherman Way, Ste. 170, Van Nuys, CA 91406 818-778-1900

San Gabriel/Pomona Regional Center 75 Rancho Camino Dr., Pomona, CA 91766 909-620-7722

South Central Los Angeles Regional Center 650 W. Adams Blvd., Ste. 200, Los Angeles, CA 90007 213-744-7000

Westside Regional Center 5901 Green Valley Circle, Ste. 320, Culver City, CA 90230-1024 310-258-4000

Sacramento

Alta California Regional Center 2241 Harvard St., Sacramento, CA 95815 916-978-6400
Fax: (916) 929-1036

San Diego

San Diego Regional Center for the Developmentally Disabled 4355 Ruffin Rd., Ste. 200, San Diego, CA 92123-1648 858-576-2931

San Joaquin and Stanislaus

Valley Mountain Regional Center 702 N. Aurora St., Stockton, CA 95202 209-473-0951
Fax: (209) 473-0256

Reinsurance Claims Unit

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

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Insured service claims should be sent to:

Reinsurance Claims Unit/LNR - C3
Attn: Mail Code - CA-100-03-02
21281 Burbank Blvd.
Woodland Hills, CA 91367

River City Medical Group

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

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River City Medical Group (RCMG) members may contact RCMG to locate a participating optometrist and optician from whom to order and receive lenses and frames.

800-928-1201

Roche

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

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Provider of insulin pumps and supplies to members with diabetes.

800-280-7801

San Diego County Aging and Independence Services

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

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The San Diego County Aging and Independence Services (AIS) provides services to seniors and persons with disabilities and their family members allowing them to remain safely in their homes.

Providers can call the San Diego County AIS for assistance with In-Home Supportive Services (IHSS) or the Multipurpose Senior Services Program (MSSP).

800-510-2020

San Francisco Medi-Cal Field Office

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

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Except for kidney transplants, major organ transplant authorization requests for Medi-Cal members age 21 and over must be sent to the San Francisco Medi-Cal Field Office. 575 Market Street, Suite 400 San Francisco, Ca 94105 415-904-9600

Mailing address: P.O. Box 193704 San Francisco, CA 94119

SilverSneakers Program

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

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Health Net contracts with American Specialty Health Fitness, Inc. to administer and arrange a fitness service for Health Net members in accordance with the member's applicable benefits plan. Refer members to the Silver&Fit® website for more information.

Smiths Medical Inc

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

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Provider of insulin pumps and supplies.

800-826-9703

Solutran

Multi-Benefit Spendables Card

Wellcare By Health Net Dual Special Needs Plan (D-SNP) offer members extra benefits at no cost. Included in the plan, members have an over-the-counter (OTC) benefit where they will receive a fixed dollar monthly allowance amount preloaded into their Wellcare Spendables Card. The monthly allowance rolls over to the following month if unused and expires at the end of the plan year.

Members may use the Wellcare Spendables Card OTC dollars to purchase everyday items like bandages, pain relievers, cold remedies, toothpaste and much more. The card can be used on any combination of the following:

- Over-the-counter items such as cold medicine, first aid supplies, and vitamins.
- Buy groceries.
- Pay for utilities such as electric, gas, trash, water, internet, cable, and phone service.
- Help with the cost of rent for their home.
- Pay for gas at the pump (cannot be used to pay in person at the cash register).

Note:

- Any unused funds will roll over to the next month and will expire at the end of the year.
- The card cannot be used to set up automated, recurring payments.
- The care can only be used up to the available allowance amount.
- The card is similar to a debit card. Members can use their card to pay for eligible items and services at participating retail location or order online that accept Visa.

For more information about this benefit, members may contact Solutran.

855-744-8550
April-September
Monday through Friday
5 a.m.-8 p.m. Pacific time (PT)

October-March
7 days a week
5 a.m.-8 p.m. PT

For more information, visit secure member website.

Sonus

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

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888-383-4521

SONUS

Special Supplemental Nutrition Program For WIC

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

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The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) provides nutrition education and specific foods for women, infants and children from families with low incomes. WIC is temporary and provides supplemental food and nutrition education for a limited time during critical periods of growth and development.

Amador

430 Sutter Hill Rd. Sutter Creek, CA 95685 209-223-7685

Calaveras

209-223-7685

Fresno

Special Supplemental Nutrition Program

Location	Phone Number
Fresno Economic Opportunity Commission	559-263-1150
Huron WIC Clinic	559-945-5090
Kerman WIC Clinic	559-846-6681
Mendota	888-638-7177
Orange Grove	888-638-7177
Parlier WIC Clinic	888-638-7177
Reedley WIC Clinic	888-638-7177
Sanger WIC Clinic	888-638-7177
Selma WIC Clinic	888-638-7177

Imperial

2600 Thomas Dr. El Centro, CA 92243 877-686-5468
Fax: 760-353-2555

Inyo

760-872-1885

Kern

Community Action Partnership 500 E. California Bakersfield, CA 93307 661-327-3074
Fax: (661) 327-2833

Clinica Sierra Vista - WIC Administrative Office 1430 Truxtun Avenue, Suite 300 Bakersfield, CA 93301
661-862-5422
661-326-6490
800-707-4401
Fax: (661) 322-1418

Kings

Special Supplemental Nutrition Program

Location	Phone Number
Hanford, Lemoore, Avenal, Corcoran, Kettleman	559-582-0180

Los Angeles

Special Supplemental Nutrition Program

Location	Phone Number
Antelope Valley Hospital	661-949-5805
Harbor - UCLA Research and Education Institute	310-661-3080
Long Beach	562-570-4242
Northeast Valley Health	818-361-7541 800-942-9675
Orange County Health Care	714-834-8333
Pasadena	626-744-6520
Public Health Foundation Enterprises	888-942-2229 626-856-6600
Watts Health Foundation	323-568-3070

Madera

Special Supplemental Nutrition Program

Location	Phone Number
Madera	559-675-7623
Oakhurst	559-658-7456
Chowchilla	559-201-5000

Mono

760-924-4610

Sacramento

Community Resource Project WIC Program 915 Broadway Sacramento, CA 95818 916-326-5830

Sacramento County Department of Health and Human Services 2251 Florin Road, Suite 100 Sacramento, CA 95822 916-427-5500

San Diego

Special Supplemental Nutrition Program

Location	Telephone Number
American Red Cross WIC	800-500-6411
North County Health Services	Appointment line: 888-477-6333 or 760-471-2743
San Diego State University Foundation	Client Call Center: 888-999-6897
San Ysidro Health Center	Appointment line: 619-426-7966

San Joaquin

San Joaquin County Public Health Services 1145 N Hunter Street Stockton, CA 95202 209-468-3281
Fax 209-468-8573

Stanislaus

Stanislaus County Health Services WIC Program 401 Building E. Paradise Road Modesto, CA 95351
209-558-7377
Fax: 209-558-8318

Tulare

New WIC appointments and client line: 800-360-8840
559-685-2521

Porterville Clinic 1055 West Henderson, Suite 5 Porterville, CA 93257 559-788-1323

Tuolumne

209-533-7434

State Hearing Division

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

Members can ask for a State Hearing in the following ways:

- Online
- By phone:
  - 800-743-8525.
  - TTY/TDD 800-952-8349.
- In writing:
  - Members should fill out a State Hearing form or write a letter. Send it by mail or fax to: Mail: California Department of Social Services

State Hearings Division P.O. Box 944243, Mail Station 9-17-37 Sacramento, CA 94244-2430 Fax:
916-309-3487 or toll-free at 833-281-0903

Teladoc Health

Wellcare By Health Net (Health Net) has partnered with Teladoc Health™ (Teladoc) to give members access to telehealth care at no additional cost. Telehealth, or virtual care, allows members to interact with a doctor, nurse or therapist by phone or video without leaving the comfort and safety of their home for many healthcare services.

Teladoc Health offers convenient telehealth services for members. Through Teladoc Health, members can get confidential access to virtual visits with quality doctors and behavioral health providers. Members can schedule a visit with one of Teladoc Health's U.S. board-certified doctors and behavioral health providers, they can be diagnosed, treated and prescribed medication if medically necessary.

Members can use their telehealth benefit for:

- Non-emergency care from in-network providers using their home phone, laptop, table, or smartphone to connect for a video call.
- Speak to a Nurse 24/7: Get answers to health questions and find out if they need to see a doctor or urgent care center.
- Book a phone or video appointment.

Telehealth services with in-network providers work just like face-to-face in office appointments. Telehealth visits do not require a prior authorization. Plan copays, coinsurance and deductible costs may apply. Members may refer to their plan Summary of Benefits for coverage.

To preregister for Teladoc services, visit Teladoc Health.

800-835-2362 Available 24 hours a day, 7 days a week

Tuberculosis Control Program

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

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Tuberculosis (TB) screening and treatment services for Health Net Medi-Cal members are covered by Health Net under the Department of Health Services (DHS) contract. Health Net collaborates with local health departments (LHDs) to control the spread of TB and to help members get TB treatment. Health Net coordinates with LHDs to establish effective coordination of care. Early diagnosis, immediate reporting to LHDs, and effective TB treatment are critical to interrupting continued transmission of TB. Physicians must report known or suspected cases to the LHD TB Control program office within one day of identification.

Fresno

1221 Fulton Mall P.O. Box 11867 Fresno, CA 93721 559-445-3434
Fax: 559-445-3598

Kern

Department of Public Health Services Chronic Disease Prevention Program 1800 Mt. Vernon Avenue
Bakersfield, CA 93306 661-321-3000

Kings

Kings County Department of Public Health Communicable Disease Services 1400 West Lacey Boulevard
Hanford, CA 93230 559- 584-1401 ext. 2741

Madera

Madera County Public Health Department Communicable Disease Control Program 14215 Road 28 Madera,
CA 93638 559-675-7893
Fax: 559-674-7262

Sacramento

Sacramento County DHHS, Chest Clinic Paul F Hom Primary Care Center 4600 Broadway, Room 1300
Sacramento, CA 95820 916-874-9823
Fax: 916-874-9442

San Diego

Tuberculosis (TB) Control Program 619-540-0194

San Joaquin

San Joaquin County Public Health Services 1601 E. Hazelton Ave. Stockton, CA 95205 209-468-3828
Fax 209-468-8222

Stanislaus

Stanislaus County Health Services Agency 209-558-7700
Fax: 209-558-5014

Tulare

Tulare County Department of Health Services 559-685-2275
Fax: 559-685-4786

Transitional Care Services

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

The Transitional Care Services (TCS) program ensures a smooth transition from one setting to another and reduces re-hospitalization risks and other potentially adverse events. Care Transition Interventions are focused on coaching the member and the member's support system during the inpatient stay and the immediate post-discharge period to ensure timely, safe, and appropriate medical care in the most efficient and cost-effective manner. Knowledge of internal and external processes surrounding the inpatient and post-discharge stay is essential in navigating the health care continuum and addressing barriers to post-discharge success for the member.

Members can call the Transitional Care Services toll free line anytime during their inpatient stay or after their discharge to request TCS support 866-801-6294.

Providers are encouraged to refer members not inpatient to the Complex Case Management Program.

Transplant Team

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

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Transplant Team

Fax: 833-769-1141

TurningPoint Healthcare Solutions, LLC

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

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TurningPoint Healthcare Solutions, LLC is responsible for prior authorization for:

- Certain inpatient and outpatient musculoskeletal surgical procedures for HMO, POS, HSP, EPO, PPO (Commercial) and Medi-Cal lines of business.
- Cardiovascular and ear, nose and throat (ENT) for Commercial lines of business.

TurningPoint Contacts

Phone: 855-332-5898

Fax: 949-774-2254

Email: centenecaum@turningpoint-healthcare.com

Website: MyTurningPoint

Training: Email provider support or contact TurningPoint by telephone at 866-422-0800

VRI

Personal Emergency Response Systems (PERS)

Medical alert systems can provide peace of mind if or when member have a medical emergency. Medicare members are covered for one personal emergency medical response (PERS) device per lifetime and the monthly fee at no additional cost. A PERS device provides peace of mind and 24/7 response to member's emergent and non-emergent needs. Prior authorization may be required.

VRI
800-860-4230, Option 2
Monday through Friday
5 a.m.-5 p.m. Pacific time

For more information, visit VRI.

Wellcare by Health Net Medicare Member Services Department

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

Health Net directs calls about coverage for Medicare members to the Health Net Medicare Member Services Department. If you have questions about Medicare services for these members, contact:

- 800-275-4737 (TTY: 711): Medicare Advantage (HMO) Plans (non-SNP)
- 800-431-9007; (TTY: 711): Medicare Advantage Dual Special Needs Plans (HMO D-SNP) and Medicare Advantage Chronic Special Needs Plans (HMO C-SNP)

Mail to:
Health Net Medicare Advantage for California
PO Box 10420

Van Nuys, CA 91410

Glossary

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

- AIDS
- Appeal
- Certificate of Insurance (COI)
- Clean Claim
- Clinical Trials
- Complaint
- Emergency
- Evidence of Coverage (EOC)
- Facility Site Review
- Grievance
- Hospice Services
- Inquiry
- Investigational Services
- Medical Necessity
- Medical Waste Management Materials
- Medical Information
- Not Medically Necessary
- Offshore
- Opt Out Provider
- Participating Provider
- Primary Care Physician (PCP)
- Psychiatric Emergency Medical Condition
- Residential Treatment
- Telehealth
- Schedule of Benefits or Summary of Benefits (SOB)
- Serious Illness
- Subcontractor
- Unclean Claim

Terms Glossary

This section contains general terms information for providers. Please select a term from the navigation list, or choose your line of business below.

- Medi-Cal Glossary
- Medicare Advantage Glossary
- HMO Glossary
- PPO Glossary

AIDS

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

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The definition of AIDS includes several diagnoses with and without HIV positivity. The services that are directly attributed to these specific diagnoses are paid for through special risk reinsurance. These diagnoses include:

- Candidiasis of esophagus, trachea, bronchi, or lungs
- Cryptococcosis, extrapulmonary
- Cryptosporidiosis with diarrhea in indivduals older than one month
- Cytomegalovirus disease in organs other than liver, spleen or lymph nodes in individuals older than one month
- Kaposi's sarcoma in indivuduals younger that age 60
- Lymphoma of the brain (primary) in individuals younger than age 60
- Mycobacterium avium complex/M. Kansasii disease, disseminate
- Pneumocystis carinii pneumonia
- Progressive multifocal leukoencephalopathy
- Toxoplasmosis of the brain in individuals older than one month
- Herpes simplex virus with an ulcer lasting longer than one month or herpes simplex virus with bronchitis, pneumonia, or esophagitis in individuals older than one month

Additional diagnoses associated with AIDS require a positive HIV test in order to be covered under the special risk reinsurance pool. These diagnoses include:

- CD4 T-lymphocyte count less than 200
- Recurrent pneumonia, more than one episode within one year
- Invasive cervical cancer
- Coccidiomycosis, disseminated
- HIV encephalopathy
- Histoplasmosis, disseminated

- Isosporiasis with diarrhea more than one month
- Non-Hodgkin's lymphoma
- Tuberculosis
- Recurrent salmonella septicemia
- HIV wasting syndrome

Appeal

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

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Member Request for Reconsideration

A verbal or written request to reconsider a previous decision or adverse determination. Requests can be from a member, the member's participating provider or the member's representative and are categorized as: pre-service, post-service, expedited, or external review.

Certificate of Insurance (COI)

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

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The Certificate of Insurance (COI) is a document issued by Health Net Life Insurance Company to employees insured under a group insurance policy, which describes the covered services, supplies and exclusions and limitations that apply to the benefits for which the employee and their insured dependents are eligible. COIs are available to members on the member portal at www.healthnet.com, or in hard copy on request. Providers may obtain a copy of a member's COI by requesting it from the Health Net Provider Services Center. COIs apply to Health Net Life, PPO, EPO and Flex Net plans.

Clean Claim

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

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Physician Clean Claim Definition

Clean claim means a claim that can be processed without obtaining additional information from the provider or from a third party, including invoices that meet DHCS established billing and invoicing requirements.

A clean claim is a claim that has no defect or impropriety, including lack of required substantiating documentation for non-participating providers and suppliers. The member's name, identification number, physician name(s), date of service (DOS), diagnosis code(s), and billed amount among, but not all, the required elements to process the claim.

Emergency services, out-of-area urgently needed services, and out-of-area renal dialysis do not require prior authorization to be considered as a clean claim.

PPG Clean Claim Definition

Clean claim means a claim that can be processed without obtaining additional information from the provider or from a third party, including invoices that meet DHCS established billing and invoicing requirements.

A clean claim is a claim that has no defect or impropriety, including lack of required substantiating documentation for non-participating providers and suppliers. The member's name, identification number, participating physician group (PPG) and physician names, date of service (DOS), diagnosis code(s), and billed amount are among, but not all, the required elements to process the claim.

Emergency services, out-of-area urgently needed services, and out-of-area renal dialysis do not require prior authorization to be considered as a clean claim.

Clinical Trials

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

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Health Net covers routine patient care costs for members participating in a qualifying clinical trial including items and services furnished in connection with participation by members in a qualifying clinical trial. A qualifying clinical trial is a clinical trial in any clinical phase of development that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition.

Routine patient care costs are costs associated with the provision of health care services, including drugs, items, devices, and services that would otherwise be covered under the Medi-Cal program if those drugs, items, devices, and services were not provided in connection with an approved clinical trial program.

Coverage of routine patient care costs is to be provided regardless of geographic location or if the treating provider or principal investigator of the qualifying clinical trial is a network provider. Coverage of routine patient care costs must be based on provider’s and principal investigator’s approval regarding the member’s appropriateness for the qualifying clinical trial.

Authorizations for items and services furnished in connection with participation by members in a qualifying clinical trial are expedited and completed within 72 hours.

Health Net requires the submission of the “Medicaid Attestation Form on the Appropriateness of the Qualifying Clinical Trial” for approval of the clinical trial. The attestation form must include the following information:

1. The member’s name and client identification number;
2. The national clinical trial number;
3. A statement signed by the principal investigator attesting to the appropriateness of the qualified clinical trial; and
4. A statement signed by the provider attesting to the appropriateness of the qualified clinical trial.

Complaint

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

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First Contact Resolution

Any verbal expression of dissatisfaction regarding quality-of-service (excluding quality-of-care) that can be resolved in an initial contact with Health Net's Member Services Department. This first contact resolution must be to the member or participating provider's satisfaction, such that they do not ask for additional assistance or recompense.

Emergency

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

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Health Net follows the Medicare definition of an emergency medical condition and emergency services as follows:

An emergency medical condition is a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency services means covered inpatient and outpatient services that are:

- Furnished by a provider qualified to furnish emergency services; and
- Needed to evaluate or treat an emergency medical condition.

Evidence of Coverage (EOC)

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

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The Evidence of Coverage (EOC) is a document containing statements of the services and benefits to which a Health Net HMO member is contractually entitled. The EOC for each HMO, HSP and POS plan contains comprehensive terms and conditions of Health Net coverage. EOCs are available to members on the member portal at www.healthnet.com, or in hard copy on request. Providers may obtain a copy of a member's EOC by requesting it from the Health Net Provider Services Center. EOCs apply to Health Net HMO, HSP and POS plans only. Language used in these documents is reflective of current laws and regulations and meets disclosure requirements applicable to health plan documents. The text included in the EOC is wholly subject to regulatory review and approval prior to use.

Facility Site Review

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

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All primary care physicians (PCPs) participating in Medi-Cal managed care are required by California statute (Title 22, CCR Section 56230) to complete an initial facility site inspection and subsequent periodic facility site inspections regardless of the status of other accreditation and/or certifications program as part of the initial credentialing process. The full scope site review includes the facility site review (FSR) and medical record review (MRR).

All PCP sites must also undergo the Physical Accessibility Review Survey (PARS). PARS is conducted for participating PCPs, high-volume specialists, ancillary providers, and hospitals. The PARS tool includes 86 criteria and highlights six specific indicators. Based on the outcome of the new PARS (Seniors and Persons with Disabilities (SPD)) evaluation, each PCP site is designated as having basic or limited access, as described below, along with the six specific accessibility indicator designations for parking, external building, interior building, restrooms, exam rooms, and medical equipment (for example, accessible weight scales and adjustable exam tables).

- Basic access - demonstrates facility site access for the members with disabilities to parking, building, elevator, doctor's office, exam room, and restroom. To meet basic access requirements, all 29 critical elements must be met.
- Limited access - demonstrates facility site access for the member with a disability are missing or incomplete in one or more features for parking, building, elevator, doctor's office, exam room, and restroom. Deficiencies in one or more of the critical elements are encountered.

Results of the PARS assessment component of the FSR audit are made available to the Health Net Medi-Cal Member Services Department and CalViva Health Medi-Cal Member Services to assist members in selecting a PCP that can best serve the member's health care needs.

Grievance

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

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Grievance means any expression of dissatisfaction about any matter other than an adverse benefit determination (ABD), and may include, but is not limited to: the quality of care or services provided, aspects of interpersonal relationships with a provider or contractor's employee, failure to respect a member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by contractor to make an authorization decision. A complaint is the same as grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other contractor processes.

Hospice Services

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

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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.

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.

Inquiry

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

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Member Question

Any verbal or written question for clarification, without an expression of dissatisfaction or request for reconsideration (such as a request for information or action by a member).

Investigational Services

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

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This definition is provided for illustrative purposes only. Consult the applicable health benefit plan contract (member's *Evidence of Coverage*) for the specific definition of *investigational or experimental.*

Investigational or experimental is used to describe a service (a medication, biological product, device, equipment, medical treatment, therapy, or procedure) that Health Net has determined is not presently recognized as standard medical care for a medically diagnosed condition, illness, disease, or injury.

A service is considered experimental or investigational if it meets any of the following criteria:

- It is currently the subject of an active and credible evaluation (such as clinical trial or research) to determine:

- ◦ Clinical efficacy
  ◦ Therapeutic value of beneficial effects on health outcomes
  ◦ Benefits beyond any established medical based alternatives

- It does not have final clearance from applicable government regulatory bodies, such as the United States Food and Drug Administration (FDA), and unrestricted market approval for use in the treatment of a specified medical condition of the condition for which authorization of the service is requested and is the subject of an active and credible evaluation
- The most recent peer-reviewed scientific studies published or accepted for publication by nationally recognized medical journals do not conclude, or are inconclusive in finding, that the service is safe and effective for the treatment of the condition for which authorization of the service is requested

Medical Necessity

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

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Definitions of Medical Necessity and Investigational Services

Health Net's has provided clarification of terms used in its medical policies for medical necessity, investigational or experimental, and not medically necessary and not investigational. This clarification should enable participating physician groups (PPGs) to more quickly determine whether a service is considered investigational and, therefore, submit the request for a proposed service timely to Health Net for utilization management (UM) review and determination based on the terms of the provider's contract.

Commercial

Except where state or federal law or regulation requires a different definition, Health Net defines “Medically Necessary” or comparable terms in each agreement with physicians, physician groups, and physician organizations and will not include in any such agreement a definition of Medical Necessity that is different from this definition. “Medically Necessary” or “Medical Necessity” shall mean health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and
- Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease. For these purposes, “generally accepted standards of medical practice” means

standards that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors.

Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease. For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors.

Pursuant to Insurance Code, Section 10144.52, Health Net bases any medical necessity determination or the utilization review criteria that the Plan, and any entity acting on the Plan's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders on current generally accepted standards of mental health and substance use disorder care.

Medi-Cal

Medically Necessary or Medical Necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I section 14059.5(a) and 22 CCR section 51303(a). Medically Necessary services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.

Medically Necessary or Medical Necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I section 14059.5(a) and 22 CCR section 51303(a). Medically Necessary services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.

Behavioral Health Medical Necessity or Medically Necessary Definition

Except where state or federal law or regulation requires a different definition, the behavioral health team shall apply the following definition of medically necessary (Health & Safety Code: 1374.72 (3)(A)

A service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

1. In accordance with the generally accepted standards of mental health and substance use disorder care.
2. Clinically appropriate in terms of type, frequency, extent, site, and duration.
3. Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.

"Generally accepted standards of mental health and substance use disorder care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment pursuant to Section 1374.73. Valid, evidence-based sources establishing generally accepted standards of mental health and substance use disorder care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

Medi-Cal Specialty Mental Health Services (SMHS)

The federal Section 1915(b) Medi-Cal Waiver requires Medi-Cal members needing SMHS to access these services through MHPs. For individuals under 21 years of age and in accordance with California Welfare & Institutions Code (W&I Code) sections 14059.5 and 14184.402, a service is "medically necessary" or a "medical necessity" if the service meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard set forth in Section 1396d(r)(5) of Title 42 of the United States Code (USC).

The federal EPSDT mandate requires states to furnish all services it defines as appropriate and medically necessary services that could be covered under Medicaid 42 USC Section 1396d(a) necessary to correct or ameliorate health conditions, including behavioral health conditions, discovered by a screening service, regardless of whether those services are covered in the state's Medicaid State Plan.

Consistent with federal guidance from the Centers for Medicare & Medicaid Services (CMS), behavioral health services need not be curative or completely restorative to ameliorate a behavioral health condition. Services that sustain, maintain, support, improve, or make more tolerable a behavioral health condition are considered to ameliorate the condition and are thus medically necessary and are covered under the EPSDT mandate.

By contrast, for members who are 21 years of age and older, a service is medically necessary when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain (W&I code section 14059.5).

Medicare Advantage

The Centers for Medicare and Medicaid Services (CMS) defines medical necessity and medically necessary services as services or supplies that: are proper and needed for the diagnosis or treatment of medical conditions, are provided for the diagnosis, direct care, and treatment of the member's medical condition, meet the standards of good medical practice in the local area; and are not mainly for the convenience of the patient or health care provider.

Medical Waste Management Materials

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

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The following are definitions of medical waste management materials:

Biohazard bag - A disposable red bag that is moisture-resistant and has sufficient strength to withstand ripping, tearing or bursting under normal conditions of use. A biohazard bag must be certified by the manufacturer and constructed of material of sufficient thickness strength to pass the 165 g dropped dart impact resistant test.

Biohazardous waste - Laboratory waste, including:

- medical and pathological human specimen cultures
- cultures and stocks of infectious agents
- waste from the production of bacteria, viruses or the use of spores, discarded live and attenuated vaccines, culture dishes and contaminated devices used for above
- discarded waste from specimens sent to the laboratory
- human specimens or tissues removed during surgery or autopsy, which are suspected by the attending physician or dentist of being contaminated with infectious agents

Medical waste - Biohazardous waste, sharps waste or waste generated or produced as a result of diagnosis, treatment or immunization of human beings. Medical waste may be infectious.

Sharps waste - Any device having acute rigid corners or edges or projections capable of cutting or piercing, including:

- hypodermic needles, syringes, blades, and needles
- broken glass items, pipettes and vials that are contaminated with other medical waste

Medical Information

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

“Medical information” is any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health care service plan, pharmaceutical company, or contractor regarding a patient’s medical history, mental health application information, reproductive or sexual health application information, mental or physical condition, or treatment.

“Individually identifiable” means that the medical information includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient’s name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the identity of the individual.

“Mental health application information” means information related to a consumer’s inferred or diagnosed mental health or substance use disorder, as defined in Section 1374.72 of the Health and Safety Code, collected by a mental health digital service.

“Mental health digital service” means a mobile-based application or internet website that collects mental health application information from a consumer, markets itself as facilitating mental health services to a consumer, and uses the information to facilitate mental health services to a consumer.

- Reproductive or sexual health application information – information about a consumer’s reproductive health, menstrual cycle, fertility, pregnancy, pregnancy outcome, plans to conceive, or type of sexual activity collected by a reproductive or sexual health digital service, including, but not

limited to, information from which one can infer someone's pregnancy status, menstrual cycle, fertility, hormone levels, birth control use, sexual activity, or gender identity.
- Reproductive or sexual health digital service – a mobile-based application or internet website that collects reproductive or sexual health application information from a consumer, markets itself as facilitating reproductive or sexual health services to a consumer, and uses the information to facilitate reproductive or sexual health services to a consumer.
- "Sensitive services" means 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, 6925, 6926, 6927, 6928, 6929, and 6930 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the service specified in the section.

A business entity that offers a "sexual health digital service" is now considered a "provider" under the California Medical Information Act (CMIA, 56.06)(e).

- Any business that offers a reproductive or sexual health digital service to a consumer for the purpose of allowing the individual to manage the individual's information, or for the diagnosis, treatment, or management of a medical condition of the individual, shall be deemed to be a provider of health care subject to the requirements of this part. However, this section shall not be construed to make a business specified in this subdivision a provider of health care for purposes of any law other than this part, including, but not limited to, laws that specifically incorporate by reference the definitions of this part.

Not Medically Necessary and Not Investigational

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

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Evaluation and clinical recommendations are assessed according to the scientific quality of the supporting evidence and rationale (such as national medical associations, independent panels or technology assessment organizations).

A service is considered not medically necessary and not investigational if it meets any of the following criteria:

- There are no studies of the service described in recently published peer-reviewed medical literature
- There are no active or ongoing credible evaluations being undertaken of the service, which has previously been considered not medically necessary
- There is conclusive evidence in published peer-reviewed medical literature that the service is not effective
- There are no peer-reviewed scientific studies published or accepted for publication by nationally recognized medical journals that demonstrate the safety or efficacy of the use of the service
- It is contraindicated

Offshore

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

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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 American 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.

Opt Out Provider

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

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A provider who has opted out of Medicare has terminated their Part B contract with Medicare by submitting a valid affidavit to the local Medicare carrier. Affidavits are valid for two years. After the two-year period has expired, the provider may elect to return to Medicare or opt out again. Services received from a provider that has opted out of Medicare are not covered.

Participating Provider

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

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A facility, physician, physician organization, other health care provider, supplier, or other organization, which has met applicable credentialing and/or recredentialing requirements, if any, and has, or is governed by, an effective written agreement directly with Health Net, or indirectly through another entity, such as, another participating provider, to provide covered services.

Primary Care Physician (PCP)

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

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A doctor of medicine (MD), doctor of osteopathy (DO) or other health care professional who: (1) is duly licensed and qualified under the laws of the relevant jurisdiction to render contracted services; (2) is a participating provider and (3) meets the credentialing standards of Health Net for designation as a PCP and who provides for continuity of care and 24-hour-a-day, seven-day-a-week availability to beneficiaries.

Psychiatric Emergency Medical Condition

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

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A psychiatric emergency medical condition is a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the member as being either of the following:

- An immediate danger to himself or herself or to others
- Immediately unable to provider for, or utilize, food, shelter, or clothing, due to the mental disorder

Residential Treatment

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

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Residential treatment is available, based on medical necessity with this added benefit. Medi-Cal members seeking residential treatment are referred to their respective county Specialty Mental Health division .

A residential treatment center is defined as a 24-hour, structured and supervised group living environment for children, adolescents or adults where psychiatric, medical and psychosocial evaluation can take place, and distinct and individualized psychotherapeutic interventions can be offered to improve their level of functioning in the community. This plan requires that all contracting residential treatment centers hold appropriate licensure by their state in order to provide residential treatment services.

This plan does not cover admission to the following residential treatment facility types as they are not considered to be medical treatment:

- Foster homes or halfway houses

- Wilderness Center training
- Therapeutic boarding schools
- Custodial care, situation or environmental change

Telehealth

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

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Telehealth is the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care. Telehealth facilitates patient self-management and caregiver suppot for patients and includes synchronous interactions and asynchronous store and forward transfers.

- **Originating site** - The site where a patient is located at the time health care services are provided via telecommunications system or where the asynchronous store and forward transfer originates.
- **Distant site** - The site where a health care provider who provides health care services is located while providing these services via a telecommunications system.
- **Synchronous interaction** - A real-time interaction between a patient and a health care provider located at a distant site.
- **Asynchronous store and forward transfer** - The transmission/transfer of a patient's medical information from an originating site without the patient being present to the health care provider at a distant site.

Schedule of Benefits or Summary of Benefits (SOB)

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

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The Schedule of Benefits is a brief list of benefits, with applicable copayment, coinsurance and deductible information for the member's health plan. It does not list the exclusions and limitations or other important legal and contractual terms applicable to the plan; these are described in the EOC or COI.

The Schedule of Benefits is called the Summary of Benefits for certain Medicare Advantage plans, including C-SNP and D-SNP. The Summary of Benefits has the same information as the Schedule of Benefits but in a slightly different format.

The Schedule of Benefits and Summary of Benefits are available to members on the member portal at www.healthnet.com, or in hard copy on request. Providers may access members' Schedule of Benefits on the provider portal. Once you log in, select *Patients* > the applicable member from the list > *Schedule of Benefits* .

Schedule of Benefits are available for all Health Net plans (except California Medi-Cal plans)

Serious Illness

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

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Serious illness is defined as a condition that may result in death, regardless of the estimated length of the patient's remaining period of life.

Subcontractor

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

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A subcontractor is any organization with which a first-tier, downstream or related entity contracts to fulfill or help fulfill requirements in its contracts.

Note: A subcontractor means an individual or entity who has a subcontract with the plan that relates directly or indirectly to the performance of the plan's obligation under the contract with the Department of Health Care Services (DHCS).

Unclean Claim

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

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An unclean claim lacks sufficient information to pay or deny, and results in an examiner requesting information from a source outside the Medicare Advantage Organizations (MAOs), such as a participating physician group (PPG) or hospital. The following are examples of claims considered to be unclean (this list is not all inclusive):

- A claim does not have the necessary fields completed to process the claim, for example, the provider identification (ID) number.
- The claim does not have a diagnosis that is immediately identifiable as an emergency, out-of-area urgently needed service, or out-of-area renal dialysis.
- The claim lacks the necessary medical records for medical review to determine the medical necessity or liability for urgent or emergency care.
- A claim that appears to be fraudulent or is in a foreign language or currency.

Unclean Claim Adjudication

In accordance with standards established by the Centers for Medicare & Medicaid Services (CMS), MAOs and PPGs are required to pay or deny non-clean claims within 60 calendar days of receipt.