Provider Manual - Combined

Table of Contents

Provider Manual

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

The “PureCare” Health Care Services Plan (HSP) Operations Manual offers Health Net providers access to important plan benefits, limitations and administration processes to make sure members enrolled in the HSP receive covered services when needed. The Health Net HSP 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 HSP Operations Manual apply to the HSP, unless specified otherwise in the Provider Participation Agreement (PPA), *Schedule of Benefits* or member's Evidence of Coverage (EOC).

The three provider types - Physicians, Hospitals and Ancillary - are listed at the top of every page. In certain instances, you may see a fourth provider type listed, Participating Physician Groups (PPGs). When a PPG provider type is listed, you will be notified that content does not apply to HSP. 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.

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

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.

Department Of Managed Health Care

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

Back to previous page

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

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.

Grievances

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

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

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

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

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

DMHC Notices of Translation Assistance, Forms and Applications

DMHC Notices of Translation Assistance

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

Translated DMHC Complaint (Grievance) Forms

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

Translated DMHC IMR Applications

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

Ancillary Providers and Notice of Language Assistance

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

Provider Appeals and Dispute Resolution

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

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

Select any subject below:

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

Overview

Provider Type: Physicians | 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 (PDF), a written determination following 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 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.

Contact the Health Net Provider Services Center to check the status of an appeal or dispute.

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.

Benefits

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

This section contains general member benefit information.

Benefits in Alphabetical Order

Select any subject below:

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

A

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

B

- Bariatric Surgery
- Behavioral Health
- Blood

C

- Chemotherapy
- Chiropractic

D

- Dental Services
- Dialysis
- Durable Medical Equipment

E

- Essential Health Benefits

F

- Family Planning

G

- General Benefit Exclusions and Limitations
- Genetic Testing

H

- Hearing
- Home Health Care
- Hospice Care
- Hospital and Skilled Nursing

I

- Immunizations

- Injectables

J

K

L

M

- Maternity
- Medical Social Services

N

- Nuclear Medicine
- Nurse Midwife

O

- Outpatient Services

P

- Periodic Health Evaluations
- Preventive Services
- Prosthesis

Q

R

- Rehabilitation Therapy

S

- Support for Disabled Members
- Surgery, Surgical Supplies and Anesthesia

T

- TMJ
- Transgender Services
- Transplants

U

V

- Vision

W

X

- X-Ray and Laboratory Services

Y

Z

Acupuncture

Provider Type: Physicians | 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).

Alcohol and Drug Abuse

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

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

Select any subject below:

- Overview
- Substance Abuse Facilities
- Substance Abuse Rehabilitation Services

Overview

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

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

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

Exclusions and Limitations

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

Substance Abuse Facilities

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

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

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

Substance Abuse Facilities - Outpatient

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

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

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

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

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

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

Substance Abuse Rehabilitation Services

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

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

Substance Abuse Rehabilitation Exclusions and Limitations

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

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

Allergy Treatment

Provider Type: Physicians | Participating Physician Groups (PPG)

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

Ambulance

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

This section contains general member benefit information on ambulance services.

Select any subject below:

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

Transfer of Members Hospitalized Out of Area

Provider Type: Hospitals | Ancillary

Occasionally, a Health Net member is hospitalized at a 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 as soon as possible. Health Net monitors the member's treatment and transfers the member, when possible, to a participating facility. Transfer is usually by nonemergent ground or air ambulance, although some members may be safely transported by other less costly means.

ModivCare

Provider Type: Physicians | Ancillary | Hospitals

ModivCare™ (formerly LogistiCare) is Health Net of California's preferred provider for all covered, non-emergency transportation services for HSP members.

Providers must request non-emergency transportation services (other than 911) through ModivCare. Health Net only reimburses for transports that are medically necessary and covered by the member's benefit plan.

Include the following information when requesting non-emergency transportation services:

- Health Net member's diagnosis.
- Reason for transport.
- Requesting party.
- Schedule and trip information.

ModivCare works with providers to determine the level of transportation needed and schedules pick-up and return time, if necessary.

Ambulance (Air or Ground)

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

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

Autism Spectrum Disorders

Provider Type: Physicians | Ancillary

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 Autism Spectrum Disorders are available online at https://brightfutures.aap.org. Additional AAP autism resources are available at www.healthychildren.org.

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 as well as the member with ASD; 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 professiona” means an individual who meets all of the following criteria:

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

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

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

- Has adequate education, training, and experience, as certified by a qualified autism service provider or an entity or group that employs qualified autism service providers.
- Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.

Educational Services

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 (IBI), 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 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 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 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

Bariatric Surgery

Provider Type: Physicians | Hospitals

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

Participating physicians may submit prior authorization requests for bariatric surgery to Health Net Prior Authorization Department.

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
- Behavioral Health Customer Service
- Coordination of Care
- Day Care Treatment
- Dual Diagnosis
- Employee Assistance Program
- Exclusions

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.

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

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.

Obtaining Behavioral Health and Substance Abuse Care

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

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

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

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

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

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

Out-of-Area Cases Involving an Acute Medical Diagnosis

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

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

Blood

Provider Type: Physicians | Participating Physician Groups (PPG)

Blood and blood plasma, and derivatives are covered.

This coverage includes all of the following:

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

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

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

Chemotherapy

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

This section contains general member benefit information on chemotherapy.

Select any subject below:

- Overview

Overview

Provider Type: Physicians | Ancillary

Chemotherapy is covered when it is provided by a participating provider in an inpatient hospital setting, outpatient setting or in the member's home. Visits for treatment are not considered office visits; however, some copayments may apply.

Health Net's preferred home infusion provider, Coram CVS, must be used for home chemotherapy services for HSP members.

Chiropractic

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

This section contains general member benefit information on chiropractic services.

Select any subject below:

- Coverage Explanation

Coverage Explanation

Provider Type: Physicians

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

Chiropractic services for treatment or diagnosis of musculosketetal and related disorders and pain syndromes are a covered benefit for some Health Net HSP members. Refer to the member's Evidence of Coverage (EOC) to confirm if the member is eligible for chiropractic services.

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

Refer the member to ASH Plans or the Health Net Member Services Department as directed by the member's EOC or Schedule of Benefits for more information.

Coverage Criteria

Chiropractic services are subject to the medical benefits exclusions, limitations and authorization protocols listed in the EOC. Members 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 as stated in the Schedule of Benefits or 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; the applicable specialist copayment applies.

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. The following services or supplies are not covered:

- Examinations or treatments for conditions other than those related to musculoskeletal 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, magnets used for diagnostic or therapeutic use, nerve conduction studies (for example, EEG, EMG, SEMG, SSEP, and NCV), electrocardiogram (EKG) studies, or interpretation or electrodiagnostic (EDX) studies performed at an outside facility.
- 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.
- Massage therapy.

- Services provided by a chiropractor practicing outside the service area, except for emergency or urgent services.

Dental Services

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

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

Select any subject below:

- Overview
- General Anesthesia Coverage and Exclusions

Overview

Provider Type: Physicians | Participating Physician Groups (PPG)

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

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

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

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

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

Coverage Explanation

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

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

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

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

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

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

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

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

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

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).

General Anesthesia Coverage and Exclusions

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

General Anesthesia Coverage

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

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

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

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

General Anesthesia Exclusions

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

Dialysis

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

This section contains general member benefit information on dialysis.

Select any subject below:

- Overview

Overview

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

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

Out-of-Area Dialysis

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

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

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

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

Out-of-Country Dialysis

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

Durable Medical Equipment

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

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

Select any subject below:

- Overview

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.

Exclusions and Limitations

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

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

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

Orthotics

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

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

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

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

Overview

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

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

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

Contraceptive Devices

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

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

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

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

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

Intrauterine Devices

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

Exclusions and Limitations

The following are exclusions and limitations on family planning coverage:

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

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

General Benefit Exclusions and Limitations

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

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

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

- Disposable supplies - Disposable supplies for home use are not covered (for example, plastic gloves, diapers, incontinence pads, and wipes). Coverage for outpatient prescription medications includes coverage for disposable devices that are medically necessary for the administration of a covered outpatient prescription medication, such as spacers and inhalers for the administration of aerosol outpatient prescription medications, and syringes for self-injectable outpatient prescription medications that are not dispensed in pre-filled syringes
- Experimental or investigative services and supplies - All services and supplies not generally recognized under standards of care in the medical community are not covered, except for routine patient care costs associated with participation in clinical trials for a Health Net member with a diagnosis of cancer and has the recommendation of their treating physician. The exclusion from coverage does not include treatment of medical complications relating to, or arising out of, such services and supplies. Health Net decides whether a service or supply is experimental or investigational
- Eyeglasses and contact lenses - Contact lenses (except an implanted lens that replaces the organic eye lens) and eyeglasses are not covered, unless specifically provided in the member's EOC
- Genetic testing and diagnostic procedures - Covered when determined by Health Net to be medically necessary. The prescribing physician must request prior authorization for coverage. Genetic testing is not covered for non-medical reasons or when a member has no medical indication or family history of a genetic abnormality. Every health care service plan contract that covers hospital, medical or surgical expenses through an employer group, and which offers maternity coverage in such groups, also offers coverage for prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy
- Hearing aids - Any device inserted in or affixed to the outer ear to improve hearing is not covered, unless specifically provided in the member's EOC
- Ineligible status - Services or supplies provided before the effective date of coverage or after the date coverage has ended are not covered, except as specified in the extension of benefits portion of the member's EOC
- No-charge items - Services or supplies the member is not required to pay for or for which no charge is made are not covered
- Non-covered items - Durable medical equipment (DME) is a covered benefit on all health plans. Refer to the Schedule of Benefits to determine exclusions, limitations and applicable copayments. Non-covered items are:
- Exercise or hygienic equipment, including shower chairs and benches, bath tub lifts, exercise bicycles, treadmills, free weights
- Supplies to achieve cleanliness even when related to other medical services
- Surgical dressings, except primary dressings that are applied directly to lesions either of the skin or surgical incision, which are covered as a standard medical benefit. Over-the-counter dressings and supplies are not covered
- Jacuzzis and whirlpools
- Stockings, such as elastic stockings, job stocking and support hose, garter belts and similar devices, as not within the definition of brace
- Orthotics that are not custom-made to fit the member's body. Orthotics are orthopedic appliances or apparatus used to support, align, prevent, or correct deformities or to improve the function of moveable parts of the body. Coverage includes leg, arm, back, and neck braces and trusses. Back braces include special corsets and sacroiliac, sacrolumbar and dorsolumbar corsets and belts
- Corrective footwear (specialized shoes, arch supports and inserts) except for the treatment of diabetes-related medical conditions or as specifically provided in the member's EOC
- Non-eligible institutions - Services or supplies provided by any institution other than a licensed and approved hospital or Medicare-approved skilled nursing facility (SNF) or other properly licensed

facility specified as covered in the member's EOC are not covered. Any institution that is primarily a place for the aged, a nursing home or any similar institution, regardless of how designated, is not an eligible institution
- Non-prescription (over-the-counter) medications, equipment and supplies - Any medication, equipment and supplies that can be purchased without a prescription order is not covered, even if a physician writes a prescription for it (except insulin and diabetic supplies or as specifically provided in the EOC)
- Personal or comfort items - Personal or comfort items such as a telephone or television in the room at a hospital or SNF are not covered
- Private-duty nursing - Private-duty nurses are not covered for a registered bed patient in a hospital or long-term care facility
- Private rooms - Private rooms in a hospital or SNF are not covered unless it is deemed to be medically necessary
- Refractive eye surgery - Any eye surgery for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), far-sightedness (hyperopia) and astigmatism, is not covered
- Reversal of surgical sterilization - Reversal of a prior voluntary surgical sterilization procedure is not covered
- Routine physical examinations - Routine physical examinations are not covered for insurance, licensing, employment, school, camp, or other non-preventive purposes, unless specifically provided otherwise in the EOC. On plans that cover routine physical examinations, the exam itself and any related X-ray and laboratory procedures are covered; however, completion of any related forms are not covered. Refer to the specific plan in the Schedule of Benefits
- Services for obtaining or maintaining insurance are not covered
- Sterilization is not covered for males and females. Refer to the specific plan in the Schedule of Benefits or EOC for exceptions
- Substance abuse - Treatment of chronic alcoholism, drug addiction and other substance abuse problems, except for acute detoxification and the acute medical treatment of these problems. Other services not covered include: non-medical ancillary services; prolonged rehabilitation services, including inpatient, residential and outpatient substance abuse program; psychological counseling and aversion therapy. The terms and conditions applied to these benefits must be the same as those applied to other medical benefits under the plan contract due to federal mental health parity laws. Refer to the specific plan in the Schedule of Benefits for exceptions
- Unauthorized services and supplies - Any services or supplies not authorized according to procedures Health Net and the participating physician group (PPG) have established are not covered
- Unlisted services - Services or supplies that are not specified as covered services or supplies are not covered, unless coverage is required by law

General Benefit Exclusions and Limitations (Physicians Only)

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

- Blood - Services and supplies for the collection, preservation and storage of umbilical cord blood, cord blood stem cells and adult stem cells are not covered

- Conception by medical procedure - The collection, storage or purchase of sperm or ova is not covered
- Cosmetic services and supplies - Services and supplies performed solely to alter or reshape normal structures of the body in order to improve appearance are not covered. These include:
    - Hair transplant, hair analysis, hairpieces, wigs, and cranial or hair prostheses
    - Chemical face peels and abrasive procedures of the skin
    - Liposuction of any body part
    - Epilation
- In contrast to the exclusion for cosmetic surgery, reconstructive surgery is performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:
    - To improve function
    - To create a normal appearance, to the extent possible
    - Coverage for reconstructive surgery also includes:
        - Breast surgery and all stages of reconstruction for the breast on which a medically necessary mastectomy was performed and to produce a symmetrical appearance, surgery and reconstruction of the unaffected breast
        - Medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate, including cleft lip or other craniofacial anomalies associated with cleft palate
    - Custodial or domiciliary care - Services and supplies that are provided primarily to assist with the activities of daily living are not covered, regardless of the type of facility. Care provided by a hospice for a terminally ill member or for a condition that requires continuous skilled nursing services is not considered custodial or domiciliary
- Dental services - Care or treatment of teeth and gingival tissues, extraction of teeth; treatment of dental abscess or granuloma, other than tumors, dental examinations, spot grinding, crowns, bridge work, onlays, inlays, dental implants, braces, and any orthodontic appliances are not covered unless specifically provided in the member's EOC
- Disorders of the jaw -Treatment and services for temporomandibular joint (TMJ) disorder are covered when determined to be medically necessary, except:
    - Crowns
    - Inlays
    - Onlays
    - Dental implants
    - Bridgework (to treat dental conditions related to TMJ disorder)
    - Braces and active splints for orthodontic purposes (movement of teeth)
- Disposable supplies - Disposable supplies for home use are not covered (for example, plastic gloves, diapers, incontinence pads, and wipes). Coverage for outpatient prescription medications includes coverage for disposable devices that are medically necessary for the administration of a covered outpatient prescription medication, such as spacers and inhalers for the administration of aerosol outpatient prescription medications, and syringes for self-injectable outpatient prescription medications that are not dispensed in pre-filled syringes
- Experimental or investigative services and supplies - All services and supplies not generally recognized under standards of care in the medical community are not covered, except for routine patient care costs associated with participation in clinical trials for a Health Net member with a diagnosis of cancer who has the recommendation of their treating physician. The exclusion from coverage does not include treatment of medical complications relating to, or arising out of, such services and supplies. Health Net decides whether a service or supply is experimental or investigational

- Eyeglasses and contact lenses - Contact lenses (except an implanted lens that replaces the organic eye lens) and eyeglasses are not covered, unless specifically provided in the member's EOC
- Genetic testing and diagnostic procedures - Covered when determined by Health Net to be medically necessary. The prescribing physician must request prior authorization for coverage. Genetic testing is not covered for non-medical reasons or when a member has no medical indication or family history of a genetic abnormality. Every health care service plan contract that covers hospital, medical or surgical expenses through an employer group, and which offers maternity coverage to such groups, also offers coverage for prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy
- Hearing aids - Any device inserted in or affixed to the outer ear to improve hearing is not covered, unless specifically provided in the member's EOC
- Ineligible status - Services or supplies provided before the effective date of coverage or after the date coverage has ended are not covered, except as specified in the extension of benefits portion of the member's EOC
- No-charge items - Services or supplies the member is not required to pay for or for which no charge is made are not covered
- Non-covered items - Durable medical equipment (DME) is a covered benefit on all health plans. Refer to the Schedule of Benefits to determine exclusions, limitations and applicable copayments. Non-covered items are:
    - Exercise or hygienic equipment, including shower chairs and benches, bath tub lifts, exercise bicycles, treadmills, and free weights
    - Supplies to achieve cleanliness even when related to other medical services
    - Surgical dressings, except primary dressings that are applied directly to lesions either of the skin or surgical incision, which are covered as a standard medical benefit. Over-the-counter dressings and supplies are not covered
    - Jacuzzis and whirlpools
    - Stockings, such as elastic stockings, job stocking and support hose, garter belts and similar devices, as not within the definition of brace
    - Orthotics that are not custom-made to fit the member's body. Orthotics are orthopedic appliance or apparatus used to support, align, prevent, or correct deformities or to improve the function of moveable parts of the body. Coverage includes leg, arm, back, and neck braces and trusses. Back braces include special corsets and sacroiliac, sacrolumbar and dorsolumbar corsets and belt
    - Corrective footwear (specialized shoes, arch supports and inserts) except for the treatment of diabetes-related medical conditions, or as specifically provided in the member's EOC
- Non-eligible institutions - Services or supplies provided by any institution other than a licensed and approved hospital or Medicare-approved skilled nursing facility (SNF) or other properly licensed facility specified as covered in the member's EOC are not covered. Any institution that is primarily a place for the aged, a nursing home, or any similar institution, regardless of how designated, is not an eligible institution
- Non-prescription (over-the-counter) medications, equipment and supplies - Any medications, equipment and supplies that can be purchased without a prescription order is not covered, even if a physician writes a prescription for it (except insulin and diabetic supplies or as specifically provided in the EOC)
- Personal or comfort items - Personal or comfort items, such as a telephone or television in the room at a hospital or SNF, are not covered
- Private-duty nursing - Private-duty nurses are not covered for a registered bed patient in a hospital or long-term care facility

- Private rooms - Private rooms in a hospital or SNF are not covered unless it is deemed to be medically necessary
- Refractive eye surgery - Any eye surgery for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), far-sightedness (hyperopia) and astigmatism is not covered
- Reversal of surgical sterilization - Reversal of a prior voluntary surgical sterilization procedure is not covered
- Routine physical examinations - Routine physical examinations are not covered for insurance, licensing, employment, school, camp, or other non-preventive purposes, unless specifically provided otherwise in the EOC. On plans that cover routine physical examinations, the exam itself and any related X-ray and laboratory procedures are covered; however, completion of any related forms are not covered. Refer to the specific plan in the Schedule of Benefits
- Services for obtaining or maintaining insurance are not covered
- Sterilization is not covered for males and females. Refer to the specific plan in the Schedule of Benefits or EOC for exceptions
- Substance abuse - Treatment of chronic alcoholism, drug addiction and other substance abuse problems are not covered, except for acute detoxification and the acute medical treatment of these problems. Other services not covered include: non-medical ancillary services; prolonged rehabilitation services, including inpatient, residential and outpatient substance abuse program; psychological counseling and aversion therapy. The terms and conditions applied to these benefits must be the same as those applied to other medical benefits under the plan contract due to federal mental health parity laws. Refer to the specific plan in the Schedule of Benefits for exceptions
- Unauthorized services and supplies - Any services or supplies not authorized according to procedures Health Net has established are not covered
- Unlisted services - Services or supplies that are not specified as covered services or supplies are not covered, unless coverage is required by law

Genetic Testing

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

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

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

Genetic Testing Coverage

Medically necessary genetic testing is covered for the following conditions:

- Tay-Sachs disease (TSD)
- Von Hippel-Lindau disease (or syndrome)

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

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

Indications for Covering Genetic Testing

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

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

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

Hearing

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

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

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

Hearing Aid

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

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

When hearing aids are a covered benefit, coverage includes a standard hearing device, analog or digital, inserted into the canal or affixed to the outer ear to restore adequate hearing to the member and as determined to be medically necessary by a Health Net participating provider or audiologist. This includes repair and maintenance of the devices at no cost to the member. Plans may limit the number of hearing aids or covered charges permitted in a certain time period.

Exclusions and Limitations

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

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

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

Home Health Care

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

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

Home Health Care Services

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

The following are additional components of home health care:

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

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

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

Service Providers

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

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

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

Homebound Determination

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

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

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

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

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

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

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

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

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

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

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

Exclusions and Limitations

The following are not covered:

- food, housing, homemaker services, and home-delivered meals.

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

Authorization Guidelines

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

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

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

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

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

Physician Certification

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

to be made only once where the member may require over a period of time the furnishing of the same item or service related to one diagnosis.

Physician Recertification

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

Ongoing Care

Participating providers initiate home health care services as follows:

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

For more information, select any subject below:

- Skilled Nursing Services MEDICARE CMC EPO HMO PPO

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.

Home Health Care

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

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

Home Health Care Services

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

The following are additional components of home health care:

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

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

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

Service Providers

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

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

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

Homebound Determination

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

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

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

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

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

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

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

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

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

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

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

Exclusions and Limitations

The following are not covered:

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

Authorization Guidelines

The participating provider prescribes treatment and the home health agency then proposes, develops and submits a treatment plan, signed by the physician, to the participating physician group (PPG) (for members affiliated with a PPG) or Health Net (for members not affiliated with a PPG) for review and approval. For members affiliated with a PPG, the PPG is required to complete the Authorization for Treatment form for the member. The treatment plan summarizes the services provided, the member's progress, the member's

response to treatment, and recommendations for continued service. The participating provider reviews the treatment plan at least every 60 days and signs it to verify that the services provided are medically necessary.

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

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

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

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

Physician Certification

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

Physician Recertification

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

Ongoing Care

Participating providers initiate home health care services as follows:

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

For more information, select any subject below:

- Skilled Nursing Services MEDICARE CMC EPO HMO PPO

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
- Claims Submission

Hospice Services

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

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

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

Description

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

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

Hospice Consideration Request

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

Certification of Terminal Illness

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

Hospice Referrals

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

Medications, Medical Equipment, and Supplies

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

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

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

Short-Term Inpatient Care

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

Short-term inpatient care is considered acute care hospitalization.

Skilled Nursing Services

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

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

Counseling Services

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

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

Bereavement Counseling

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

Period of Crisis

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

Respite Care

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

Volunteer Services

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

Claims Submission

Provider Type: Physicians | 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.

To avoid rejections and delays in payment, all hospice providers are required to submit their claims with the authorization number to the Health Net Claims Department.

Hospital and Skilled Nursing

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

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

Select any subject below:

- Claims Submissions
- Inpatient Services and Skilled Nursing Facility Admissions
- Transfer of Hospitalzed Member to Participating Facility

Claims Submissions

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

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

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

Inpatient Services and Skilled Nursing Facility Admissions

Provider Type: Physicians | Hospitals | Ancillary

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. Some plans, however, charge a flat dollar amount or percentage of the inpatient allowed amount. Participating providers must contact Health Net within 24 hours or by the next business day after a member is admitted into a hospital. Services can be in an acute, general or specialized care hospital.
- 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.
- All inpatient 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) 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 from 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

Some Health Net plans limit SNF services to 100 days per calendar year as stated in the EOC. To improve continuity and coordination of care for its members, Health Net requests that SNFs notify the member's primary care physician (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 that 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 documents under the Utilization Management topic.

Transfer of Hospitalized Member to Participating Facility

Provider Type: Physicians | Hospitals | Ancillary

A Health Net member may be hospitalized at an out-of-network facility for emergency care. Members should be transferred to a participating network facility as soon as the member's medical condition allows.

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.

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:

- Human Growth Hormone and Antihemophilic Factor
- Prior Authorization

Human Growth Hormone and Antihemophilic Factor

Provider Type: Physicians | Ancillary

Human growth hormone (HGH) and antihemophilic factors for U.S. Food and Drug Administration (FDA)-approved indications are covered.

HGH and antihemophilic factors must be obtained through Health Net Pharmaceutical Services contracted specialty pharmacy after receiving authorization from Health Net.

Prior Authorization

Provider Type: Physicians

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, prior authorization must be obtained through Pharmacy Services. The only injectable medications that require prior authorization are self-injectable medications and a few specific injectable medications.

The participating provider must complete the Prescription Drug Prior Authorization or Step Therapy Exception Request Form (PDF) detailing the medical necessity and the duration of the requested medication. The completed form must be faxed to Pharmacy Services or the participating provider may telephone Pharmacy Services directly for urgent requests.

The approval or request for additional information is faxed back to the original requestor as noted on the form. Upon approval, Pharmacy Services forwards the authorization to one of Health Net's participating specialty pharmacy providers. The specialty provider contacts the Health Net member to arrange for delivery.

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
- Healthy Pregnancy
- Maternal Mental Health Screening Requirement
- Pediatric Services
- Pregnancy Termination
- Surrogacy

Emergency Services

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

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

Start Smart for Your Baby Care

Provider Type: Physicians | Participating Physician Groups (PPG)

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

- Trimester-based assessments administered by care managers progressing from pregnancy through postpartum help with early identification of needs related to physical health, behavioral health, and social drivers of health.
- These assessments influence how care managers engage and empower members in accessing medical and behavioral healthcare, wellness programs, medical equipment, community resources to support social barriers to health, and educational resources to fully equip them to manage their health before and after delivery.
- Member maternal risk stratification is designed to evolve throughout pregnancy and after delivery to account for changes that may require adjustments to the member's care management needs, enabling processes to allocate resources and coordinate care.
- Care managers create care plans to address the unique needs of each participant.
- Support extends past delivery to improve long-term health during the postpartum period and beyond.

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

PROFESSIONAL CARE FOR PREGNANCY

Hospital and professional pregnancy services are covered, including:

- Prenatal, postnatal and newborn care and delivery, including:
  - Professional care for pregnancy provided by a participating provider, including prenatal and postnatal care, delivery and newborn care, subject to the scheduled copayments (Note: Newborn care is not covered under Medicare Advantage plans)
  - Office calls, consultations, laboratory tests, hospital visits, and normal vaginal or cesarean section deliveries.
- In identified cases of high-risk pregnancy, prenatal diagnostic procedures and genetic testing of the fetus are covered.
- Blood specimens. The California Health and Safety Code requires a blood specimen to be obtained on the first prenatal visit or within 10 days of the visit. The blood specimen must be submitted to an approved laboratory for a standard laboratory test for syphilis.
- Maternity care. A female member is entitled to coverage for maternity care and is not required to complete a waiting period. Therefore, a pregnant woman may enroll in Health Net at any time, and the participating physician group (PPG) is obligated to provide covered obstetrical services.
- Minimum maternity inpatient stays required by law: The California Health and Safety Code requires health care plans to provide mothers and newborns with coverage for minimum hospital stays of at

least 48 hours following a vaginal delivery, or at least 96 hours following a cesarean section delivery (Note: Newborn care is not covered under Medicare Advantage plans).
    - When a delivery occurs in the hospital, the stay begins at the time of delivery (in the case of multiple births, at the time of the last delivery).
    - When a delivery occurs outside a hospital, the stay begins at the time the mother or newborn is admitted.
    - Coverage for inpatient hospital care may be for less than 48 or 96 hours, respectively, only if both the treating provider and the member agree to an earlier discharge.
- In cases of an early discharge, a member receives a post-discharge follow-up visit at home, in a facility, or in the provider's office within 48 hours of the discharge, as prescribed by the treating provider with no authorization requirement. A licensed health care provider whose scope of practice includes postpartum care and newborn care must provide this covered visit. The treating provider must provide written disclosure of all the above to the member (Note: Newborn care is not covered under Medicare Advantage plans).
- Continuation of obstetrical services for terminated members. If a female member is terminated from a Health Net group agreement, coverage for obstetrical services is provided when there is a continuation of coverage through Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or the conversion plan.

GENETIC TESTING AND COUNSELING

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

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

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

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

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

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

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

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

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

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.

Maternal Mental Health Screening Requirement

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

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

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

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

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

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

Pregnancy Program

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

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

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

Pediatric Services

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

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

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

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

Surrogacy

Provider Type: Physicians | Participating Physician Groups (PPG)

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

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

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

Pregnancy Termination

Provider Type: Physicians | Participating Physician Groups (PPG)

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

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

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

Medical Social Services

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

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

Select any subject below:

- Coverage Explanation

Coverage Explanation

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

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

Nuclear Medicine

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

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

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

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 network participating CNMs are covered.

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
- Office Visit

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).

Office Visit

Provider Type: Physicians

Office visits to a physician, physician assistant (PA) and nurse practitioner (NP) are covered on all Health Net plans. Specialist consultations do not require a referral from the member's primary care physician (PCP).

Periodic Health Evaluation

Provider Type: Physicians

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), and other evidence-based agencies. 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). 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.

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 | Hospitals | Participating Physician Groups (PPG) | Ancillary

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

Select any subject below

- Phenylketonuria

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.

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)

Rehabilitation Therapy

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

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

Select any subject below:

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

Coverage Explanation

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

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

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

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

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

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

Home Health Services

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

To receive home health services, a member must be confined to the home, under the care of a participating provider and be in need of physical therapy (PT), respiratory therapy (RT), speech therapy (ST), occupational therapy (OT), or nursing services.

These services must relate directly and specifically to an active treatment plan written by the participating provider after the physician consults with a qualified therapist. The therapy must be reasonable and necessary to the treatment of the member's illness or injury.

Physical, Occupational or Speech Therapy Services Concurrent Review Forms

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

Providers must use the Urgent Request for Continuing Occupational, Physical or Speech Therapy (PDF) concurrent review form for HMO/POS, PPO, EPO, and Medicare Advantage members continuing physical, occupational or speech therapy and home health services. Completed forms must be faxed to the Health Net Prior Authorization Department.

Support for Disabled Members

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

This section contains general member benefit information about support for disabled members.

Select any subject below:

- Americans with Disabilities Act of 1990
- Auxiliary Aids and Services
- Effective Communication
- Financial Responsibility

Americans with Disabilities Act of 1990

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

Health Net and its participating providers do not discriminate against members who have physical disabilities. The Americans with Disabilities Act of 1990 (ADA) requires that places of public accommodation, including hospitals and medical offices, provide auxiliary aids and services (for example, an interpreter for deaf members) to disabled members. Health Net's policy describes nondiscrimination toward members with physical disabilities and the participating providers' responsibility to provide needed auxiliary aids and services.

Auxiliary Aids and Services

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

Participating providers are required to take steps to ensure that no person with a disability is excluded, denied services, segregated, or otherwise treated differently. Health Net provides no-cost aids and services to people with disabilities to communicate effectively, such as qualified Sign Language interpreters, closed captioning interpreters, video remote interpreters, and written information in other formats (large print, audio, accessible electronic formats and additional formats), upon request and at no cost for members with disabilities.

Providers can request interpreter support for members, including auxiliary aids and services, by calling the Health Net Provider Services Department.

Effective Communication

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

Participating providers must communicate with members effectively and make verbally delivered information available to people with hearing impairments. Use of the most advanced technology is not required, as long as effective communication is ensured.

When a member requests a specific auxiliary aid or service for effective communication, the provider must evaluate the request and determine how to ensure effective communication. The ultimate decision about what measures should be taken to facilitate communication rests with the health care provider.

Financial Responsibility

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

Under federal regulations promulgated for use under the Americans with Disabilities Act of 1990 (ADA), participating providers bear the financial responsibility when auxiliary aids or services for the hearing impaired (such as an interpreter) are necessary to ensure effective communication with a member, unless this creates an undue burden or fundamentally alters the nature of the goods, services or operation.

Undue Burden

An undue burden is a significant difficulty or expense. Several factors may be relevant when determining whether providing an auxiliary aid or service is an undue burden, including:

- Nature and cost.
- Overall financial resources of the site or sites involved; the number of employees at the site; the effect on expenses and resources; legitimate safety requirements necessary for safe operation, including crime prevention measures; or any other negative effect on the operation of the site.
- The geographic separateness, and the administrative or fiscal relationship of the site or sites in question, to any parent corporation or entity.
- The overall financial resources of any parent corporation or entity; the overall size of the parent corporation or entity with respect to the number of its employees; and the number, type and location of its facilities.
- The type of operation or operations of any parent corporation or entity, including the composition, structure and functions of the workforce of the parent corporation or entity.

Surgery, Surgical Supplies, and Anesthesia

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

This section contains general member benefit information for surgery, surgical supplies and anesthesia.

Select any subject below:

- Coverage Explanation
- Exclusions and Limitations
- Human Growth Hormones and Antihemophilic Factors

Coverage Explanation

Provider Type: Physicians | Hospitals

When arranged and authorized by Health Net, surgery and anesthesia are covered on all plans. Surgical services, including pre- and post-operative care, in an inpatient or outpatient surgery center or hospital are covered. This includes the services of the surgeon or specialist, assistant, and anesthetist or anesthesiologist, including administration of anesthetics in conjunction with surgical services in the hospital.

The services of a Doctor of Dental Surgery (DDS) are covered if this specialty is necessary for the medical procedure.

Surgical supplies are covered when billed by the hospital in connection with an authorized hospital admission, outpatient surgery, renal dialysis, or emergency.

Refer to the Schedule of Benefits for specific plan coverage information.

Exclusions and Limitations

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

Surgical dressings are therapeutic and protective coverings applied directly to lesions either on the skin or opening to the skin required as a result of a surgical procedures performed by a physician are primary dressings and are covered. Surgical dressings for outpatient surgery, with the exception of primary dressings, are not covered.

Human Growth Hormones and Anithemophilic Factors

Provider Type: Physicians | Ancillary

Human growth hormone (HGH) and antihemophilic factors for U.S. Food and Drug Administration (FDA)-approved indications are covered.

HGH and antihemophilic factors must be obtained through Health Net Pharmaceutical Services contracted specialty pharmacy after receiving authorization from Health Net.

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.

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 | Hospitals | Participating Physician Groups (PPG) | Ancillary

This section contains general member benefit information on transplant evaluations and services.

Select any subject below:

- Health Net Transplant Performance Centers

Health Net Transplant Performance Centers

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

Refer to the Health Net Transplant Performance Center (PDF) matrix, which lists the Transplant Performance Centers and programs by region, when referring Health Net members for a transplant procedure.

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

Compliance for Transplant Performance Centers Standardized Process

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

Designated Transplant Network Participation

Health Net will designate certain transplant programs as “center of excellence” programs (“Tier 1”). In order to be designated a center of excellence, a program must meet minimum volume, outcome and quality criteria, which Health Net may modify from year to year at its discretion. Information regarding the transplant program(s) will be required from the provider on an annual basis to confirm tier status. Health Net may include transplant programs without the center of excellence designation in a network where additional consideration may be warranted (“Tier 2”), including but not limited to a covered person’s access/choice or if the provider can document exceptional circumstances that would mitigate an individual metric. Health Net will consider these factors, in combination with the transplant program criteria and other factors, to reach a determination on a program’s eligibility to provide transplant services without center of excellence designation. Transplant programs may, at Health Net’s sole discretion, move from one tier to the other on an annual basis, depending upon the data and performance of the transplant program from year to year.

Annual Transplant Program Review

The provider shall comply with Health Net’s annual transplant program review process and shall provide to Health Net, or its designee, such transplant program information and data on an annual basis as necessary, for Health Net to complete its annual review of the provider’s transplant program(s). The provider acknowledges that the provider’s failure to provide information in connection with such annual review process within 30 days of the request may result in suspension of the provider’s transplant programs from participation in the network. Health Net shall provide the provider with 30 days prior written notice in the event of the suspension of any transplant program.

Data Submission

The provider will submit transplant program performance data relating to all transplant services provided by the provider (whether to covered persons or other individuals), including but not limited to volume and outcomes, to the appropriate national reporting agency on each transplant program in accordance with the required reporting schedule. Health Net shall access and utilize the reported data. In the event Health Net determines that it requires additional information, such information will be requested from the provider. The provider shall respond to such request within 30 days.

Transplant Program Change Notification

The provider shall notify Health Net of any changes in the provider’s transplant program(s) and/or medical team. Health Net shall be notified immediately of any changes that could impact the quality of the provider’s transplant program, including but not limited to the loss of transplant program surgeons, loss or suspension of Centers for Medicare & Medicaid Services (CMS) certification, shutdown of transplant program.

Performance Requirements

In the event Health Net determines that the provider did not maintain compliance with applicable network criteria, quality standards or other performance requirements, Health Net may require corrective action.

Required Accreditation

Hospital accreditation: The Joint Commission (TJC), NIAHO or local alternative.

Solid organ: CMS certification and member in good standing with United Network for Organ Sharing (UNOS).

Blood and Marrow: Accreditation by Foundation of Accreditation of Cellular Therapy (FACT) and certification by the National Marrow Donor Program (NMDP).

Two Levels of Participation –

- National Network – Program must meet or exceed minimum volumes and survival/outcomes criteria below and have all accreditations noted above.
- Regional Network – Program must have all accreditations noted above and be an active program for at least two years.

Volume Criteria

The minimum volume criteria required by adult-specific Transplant Performance Center programs is maintained. A combined volume is calculated for transplant performance centers that contract for both adult and pediatric populations.

Minimum Transplant Volume required per calendar year:

Transplant Type	Adult	Pediatric
Kidney	30	3
Liver	15	3
Heart	12	2
Lung	12	1
Pancreas or SPK	No minimum if kidney meets	N/A

Transplant Type	Adult	Pediatric
Intestinal/Small Bowel	3	1
Blood and Marrow	40 total, with at least 20 being allogeneic	10

Survival/Outcomes Criteria:

Solid Organ – Outcomes are reviewed for one-year graft survival, three-year patient survival, mortality rate while on the waitlist and offer acceptance ratio. They are measured as follows:

- Graft Survival – One-year Graft Survival Hazard Ratio Z-Score of the 95% Lower Credibility Limit to adjust for observed vs. expected survival rates as compared to transplant programs throughout the country.
- Patient Survival – Three-year Patient Survival Hazard Ratio Z-Score of the 95% Lower Credibility Limit to adjust for observed vs. expected survival rates as compared to transplant programs throughout the country.
- Waitlist Mortality – Waitlist time to mortality Hazard Ratio Z-Score of the 95% Lower Credibility Limit to compare experiences of transplant programs throughout the country.
- Offer Acceptance Ratio-Number of expected offers to number of accepted offers is equal to or exceeds 1.0.

Total final score must meet or exceed 2.0 to be considered for participation.

If a total score was given that includes each of the measurements above, then the programs that are in the top 55% of all programs of the same transplant type were deemed to have met the quality criteria and hence, eligible to be included in the national network.

Blood and Marrow –

Autologous: 100-day survival must be at least 90%.

Allogeneic: 100-day survival must be at least 60% and the actual one-year survival must be “similar to” or “above” the expected rate as reported on Bethematch.org (for NMDP).

All programs must meet for both autologous and allogeneic to be included in the national network.

Vision

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

EyeMed Vision Care

Provider Type: Physicians

Health Net contracts with Envolve Vision, Inc.to provide vision benefits to Health Net members whose coverage includes vision plan benefits. Envolve 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).

Eye Care Network Responsibilities

The primary care physician (PCP) is not responsible for referring Health Net members to EyeMed Vision Care for a refraction examination; however, PCPs should be aware of which members have this benefit so they can direct the member to contact EyeMed Vision Care.

If the EyeMed Vision Care provider finds a medical problem during the refraction examination, the provider must refer the member back to the PCP. If the medical condition is considered acute or emergent, the provider must 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 identifying the problem and instructs the member to follow up with their PCP for further evaluation and treatment.

Criteria for Vision Services

Members are required to obtain eyewear services through participating providers. Refer to the member's Evidence of Coverage (EOC) or Schedule of Benefits for additional information or contact Health Net vision plan.

X-Ray and Laboratory Services

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

This section contains general member benefit information on x-ray and laboratory services.

Select any subject below:

- Overview
- Diagnostic Procedures

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

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) (does not apply to HSP) | Ancillary

To obtain step-by-step guidance on how to access the claims and more on Health Net's provider portal download the Save Time Navigating the Provider Portal (PDF), Save Time Navigating the Provider Portal – Community Health Plan of Imperial Valley (PDF), Save Time Navigating the Provider Portal – CalViva (PDF) or Save Time Navigating the Provider Portal – WellCare by Health Net booklet.

- Accessing member claims
- Submitting professional claims
- Submitting institutional claims
- Viewing claims
- View details of individual claims
- Correct claims
- Copy claims
- Saved claims
- Submitted claims
- Batch claims
- Viewing submitted batch claims
- Payment history
- Explanation of payment details
- Downloading the explanation of payment
- Claims audit tool

Adjustments

Provider Type: Physicians | 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
- 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

Form Fields	Electronic	CMS-1500	UB-04
Referring provider with NPI	Loop 2300 NM1 with DN qualifier	Box 17	N/A
Attending provider with NPI	Loop 2300 NM1with DN qualifier	N/A	Box 76
Rendering provider	Loop 2300 NM1 with 82 qualifier (if differs from billing provider)	NPI in Box 24J	N/A
Service facility information	Loop 2310C or 2310E NM1 with 77 qualifier (if differs from billing provider)	Box 32	N/A
Procedure code	Loop 2400 SV segment	Box 24D	Box 44 if applicable
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

Form Fields	Electronic	CMS-1500	UB-04
Condition codes	Loop 2300 HI segment with qualifier BG	N/A	Box 18-28
COB-other subscriber or third party liability	Loop 2320, 2330A and 2330 B	Box 9, if applicable (requires paper EOB from other payer), 10, 11	Box 50-62 (requires paper EOB from other payer)
Claim DOS	Loop 2400 DTP segment with 472 qualifier	Box 24A	Box 45 for outpatient when required
Claim statement date	Loop 2300 with 434 qualifier	N/A	Box 6 from and through

Claims Rejection Reasons and Resolutions

The following are some claims rejection reasons, challenges and possible resolutions.

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
01	Member's DOB is missing or invalid	Enter the member's 8-digit date of birth (MM/DD/YYYY)	CMS-1500 box 3 UB-04 box 10	Section 2 [1]Non-standard submission or equivalent
02	Incomplete or invalid member information	Enter the member's Health Plan member identification (ID) for Commercial and Medicare or Client Identification Number (CIN) for Medi-Cal. Social	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
		Security number (SSN) should not be used. Check eligibility online, electronically, or refer to the member's current ID card to determine ID numbers		
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	UB-04 box 66-70 UB-04 box 71	Section 3 [1]Non-standard submission or equivalent

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
		inpatient admission. Leave blank if cannot be determined		
75	The claim(s) submitted has missing, illegible or invalid value for anesthesia minutes	When box 24 is completed, then box 24G must be completed as well	CMS-1500 box 24D and 24G	N/A
76	Original claim number and frequency code required	When submitting a corrected claim, for UB-04 box 64 and CMS-1500 box 22, you must reference the original claim. Claim numbers can be found on your Remittance Advice (RA)/ Explanation of Payment (EOP) 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	CMS-1500 box 22 UB-04 box 4 and 64	Section 4 [1]Non-standard submission or equivalent

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
		and 22 blank. Submit contested claims to Medi-Cal Provider Contested Claims.		
77	Type of bill or place of service invalid or missing	Enter the appropriate type of bill (TOB) code as specified by the NUBC UB-04 Uniform Billing Manual minus the leading "0" (zero). A leading "0" is not needed. Digits should be reflected as follows: 1st digit – Indicating the type of facility 2nd digit – Indicating the type of care 3rd digit – Indicating the bill sequence (frequency code)	UB-04 box 4	N/A
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

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
				[1]Non-standard submission or equivalent
A5	NDC or UPIN information missing/invalid	Providers must bill the UPIN qualifier, number, quantity, and type or National Drug Code (NDC) qualifier, number, quantity, and unit/basis of measure. If any of these elements are missing, the claim will reject	CMS-1500 box 24D UB-04 box 43	N/A
A7	Invalid/missing ambulance point of pick- up ZIP Code	When box 24 D is completed, include the pickup/drop off address in attachments	CMS-1500 box 24 or box 32. Medicare claims require a point of pickup (POP) ZIP in box 23 in addition to the addresses in 24 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	When submitting an initial claim, leave CMS 1500 box 22 and	CMS-1500 box 22 UB-04 box 64	Section 4

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
	not an adjustment	UB-04 box 64 blank. Any values entered in these boxes will cause a claim to reject.		[1]Non-standard submission or equivalent
C8	Valid POA required for all DX fields	Do not include the POA of 1. The valid values for this field are Y or N or blank. (for description see Reject code 17)	UB-04 box 67–67Q and 72A–72C	N/A
B7	Review NUCC guidelines for proper billing of the CMS-1500 versions (08/05) and (02/12). Claims will be rejected if data is not submitted and/or formatted appropriately	Only CMS-1500 02/12 version is accepted	N/A	N/A
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	Include patient reason for visit for bill type 013x,	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
	when claim does not involve outpatient visits	078x, and 085x (outpatient) when Type of Admission/Visit (Box 14) is 1 (emergency), 2 (urgent) or 5 (trauma) and revenue code 045x, 0516 or 0762 are reported. Otherwise, do not populate		
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.

UB-04 Billing Instructions

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

All claims from participating providers that are Health Net's responsibility must be submitted to Health Net Medi-Cal claims within 180 days from the last day of the month of the date services were rendered. EPO, HMO, HSP, Medicare Advantage, and PPO participating providers must be submitted claims to Health Net within 120 days from the date services were rendered, unless a different time frame is stated in the providers' contract. Health Net accepts claims submitted on the standard CMS-1500 and UB-04 form and computer generated claims using these formats.

Field number	Field description	Instruction or comments	Required, conditional or not required
1	Unlabeled field	Line 1: Enter the complete provider name. Line 2: Enter the complete mailing address. Line 3: Enter the city, state, and ZIP +4 Codes (include hyphen). Note: The 9 digit ZIP (ZIP +4 codes) is a requirement for paper and EDI claims. Line 4: Enter the area code and telephone number **ALERT: Providers submitting paper claims should left-align data in this field.	Required
2	Unlabeled field	Enter the pay-to name and address	Not required
3a	Patient control no	Enter the facility patient account/control number	Not required

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

CMS-1500 Billing Instructions

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

All claims from participating providers that are Health Net's responsibility must be submitted to Health Net Medi-Cal claims within 180 days from the last day of the month of the date services were rendered. Medicare Advantage, EPO, HMO, HSP and PPO participating providers must be submitted claims to Health Net within 120 days from the date services were rendered, unless a different time frame is stated in the providers' contract. Health Net accepts claims submitted on the standard CMS-1500 and computer generated claims using these formats.

Field number	Field description	Instruction or comments	Required, conditional or not required
1	Insurance program identification	Check only the type of health coverage applicable to the claim. This field indicated the payer to whom the claim is being field. Enter "X" in the box noted "Other"	Required
1a	Insured identification (ID) number	The nine-digit identification number on the member's ID card	Required
2	Patient's name (Last name, first name, middle initial)	Enter the patient's name as it appears on the member's ID. card. Do not use nicknames	Required
3	Patient's birth date and sex	Enter the patient's eight-digit date of birth (MM/DD/YYYY), and mark the appropriate box to indicate the patient's sex/gender. M= Male or F= Female	Required

Field number	Field description	Instruction or comments	Required, conditional or not 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 such as (803)5551414. Note: Patient's telephone does not exist in the electronic 837 Professional 4010A1	Conditional

Field number	Field description	Instruction or comments	Required, conditional or not required
6	Patient's relationship to insured	Always mark to indicate self if the same	Conditional - Always mark to indicate self if the same
7	Insured's address (number, street, city, state, ZIP code) Telephone number (include area code)	Enter the insured's complete address and telephone number, including area code on the appropriate line. First line - Enter the street address. Do not use commas, periods, or other punctuation in the address such as 123 N Main Street 101 instead of 123 N. Main Street, #101. Second line - In the designated block, enter the city and state. Third line - Enter the ZIP code and telephone number. When entering a nine-digit zip code (ZIP + 4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number such as (803)5551414. Note: Patient's telephone does not exist in the electronic 837 Professional 4010A1	Conditional

Field number	Field description	Instruction or comments	Required, conditional or not required
8	Reserved for NUCC	N/A	Not required
9	Other insured's name (last name, first name, middle initial)	Refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan. Enter the complete name of the insured	Conditional refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan
9a	Other insured's policy or group number	REQUIRED if field 9 is completed. Enter the policy of group number of the other insurance plan	Conditional REQUIRED if field 9 is completed. Enter the policy for group number of the other insurance plan
9b	Reserved for NUCC	N/A	Not required
9c	Reserved for NUCC	N/A	Not required
9d	Insurance plan name or program name	REQUIRED if field 9 is completed. Enter the other insured's (name of person listed in field 9) insurance plan or program name	Conditional REQUIRED if field 9 is completed
10 a, b, c	Is patient's condition related to:	Enter a Yes or No for each category/line (a, b and c). Do not enter a Yes and No in the same category/line. When marked Yes, primary insurance information must then be shown in box 11	Required

Field number	Field description	Instruction or comments	Required, conditional or not 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 insurance. If box 10 a, b or c is marked Y, this field should be populated	Conditional REQUIRED when other insurance is available
11a	Insured date of birth and sex	Enter the eight-digit date of birth (MM/DD/YYYY) of the insured and an X to indicate the sex (gender) of the insured. Only one box can be marked. If gender is unknown, leave blank	Conditional
11b	Other claims ID (Designated by NUCC)	The following qualifier and accompanying identifier has been designated for use: Y4 Property Casualty Claim Number For worker's compensation of property and casualty: Required if known. Enter the claim number assigned by the payer	Conditional

Field number	Field description	Instruction or comments	Required, conditional or not required
11c	Insurance plan name or program number	Enter name of the insurance health plan or program	Conditional
11d	Is there another health benefit plan	Mark Yes or No. If Yes, complete field's 9a-d and 11c	Required
12	Patient's or authorized person's signature	Enter "Signature on File," "SOF," or the actual legal signature. The provider must have the member's or legal guardian's signature on file or obtain his/her legal signature in this box for the release of information necessary to process and/or adjudicate the claim	Conditional - Enter "Signature on File," "SOF," or the actual legal signature
13	Insured's or authorized person's signature	Obtain signature if appropriate.	Not required
14	Date of current: Illness (First symptom) or Injury (Accident) or Pregnancy (LMP)	Enter the six-digit (MM/DD/YY) or eight-digit (MM/DD/YYYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date.	Conditional

Field number	Field description	Instruction or comments	Required, conditional or not required
		Enter the applicable qualifier to identify which date is being reported. 431 Onset of Current Symptoms or Illness 484 Last Menstrual Period	
15	If patient has same or similar illness. Give first date.	Enter another date related to the patient's condition or treatment. Enter the date in the six-digit (MM/DD/YY) or eight-digit (MM/DD/YYYY) format	Conditional
16	Dates patient unable to work in current occupation	Enter the six-digit (MM/DD/YY) or eight-digit (MM/DD/YYYY)	Conditional
17	Name of referring physician or other source	Enter the name of the referring physician or professional (first name, middle initial, last name, and credentials)	Conditional - Enter the name of the referring physician or professional (first name, middle initial, last name, and credentials)
17a	ID number of referring physician	Required if field 17 is completed. Use ZZ qualifier for Taxonomy code	Conditional REQUIRED if field 17 is completed
17b	NPI number of referring physician	Required if field 17 is completed. If unable to obtain referring NPI,	Conditional

Field number	Field description	Instruction or comments	Required, conditional or not required
		servicing NPI may be used	REQUIRED if field 17 is completed. If unable to obtain referring NPI, servicing NPI may be used
18	Hospitalization on dates related to current services		Conditional
19	Reserved for local use - new form: Additional claim information		Conditional
20	Outside lab/ charges		Conditional
21	Diagnosis or nature of illness or injury (related items A-L to item 24E by line). New form allows up to 12 diagnoses, and ICD indicator	Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD-10-CM diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field. Note: Claims missing or with invalid diagnosis codes will be rejected or denied for payment	Required - Include the ICD indicator
22	Resubmission code / original REF	For resubmissions or adjustments, enter the original claim number of the original claim.	Conditional - For resubmissions or adjustments, enter the original claim number of the original claim

Field number	Field description	Instruction or comments	Required, conditional or not required
		New form - for resubmissions only: - Replacement of Prior Claim - Void/Cancel Prior Claim	
23	Prior authorization number or CLIA number	Enter the authorization or referral number. Refer to the provider operations manual for information on services requiring referral and/or prior authorization. CLIA number for CLIA waived or CLIA certified laboratory services	If authorization, then conditional If CLIA, then required If both, submit the CLIA number Enter the authorization or referral number. Refer to the provider operations manual for information on services requiring referral and/or prior authorization. CLIA number for CLIA waived or CLIA certified laboratory services
24 A-G Shaded	Supplemental information	The shaded top portion of each service claim line is used to report supplemental information for: • NDC • Narrative description of unspecified codes • Contract rate • For detailed instructions and qualifiers refer	Conditional - The shaded top portion of each service claim line is used to report supplemental information for: NDC Narrative description of unspecified codes Contract rate

Field number	Field description	Instruction or comments	Required, conditional or not required
		to Appendix IV of this guide	
24A Unshaded	Dates of service	Enter the date the service listed in field 24D was performed (MM/DD/YYYY). If there is only one date, enter that date in the "From" field. The "To" field may be left blank or populated with the "From" date. If identical services (identical CPT/HCPC code(s)) were performed, each date must be entered on a separate line	Required
24B Unshaded	Place of service	Enter the appropriate two-digit CMS standard place of service (POS) code. A list of current POS codes may be found on the CMS website	Required
24C Unshaded	EMG	Enter Y (Yes) or N (No) to indicate if the service was an emergency	Not required
24D Unshaded	Procedures, services or supplies CPT/ HCPCS modifier	Enter the five-digit CPT or HCPCS code and two-character modifier, if applicable. Only one CPT or HCPCS and up to four	Required - Ensure NDC or UPIN is included if applicable

Field number	Field description	Instruction or comments	Required, conditional or not required
		modifiers may be entered per claim line. Codes entered must be valid for date of service. Missing or invalid codes will be denied for payment. Only the first modifier entered is used for pricing the claim. Failure to use modifiers in the correct position or combination with the procedure code, or invalid use of modifiers, will result in a rejected, denied, or incorrectly paid claim	
24 E Unshaded	Diagnosis code	In 24E, enter the diagnosis code reference letter (pointer) as shown in box 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. ICD-10-	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		CM diagnosis codes must be entered in box 21 only. Do not enter them in 24E. Do not use commas between the diagnosis pointer numbers. Diagnosis Codes must be valid ICD-10 codes for the date of service, or the claim will be rejected/denied	
24 F Unshaded	Charges	Enter the charge amount for the claim line item service billed. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line	Required
24 G Unshaded	Days or units	Enter quantity (days, visits, units). If only one service provided, enter a numeric value of one	Required
24 H Shaded	EPSDT (Family Planning)	Leave blank or enter "Y" if the services were performed as a result of an EPSDT referral	Conditional - Leave blank or enter "Y" if the services were performed as a result of an Early and Periodic Screening, Diagnostic and

Field number	Field description	Instruction or comments	Required, conditional or not required
			Treatment (EPSDT) referral
24 H Unshaded	EPSDT (Family Planning)	Enter the appropriate qualifier for EPSDT visit	Conditional - Enter the appropriate qualifier for EPSDT visit
24 I Shaded	ID qualifier	Use ZZ qualifier for taxonomy. Use 1D qualifier for ID, if an atypical provider	Required
24 J Shaded	Non-NPI provider ID#	Typical providers: Enter the provider taxonomy code that corresponds to the qualifier entered in box 24I shaded. Use ZZ qualifier for taxonomy code Atypical providers: Enter the provider ID number.	Required
24 J Unshaded	NPI provider ID	Typical providers ONLY: Enter the 10-character NPI of the provider who rendered services. If the provider is billing as a member of a group, the rendering individual provider's 10-character NPI may be entered. Enter the billing NPI if services are not provided by an individual (such as DME, independent lab, home health,	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		RHC/FQHC general medical exam)	
25	Federal Tax ID number SSN/EIN	Enter the provider or supplier nine-digit federal tax ID number, and mark the box labeled EIN	Required
26	Patient's account NO	Enter the provider's billing account number	Conditional - Enter the provider's billing account number
27	Accept Assignment?	Enter an X in the YES box. Submission of a claim for reimbursement of services provided to a recipient using state funds indicates the provider accepts assignment. Refer to the back of the CMS-1500 (02-12) claim form for the section pertaining to payments	Conditional - Enter an X in the YES box. Submission of a claim for reimbursement of services provided to a recipient using state funds indicates the provider accepts assignment
28	Total charge	Enter the total charges for all claim line items billed - claim lines 24F. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e., 10.00),	Required

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

Field number	Field description	Instruction or comments	Required, conditional or not required
		number (i.e., 10.00), enter 00 in the area to the right of the vertical line	
31	Signature of physician or supplier including degrees or credentials	If there is a signature waiver on file, you may stamp, print, or computer-generate the signature; otherwise, the practitioner or practitioner's authorized representative MUST sign the form. If signature is missing or invalid, the claim will be returned unprocessed. Note: Does not exist in the electronic 837P	Required
32	Service facility location information	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the name and physical location. (PO box numbers are not acceptable here.) First line - Enter the business/facility/ practice name. Second line- Enter the street address. Do not use commas, periods, or other punctuation in	Conditional REQUIRED if the location where services were rendered is different from the billing address listed in field 33

Field number	Field description	Instruction or comments	Required, conditional or not required
		the address (for example, 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line - In the designated block, enter the city and state. Fourth line - Enter the ZIP code and telephone number. When entering a nine-digit ZIP code (ZIP + 4 codes), include the hyphen	
32a	NPI - Services rendered	Typical providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI of the facility where services were rendered.	Conditional Typical providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33.
32b	Other provider ID	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Typical providers: Enter the 2-character qualifier ZZ followed	Conditional REQUIRED if the location where services were rendered is different from the billing address listed in field 33

Field number	Field description	Instruction or comments	Required, conditional or not required
		by the taxonomy code (no spaces). Atypical providers: Enter the 2-character qualifier 1D (no spaces)	
33	Billing provider INFO & PH#	Enter the billing provider's complete name, address (include the ZIP + 4 code), and telephone number. First line -Enter the business/facility/ practice name. Second line - Enter the street address. Do not use commas, periods, or other punctuation in the address (for example, 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line - In the designated block, enter the city and state. Fourth line- Enter the ZIP code and telephone number. When entering a nine-digit ZIP code (ZIP + 4 code), include the hyphen. Do not use a hyphen or space as a separator within the	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		telephone number (i.e., (555)555-5555). NOTE: The nine digit ZIP code (ZIP + 4 code) is a requirement for paper and EDI claim submission	
33a	Group billing NPI	Typical providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI .	Required
33b	Group billing other ID	Enter as designated below the billing group taxonomy code. Typical providers: Enter the provider taxonomy code. Use ZZ qualifier. Atypical providers: Enter the provider ID number	Required

Hospital Acquired Conditions

Provider Type: Hospitals

Hospital-acquired conditions (HACs) are a set of hospital complications and medical errors that may cause severe consequences. They occur during a hospital stay (are not present at the time of admission) and can

reasonably be prevented through the application of appropriate evidence-based protocols. These events may result in more serious outcomes to the member, including loss of function, disability and death. Their occurrence may also prolong hospital stays.

Billing Instructions

Each HAC is to be reported on the claim and must be catalogued according to when it occurred. Like the Centers for Medicare & Medicaid Services (CMS), Health Net requests hospitals to submit inpatient hospital claims (UB-04/CMS 1450) with Present on Admission (POA) indicators. POA is defined as a condition that is present at the time the order for inpatient admission occured. Conditions that develop during an outpatient encounter, including in the emergency department or during observation or outpatient surgery, are included within the definition of POA conditions.

The POA indicator must be assigned to all ICD-10 diagnoses (primary and secondary diagnosis codes, as well as to external cause of injury codes) on all inpatient claims (UB-04/CMS 1450) for all lines of business. Categories and codes exempt from reporting include late effect codes, normal delivery, Z-codes, and certain external codes (for example, railway, motor vehicle, water transport, air transport, and space transport).

Refer to the current HAC ICD-10 codes available on the CMS website at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.html; select FY 2017 HOSPITAL ACQUIRED CONDITIONS LIST under Downloads. This list includes the HAC descriptions, codes and diagnoses, and is subject to change, as Health Net relies on guidance from CMS on these diagnoses. An HTML version of the ICD-10 HAC list is also available. Look for a link on the same page, titled Appendix I Hospital Acquired Conditions (HACS) List.

The following POA indicators should be submitted in field locator 67 of the UB-04/CMS 1450, and in segment K3 in the 2300 loop, data element K301 for the 837I electronic claim submission.

Indicator	Description
Y	Present at the time of inpatient admission
N	Not present at the time of inpatient admission
U	Documentation is insufficient to determine if condition is present on admission
W	Provider is unable to clinically determine whether condition was present on admission or not
1	Exempt from POA reporting (equivalent of a blank code on UB-04/CMS 1450 form). This code should rarely be used and every effort to

Indicator	Description
	determine the appropriate indicator must be made

The POA only applies to inpatient prospective payment systems (IPPS) hospitals. The following hospitals are exempt from the POA indicator:

- Critical access hospitals (CAHs)
- Long-term care hospitals (LTCHs)
- Maryland waiver hospitals
- Cancer hospitals
- Children's inpatient facilities
- Religious non-medical health care institutions
- Inpatient psychiatric hospitals
- Inpatient rehabilitation facilities
- Veterans Administration (VA)/Department of Defense (DOD) hospitals

Source: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/wPOA-Fact-Sheet.pdf

Quality Improvement HAC Program

Health Net's Quality Improvement (QI) HAC program is designed to encourage hospitals to improve patient safety by reducing or eliminating the occurrence of serious and costly errors in the provision of health care services. The QI HAC program supports improving hospital reporting and member awareness about hospital quality issues. The program also serves to more closely align Health Net practices with those of CMS and The Leapfrog Group, which represents purchasers and employer groups.

HAC Confirmation

Health Net's QI Department monitors claims submitted by the hospital after discharge for evidence of reported Not Present on Admission indicators of HACs. In accordance with the QI HAC Program, if a Health Net member experiences a HAC noted on the CMS website, Health Net requests that the admitting hospital take the following action:

- Determine if the event was potentially preventable and within the control of the hospital and the medical staff who provided care during the member's stay.
- Agree to refrain from billing or adjust billing to Health Net or the member for any charges associated with the HAC if it is determined that the HAC was preventable.
- Perform a root cause analysis and take measures to prevent recurrences as necessary.

HAC Notification

Health Net's QI Department notifies the hospital's QI Department director or whoever is responsible to confirm that the above actions were taken according to the instructions in the notification. The notification also allows the hospital to explain extenuating circumstances that preclude these actions from being taken. The hospital has 30 days to complete and fax-back the confirmation to Health Net's QI Department. Health Net may also address potential HACs through the plan's established potential quality of care issues (PQI) process.

Trauma Services

Provider Type: Hospitals

Hospitals billing Health Net for trauma admissions, trauma care or other trauma-related services must submit complete documentation with the UB-04 (CMS-1450) and the itemized claim form at the time of billing. Submission of complete trauma service records assists Health Net with timely claims processing and payment. Failure to submit the required documentation can lead to delay in claims processing or denial of the claim.

The following documents may be required when billing any trauma-related services (documents may be handwritten or transcribed):

- Emergency room (ER) report.
- Trauma activation/trauma team involvement (for example, members or specialties).
- Complete clinical hospital records, if admitted.
- Admitting notes.
- Emergency medical services (EMS or paramedic) record.
- ER attending physician's report.
- All additional reports from any other physician.

Documentation for inpatient admissions must include the above documents and the following:

- Admission history and physical.
- Discharge summary.
- Operating room reports, if applicable.
- Complete clinical hospital records.
- All additional reports from any other physician.

UB-04 Billing Instructions

Provider Type: Physicians | 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 or Cal MediConnect claims within 180 days from the last day of the month of the date services were rendered. EPO, HMO, HSP, Medicare Advantage, and PPO participating providers must be submitted claims to Health Net within 120 days from the date services were rendered, unless a different time frame is stated in the providers' contract. Health Net accepts claims submitted on the standard CMS-1500 and UB-04 form and computer generated claims using these formats.

Field number	Field description	Instruction or comments	Required, conditional or not required
1	Unlabeled field	Line 1: Enter the complete provider name. Line 2: Enter the complete mailing address. Line 3: Enter the city, state, and ZIP +4 Codes (include hyphen). Note: The 9 digit ZIP (ZIP +4 codes) is a requirement for paper and EDI claims. Line 4: Enter the area code and telephone number **ALERT: Providers submitting paper claims should left-align data in this field.	Required
2	Unlabeled field	Enter the pay-to name and address	Not required
3a	Patient control no	Enter the facility patient account/control number	Not required
3b	Medical record number	Enter the facility patient medical or health record number	Required
4	Type of bill	Enter the appropriate type of bill (TOB) code as specified by the NUBC UB-04 Uniform Billing Manual minus the leading "0" (zero). A leading "0" is not needed. Digits should	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		be reflected as follows: 1st Digit - Indicating the type of facility. 2nd Digit - Indicating the type of care. 3rd Digit- Indicating the bill sequence (frequency code).	
5	Fed Tax No	Enter the nine-digit number assigned by the federal government for tax reporting purposes	Required
6	Statement covers period from/through	Enter begin and end, or admission and discharge dates, for the services billed. Inpatient and outpatient observation stays must be billed using the admission date and discharge date. Outpatient therapy, chemotherapy, laboratory, pathology, radiology, and dialysis may be billed using a date span. All other outpatient services must be billed using the actual date of service (MMDDYY).	Required
7	Unlabeled field	Not used.	Not required
8a	Patient name	8a - Enter the first nine digits of the identification number	Not required

Field number	Field description	Instruction or comments	Required, conditional or not required
		on the member's ID card.	
8b		Enter the patient's last name, first name, and middle initial as it appears on the ID card. Use a comma or space to separate the last and first names. Titles: (Mr., Mrs., etc.) should not be reported in this field. Prefix: No space should be left after the prefix of a name (e.g., McKendrick. H). Hyphenated names: Both names should be capitalized and separated by a hyphen (no space). Suffix: a space should separate a last name and suffix. Enter the patient's complete mailing address.	Required
9	Patient address	Enter the patient's complete mailing address. Line a: Street address Line b: City Line c: State Line d: ZIP code Line e: Country code (NOT REQUIRED)	Required - Except line 9e county code

Field number	Field description	Instruction or comments	Required, conditional or not required
10	Birthdate	Enter the patient's date of birth (MMDDYYYY)	Required - Ensure DOB of patient is entered and not the insured)
11	Sex	Enter the patient's sex. Only M or F is accepted	Required
12	Admission date	Enter the date of admission for inpatient claims and date of service for outpatient claims (MMDDYY)	Required for Inpatient claims. Leave blank for Outpatient claims. Exceptions: Type of bill codes 012x, 022x, 032x, 034x, 081x, and 082x require boxes 12–13 to be populated.
13	Admission hour	Enter the time using two-digit military time (00-23) for the time of inpatient admission or time of treatment for outpatient services. • 00 - 12:00 a.m. 01 - 1:00 a.m. • 02 - 2:00 a.m. 03 - 3:00 a.m. • 04 - 4:00 a.m. 05 - 5:00 a.m. • 06 - 6:00 a.m. 07 - 7:00 a.m. • 08 - 8:00 a..m 09 - 9:00 a.m. • 10 - 10:00 a.m. 11 - 11:00 a.m. • 12 - 12:00 p.m. 13 - 1:00 p.m.	Required for Inpatient claims. Leave blank for Outpatient claims. Exceptions: Type of bill codes 012x, 022x, 032x, 034x, 081x, and 082x require boxes 12–13 to be populated.

Field number	Field description	Instruction or comments	Required, conditional or not required
		• 14 - 2:00 p.m. 15 - 3:00 p.m. • 16 - 4:00 p.m. 17 - 5:00 p.m. • 18 - 6:00 p.m. 19 - 7:00 p.m. • 20 - 8:00 p.m. 21 - 9:00 p.m. • 22 - 10:00 p.m. 23 - 11:00 p.m.	
14	Admission type	Require for inpatient and outpatient admissions. Enter the one-digit code indicating the type of the admission using the appropriate following codes: • 1 - Emergency • 2 - Urgent • 3 - Elective • 4 - Newborn • 5 - Trauma	Required
15	Admission source	Required for inpatient and outpatient admissions. Enter the one-digit code indicating the source of the admission or outpatient service using one of the following codes. For type of admission 1,2,3, or 5: • 1 - Physician referral	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		• 2 - Clinic referral • 3 - Health maintenance referral (HMO) • 4 - Transfer from a hospital • 5 - Transfer from skilled nursing facility • 6 - Transfer from another health care facility • 7 - Emergency room • 8 - Court/law enforcement • 9 - Information not available For type of admission 4 (newborn): • 1 - Normal delivery • 2 - Premature delivery • 3 - Sick baby • 4 - Extramural birth • Information not available	
16	Discharge hour	Enter the time using two-digit military times (00-23) for the time of the inpatient or outpatient discharge. • 00 - 12:00 a.m. 01 - 1:00 a.m.	Conditional - Enter the time using two-digit military times (00-23) for the time of the inpatient or outpatient discharge

Field number	Field description	Instruction or comments	Required, conditional or not required
		• 02 - 2:00 a.m. 03 - 3:00 a.m. • 04 - 4:00 a.m. 05 - 5:00 a.m. • 06 - 6:00 a.m. 07 - 7:00 a.m. • 08 - 8:00 a.m 09 - 9:00 a.m. • 10 - 10:00 a.m. 11 - 11:00 a.m. • 12 - 12:00 p.m. 13 - 1:00 p.m. • 14 - 2:00 p.m. 15 - 3:00 p.m. • 16 - 4:00 p.m. 17 - 5:00 p.m. • 18 - 6:00 p.m. 19 - 7:00 p.m. • 20 - 8:00 p.m. 21 - 9:00 p.m. • 22 - 10:00 p.m. 23 - 11:00 p.m.	
17	Patient status	REQUIRED for inpatient and outpatient claims. Enter the two-digit disposition of the patient as of the "through" date for the billing period listed in field 6 using one of the following codes: • 01 - Routine discharge • 02 - Discharged to another short-term general hospital • 03 - Discharged to SNF	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		• 04 - Discharged to ICF • 05 - Discharged to another type of institution • 06 - Discharged to care of home health service organization • 07 - Left against medical advice • 09 - Discharged/ transferred to home under care of a home IV provider • 09 - Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims) • 20 - Expired or did not recover • 30 - Still patient (To be used only when the client has been in the facility for 30 consecutive days if payment is based on DRG) • 40 - Expired at home (hospice use only) • 41 - Expired in a medical facility (hospice use only) • 42 - Expired-place unknown	

Field number	Field description	Instruction or comments	Required, conditional or not required
		(hospice use only) • 43 - Discharged/ transferred to a federal hospital (such as a Veteran's Administration [VA] hospital) • 50 - Hospice-Home • 51 - Hospice-Medical Facility • 61 - Discharged/ transferred within this institution to a hospital-based Medicare approved swing bed • 62 - Discharged/ transferred to an Inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital • 63 - Discharged/ transferred to a Medicare certified long-term care hospital (LTCH) • 64 - Discharged/ transferred to a nursing facility	

Field number	Field description	Instruction or comments	Required, conditional or not required
		certified under Medicaid but not certified under Medicare • 65 - Discharged/ transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital • 66 - Discharged/ transferred to a critical access hospital (CAH)	
18-28	Condition codes	REQUIRED when applicable. Condition codes are used to identify conditions relating to the bill that may affect payer processing. Each field (18-24) allows entry of a two-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual	Conditional REQUIRED when condition codes are used to identify conditions relating to the bill that may affect payer processing
29	Accident state	N/A	Not required

Field number	Field description	Instruction or comments	Required, conditional or not required
30	Unlabeled Field	N/A	Not required
31-34 a-b	Occurrence code and occurrence date	Occurrence code: REQUIRED when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows for entry of a two-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence date: REQUIRED when applicable or when a corresponding occurrence code is present on the same line (31a-34a). Enter the date for the associated occurrence code in MMDDYY format	Conditional REQUIRED when occurrence codes are used to identify events relating to the bill that may affect payer processing
35-36 a-b	Occurrence SPAN code and Occurrence date	Occurrence span code: REQUIRED when applicable. Occurrence codes are	Conditional REQUIRED when occurrence codes are

Field number	Field description	Instruction or comments	Required, conditional or not required
		used to identify events relating to the bill that may affect payer processing. Each field (35-36a) allows for entry of a two-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence span date: REQUIRED when applicable or when a corresponding occurrence span code is present on the same line (35a-36a). Enter the date for the associated occurrence code in MMDDYY format.	used to identify events relating to the bill that may affect payer processing
37	Unlabeled field	REQUIRED for re-submissions or adjustments. Enter the DCN (document control number) of the original claim	Conditional REQUIRED for resubmissions or adjustments. Enter the DCN (document control number) of the original claim
38	Responsible party name and address	N/A	Not required

Field number	Field description	Instruction or comments	Required, conditional or not required
39-41 a-d	Value codes and amounts	Code: REQUIRED when applicable. Value codes are used to identify events relating to the bill that may affect payer processing. Each field (39-41) allows for entry of a two-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). Up to 12 codes can be entered. All "a" fields must be completed before using "b" fields, all "b" fields before using "c" fields, and all "c" fields before using "d" fields. For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Amount: REQUIRED when applicable or when a value code is entered. Enter the dollar amount for the associated value code. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199,999.99). Do not enter a dollar sign ($)	Conditional REQUIRED when value codes are used to identify events relating to the bill that may affect payer processing

Field number	Field description	Instruction or comments	Required, conditional or not required
		or a decimal. A decimal is implied. If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to the right of the vertical line	
42 Lines 1-22	REV CD	Enter the appropriate revenue codes itemizing accommodations, services, and items furnished to the patient. Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Enter accommodation revenue codes first followed by ancillary revenue codes. Enter codes in ascending numerical value	Required
42 Line 23	Rev CD	Enter 0001 for total charges.	Required
43 Lines 1-22	Description	Enter a brief description that corresponds to the revenue code entered in the service line of field 42	Required
43 Line 23	PAGE ___ OF ___	Enter the number of pages. Indicate the page sequence in the "PAGE" field and the total number of pages	Conditional - Enter the number of pages. (Limited to 4 pages per claim)

Field number	Field description	Instruction or comments	Required, conditional or not required
		in the "OF" field. If only one claim form is submitted, enter a "1" in both fields (i.e., PAGE "1" OF "1"). (Limited to 4 pages per claim)	
44 lines 1-22	HCPCS/Rates	REQUIRED for outpatient claims when an appropriate CPT/HCPCS code exists for the service line revenue code billed. The field allows up to nine characters. Only one CPT/HCPCS and up to two modifiers are accepted. When entering a CPT/ HCPCS with a modifier(s), do not use spaces, commas, dashes, or the like between the CPT/ HCPCS and modifier(s). Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Please refer to your current provider contract	Conditional REQUIRED for outpatient claims when an appropriate CPT/HCPCS code exists for the service line revenue code billed
45 Lines 1-22	Service date	REQUIRED on all outpatient claims. Enter the date of service for each	Conditional REQUIRED on all outpatient claims. Enter the date of

Field number	Field description	Instruction or comments	Required, conditional or not required
		service line billed (MMDDYY). Multiple dates of service may not be combined for outpatient claims	service for each service line billed (MMDDYY). Multiple dates of service may not be combined for outpatient claims
45 Line 23	Creation date	Enter the date the bill was created or prepared for submission on all pages submitted (MMDDYY).	Required
46 lines 1-22	Service units	Enter the number of units, days, or visits for the service. A value of at least "1" must be entered. For inpatient room charges, enter the number of days for each accommodation listed	Required
47 Lines 1-22	Total charges	Enter the total charge for each service line	Required
47 Line 23	Totals	Enter the total charges for all service lines	Required
48 Lines 1-22	Non-covered charges	Enter the non-covered charges included in field 47 for the revenue code listed in field 42 of the service line. Do not list negative amounts	Conditional - Enter the noncovered charges included in field 47 for the revenue code listed in field 42 of the service line. Do not list negative amounts

Field number	Field description	Instruction or comments	Required, conditional or not required
48 Line 23	Totals	Enter the total non-covered charges for all service lines	Conditional - Enter the total noncovered charges for all service lines
49	Unlabeled field	Not used	Not required
50 A-C	Payer	Enter the name of each payer from which reimbursement is being sought in the order of the payer liability. Line A refers to the primary payer; B, secondary; and C, tertiary	Required
51 A-C	Health plan identification number	N/A	Not required
52 A-C	REL information	REQUIRED for each line (A, B, C) completed in field 50. Release of Information Certification Indicator. Enter 'Y' (yes) or 'N' (no). Providers are expected to have necessary release information on file. It is expected that all released invoices contain 'Y'	Required
53	ASG. BEN.	Enter 'Y' (yes) or 'N' (no) to indicate a signed form is on file authorizing payment by the payer directly to	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		the provider for services	
54	Prior payments	Enter the amount received from the primary payer on the appropriate line	Conditional - Enter the amount received from the primary payer on the appropriate line when Health Net is listed as secondary or tertiary
55	EST amount due	N/A	Not required
56	National Provider Identifier or provider ID	REQUIRED: Enter providers 10-character NPI ID	Required
57	Other provider ID	Enter the numeric provider identification number. Enter the TPI number (non-NPI number) of the billing provider	Required
58	Insured's name	For each line (A, B, C) completed in field 50, enter the name of the person who carries the insurance for the patient. In most cases this will be the patient's name. Enter the name as last name, first name, middle initial	Required
59	Patient relationship	N/A	Not required

Field number	Field description	Instruction or comments	Required, conditional or not required
60	Insured unique ID	REQUIRED: Enter the patient's insurance ID exactly as it appears on the patient's ID card. Enter the insurance ID in the order of liability listed in field 50	Required
61	Group name	N/A	Not required
62	Insurance group no.	N/A	Not required
63	Treatment authorization code	Enter the prior authorization or referral when services require precertification	Conditional - Enter the prior authorization or referral when services require precertification
64	Document control number	Enter the 12-character original claim number of the paid/denied claim when submitting a replacement or void on the corresponding A, B, C line Applies to claim submitted with a type of bill (field 4), frequency of "7" (replacement of prior claim) or type of bill, frequency of "8" (void/cancel of prior claim). *Please refer to the reconsider/corrected claims section	Conditional - Enter the 12-character original claim number of the paid/denied claim when submitting a replacement or void on the corresponding A, B, C line reflecting Payer from field 50

Field number	Field description	Instruction or comments	Required, conditional or not required
65	Employer name	N/A	Not required
66	DX version qualifier	N/A	Required
67	Principal diagnosis code	Enter the principal/ primary diagnosis or condition using the appropriate release/ update of ICD-10-CM Volume 1 & 3 for the date of service	Required
67 A-Q	Other diagnosis code	Enter additional diagnosis or conditions that coexist at the time of admission or that develop subsequent to the admission and have an effect on the treatment or care received using the appropriate release/ update of ICD-10CM Volume 1 & 3 for the date of service. Diagnosis codes submitted must be valid ICD-10 Codes for the date of service and carried out to its highest level of specificity - 4th or 5th digit. "E" and most "V" codes are NOT acceptable as a primary diagnosis. Note: Claims with incomplete or invalid	Conditional - Enter additional diagnosis or conditions that coexist at the time of admission

Field number	Field description	Instruction or comments	Required, conditional or not required
		diagnosis codes will be denied	
68	Present on admission indicator		Required
69	Admitting diagnosis code	Enter the diagnosis or condition provided at the time of admission as stated by the physician using the appropriate release/ update of ICD-10-CM Volume 1 & 3 for the date of service. Diagnosis codes submitted must be valid ICD-10 codes for the date of service and carried out to its highest level of specificity - 4th or 5th digit. "E" codes and most "V" are NOT acceptable as a primary diagnosis. Note: Claims with missing or invalid diagnosis codes will be denied	Required
70	Patient reason code	Enter the ICD-10-CM code that reflects the patient's reason for visit at the time of outpatient registration. Field 70a requires entry; fields 70b-70c are conditional.	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		Diagnosis codes submitted must be valid ICD-10 codes for the date of service and carried out to its highest digit - 4th or 5th. "E" codes and most "V" codes are NOT acceptable as a primary diagnosis. NOTE: Claims with missing or invalid diagnosis codes will be denied	
71	PPS/DRG code	N/A	Not required
72 a, b, c	External cause code	N/A	Not required
73	Unlabeled field	N/A	Not required
74	Principal procedure code/date	CODE: Enter the ICD-10 procedure code that identifies the principal/primary procedure performed. Do not enter the decimal between the 2nd or 3rd digits of code; it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).	Conditional - Enter the ICD-10 procedure code that identifies the principal/primary procedure performed. Do not enter the decimal between the 2nd or 3rd digits of code; it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY)
74 a-e	Other procedure code date	REQUIRED on inpatient claims when a procedure is	Conditional REQUIRED on inpatient claims when

Field number	Field description	Instruction or comments	Required, conditional or not required
		performed during the date span of the bill. CODE: Enter the ICD-10 procedure code(s) that identify significant procedure(s) performed other than the principal/primary procedure. Up to five ICD-10 procedure codes may be entered. Do not enter the decimal; it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).	a procedure is performed during the date span of the bill
75	Unlabeled field	N/A	Not required
76	Attending physician	Enter the NPI and name of the physician in charge of the patient care. • NPI: Enter the attending physician 10-character NPI ID. • Taxonomy code: Enter valid taxonomy code. • QUAL: Enter one of the following	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		qualifier and ID number: • 0B - State license #. • 1G - Provider UPIN. • G2 - Provider commercial #. • B3 - Taxonomy code. • LAST: Enter the attending physician's last name. • FIRST: Enter the attending physician's first name	
77	Operating physician	REQUIRED when a surgical procedure is performed. Enter the NPI and name of the physician in charge of the patient care. • NPI: Enter the attending physician 10-character NPI ID. • Taxonomy code: Enter valid taxonomy code. • QUAL: Enter one of the following qualifier and ID number:	Conditional REQUIRED when a surgical procedure is performed. Enter the NPI and name of the physician in charge of the patient care

Field number	Field description	Instruction or comments	Required, conditional or not required
		• 0B - State license #. • 1G - Provider UPIN. • G2 - Provider commercial #. • B3 - Taxonomy code. • LAST: Enter the attending physician's last name. • FIRST: Enter the attending physician's first name.	
78 & 79	Other physician	Enter the provider type qualifier, NPI and name of the physician in charge of the patient care. • (Blank Field): Enter one of the following provider type qualifiers: • DN - Referring provider. • ZZ - Other operating MD. • 82 - Rendering provider. • NPI: Enter the other physician 10-character NPI ID. • QUAL: Enter one of the following qualifier and ID	Conditional

Field number	Field description	Instruction or comments	Required, conditional or not required
		number, or 0B - State license number • 1G - Provider UPIN number • G2 - Provider commercial number	
80	Remarks	N/A	Not required
81	CC	A: Taxonomy of billing provider. Use B3 qualifier.	Required
82	Attending Physician	Enter name or seven-digit provider number of ordering physician	Required

Workers' Compensation

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

If a Health Net member suffers a job-related illness or injury and receives medical services, these services are covered under California workers' compensation. Providers should question the member for possible workers' compensation liability and enter information on the claim.

Health Net may file a lien against the member's workers' compensation benefits. In the interim, Health Net pays the covered charges. When the case is settled, Health Net may recover charges for services from the member's workers' compensation settlement.

Capitated Claims Billing Information

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

Providers who participate in Health Net's Medi-Cal program under a capitated agreement with a participating physician group (PPG) must follow the instructions below.

- Providers must contact their PPG to check for any special billing requirements that the providers' failure to follow could delay the processing of their claims, and to verify the billing address for claims submission.
- Providers have 180 days from the last day of the month of service to submit initial Medi-Cal claims. Exceptions for late filing are:
- New Medi-Cal claims between six-months and one-year-old are permitted without penalty for unknown eligibility status, antepartum obstetric care or a delay in delivery of a custom-made prosthesis
- Claims one-year-old or more are permitted without penalty for retroactive eligibility situations, court orders, state or administrative hearings, county errors in eligibility, Department of Health Care Services (DHCS) orders, reversal of appeal decisions on a Treatment Authorization Request (TAR) form, or if other coverage is primary

Capitated Risk Claims

Capitated-risk claims received by Health Net through paper submissions are forwarded back to the PPG or third-party administrator (TPA) for processing.

Electronically Submitted Claims

Electronically submitted claims that are participating physician group (PPG) capitated-risk claims are forwarded to the PPG or third-party administrator (TPA) for processing. A claim fax summary is printed, batched and forwarded. A batch trailer sheet, indicating the number of claims within a batch, is sent.

EOC 300/308 Report

Denied Claims

Claims received by Health Net or an affiliated health plan for services that are the capitated-risk of a participating physician group (PPG), hospital or other ancillary provider as applicable are forwarded by Health Net or the affiliated health plan to the PPG, hospital or ancillary provider for processing. This may delay payment by several days to several weeks.

The Health Net Medi-Cal Claims Department sends a weekly report to any provider who has submitted claims to Health Net that are denied by Health Net as services capitated to a participating physician group (PPG) or

hospital. The report provides the name and telephone number of the PPG or hospital to which the denied claims have been forwarded for processing.

The EOC 300/308 Report is generated using two explanation of check codes:

- 300 - Service capitated to member's PPG, claim sent to PPG
- 308 - Service capitated to facility, claim sent for processing

Denied claims with these EOC codes are grouped according to the capitated PPG or hospital responsible for the claim.

Field Descriptions

The following information correlates to the numbered fields on the Health Net EOC 300/308 Report (PDF) of denied capitated claims:

Header Information

#	Field	Description
1.	ABS	Health Net's operating system
2.	Program ID	Health Net's assigned number for the report
4.	Claim Type	Facility = UB-04 form Professional = CMS-1500 form
4.	Report Title	The name of the report
5.	Run Date	The day/month/year that the report was generated
6.	Run Time	The time that the report was generated
7.	Page Number	The page number of the report
8.	Remit Num	A 14-digit internal number that gives information about the claim's financial status

#	Field	Description
9.	Check Date	The date of the check issued to a provider for claim payment
10.	Servicing Provider	The TIN and name of the provider who submitted the claim to Health Net for payment
11.	Pay To	The name of the group that the Servicing Provider is linked to. The Servicing Provider and Pay To can be the same

Detail Information

#	Field	Description
12.	Capped PPG/HOSP/PHONE	If a claim was denied on the explanation of check (EOC), then the name of the PPG or hospital where the claim was sent for processing would be listed here with the most current phone number that Health Net has on file
13.	Member ID	Health Net's member identification number
14.	MBR Last Name	The last name of the member
15.	MBR First Name	The first name of the member
16.	Claim Number	Health Net's 11-digit Document Control Number (DCN)
17	Beg DOS	The starting date of facility/ professional services

#	Field	Description
18	End DOS	The ending date of facility/ professional services
19.	PROC	The billed procedure code on the UB-04 or CMS-1500 claim (if services billed are revenue, this field is blank)
20.	DIAG	A three to seven character code based on the ICD-10 coding system, indicating the condition for which services on this claim were rendered
21.	EOC	A three-digit code appears on the provider's EOC explaining the action taken on this claim line. If a claim is coded with EOC 300 or 308, then the claim was denied to responsible capitated PPG or capitated facility for services rendered 300 = Service capitated to member's PPG, claim sent to PPG 308 = Service capitated to facility, claim sent for processing
22.	Billed Amt	The amount billed for a claim line

All provider inquiries about claim status, payment amounts, or denial reasons should be directed to the capitated provider responsible for the services.

Plan-Risk or Shared-Risk Claims

Plan-risk or shared-risk claims must be sent to Health Net for adjudication. Attach a copy of the Plan/Shared-Risk Cover Sheet to each group of claims the provider submits. Additionally, the claims should be separated and batched into plan or shared-risk services and claim types. All claims submitted to Health Net must be on

CMS-1500, LTC form 25-1 or UB-04 claim forms, and must indicate the date of receipt by the participating physician group (PPG). Claims for plan-risk or shared-risk services must be submitted to Health Net.

The following information must be included on every claim:

- Health Net member identification (ID) number or reference number located on the member's ID card
- Provider name and address
- ICD-10 diagnosis code
- Service dates
- Billed charge per service
- Current year CPT procedure or UB-04 revenue code
- Place of service or UB-04 bill type code
- Submitting provider tax identification number or National Provider Identifier (NPI) number
- Member name and date of birth as it appears on the member's ID card
- State license number of the attending provider

If a provider submits a claim directly to Health Net rather than the PPG and the claim includes both plan-risk services and capitated-risk services, Health Net processes the plan-risk services. Services that are the responsibility of the PPG are denied by Health Net and forwarded to the PPG for processing. The Explanation of Check contains the message, "Capitated services, no payment issued-claim sent to IPA, Hospital or Ancillary provider."

Claims for capitated services that are misrouted to Health Net are denied and forwarded to the capitated provider with a copy of the explanation.

In some instances, Health Net is able to split a claim that has both plan-risk and capitated-risk services (for example, chemotherapy provider claims). In these cases, a claim fax is attached to the original claim. The fax contains only those service lines that appear to be capitated-risk. The message "POSSIBLE CAP RISK" appears in the member's address field (box 4 on the fax). These services do not appear on the explanation of check, but appear on the capitated-risk services report.

All other lines on the original claim document are assumed to be plan-risk and are processed by Health Net. It is not necessary to return the claim for those plan-risk services not appearing on the fax.

If, after processing the services on the fax, the capitated provider determines that any of those services are actually plan-risk (for example, out-of-area emergency), return them to Health Net for special handling and processing. Attach the Plan/Shared Risk Services Cover Sheet and return those claims to Health Net.

For more information, select any subject below:

- Excessive Fees by Hospital-Based Providers HMO
- Shared-Risk Claims MEDI-CAL (LA)

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.

Shared-Risk Claims

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

Shared-risk claims must be sent to Health Net or the affiliated health plan for adjudication. Additionally, the claims should be separated by plan or shared-risk services and claim types. All claims submitted to Health Net or Molina Healthcare must be on CMS-1500, LTC form 25-1, UB-92 or UB-04 claim forms and indicate the date of receipt by the participating physician group (PPG). Claims for plan or shared-risk services must be submitted to Health Net or Molina.

The following information must be included on every claim:

- Health Net member identification (ID) number or reference number, which is 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 U-92 (CMS-1450) revenue code
- Place of service or UB-92 or UB-04 bill type code
- Submitting provider tax identification number and national provider identifier (NPI) number
- Member name and date of birth as indicated on the member ID card
- State license number of the attending provider

If a claim is sent directly to Health Net or its affiliated health plans, rather than the capitated PPG, and the claim includes both plan risk services and capitated-risk services, the plans process the plan risk services. Claims for services that are the PPG's responsibility are forwarded to them for processing.

Claims for capitated services that are misrouted to Health Net or an affiliated health plan are routed back to the appropriate PPG.

In some instances, Health Net is able to split a claim that has both plan and capitated-risk services (for example, chemotherapy provider claims).

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

Eligibility Guarantee Under COBRA

Provider Type: Participating Physician Groups (PPG) | Hospitals

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) generally allows those who lose eligibility under a group health plan to continue that coverage for a certain period of time at the group rate. Subscribers, and their covered dependents who qualify, are called qualified beneficiaries. Generally, qualified beneficiaries may take up to 60 days from their last day of regular coverage to elect COBRA continuation coverage.

Eligibility guarantee under COBRA does not apply to individual family plans (IFP).

In many cases, COBRA creates problems and delays as the employer sponsor and former plan member carry out various steps before COBRA continuation coverage is effective.

Knowing this, Health Net provides eligibility guarantee protection when the former member certifies that a request for COBRA continuation coverage has been submitted to the employer sponsor of the prior plan. This guarantee is not provided for those who contend that they have not yet requested COBRA continuation coverage, regardless of the time remaining for the former member to elect coverage.

COBRA Eligibility Determination - Not applicable to IFP

Members may be covered by COBRA continuation coverage for up to 18, 29 or 36 months, depending on the event that qualified them for coverage. COBRA continuation can also end at any time.

A member whose name does not appear on the participating physician group's (PPG's) or hospital's current Health Net Eligibility Report or appears with a cancellation notation (a past date in the Provider Cancel Date column of the report) may have become a private-pay member. If the member claims current eligibility because of COBRA, the PPG or hospital should ask the member if COBRA continuation coverage through the employer sponsor of the subscriber's group health plan has been requested.

If the member answers "yes":

- Ask the member to fill out an Eligibility Certification form.
- Provide services with reliance on the eligibility guarantee for the 60-day period following the last day of regular coverage. The PPG or hospital can determine the last day of coverage from an Activity Analysis report from a previous month.
- Call the Health Net Provider Services Center if 60 days pass after the last day of regular coverage and the member does not appear on the PPG's or hospital's current Eligibility Report as NEW CONTRACT with a past date in the Provider Effective Date column.

If the member answers, "No, but I intend to do it within the time period permitted by law," handle the member as a private-pay member, but state that if the member becomes reinstated through COBRA, the member receives a refund of any fees paid.

Eligibility Reports (only applicable to PPGs)

Eligibility records for members who lose eligibility under a group health plan and then obtain COBRA coverage show the following sequence of changes:

1. On member's loss of eligibility, the Eligibility Report states "CANCEL MEMBER" or "CANCEL CONTRACT."
2. When the member is granted COBRA continuation coverage, the Eligibility Report states "ADD CONTRACT."
3. Members who were previously covered as dependents but become subscribers through COBRA are assigned their own subscriber identification numbers.
4. COBRA members are assigned group numbers that differ from their previous group numbers only in that the suffix is a different letter.

Filing a COBRA Eligibility Guarantee Claim

COBRA eligibility guarantee claims are filed in the same manner as non-COBRA claims. All requirements and procedures are the same. Refer to the Eligibility Guarantee topic for more information.

Members Not Entitled to COBRA Continuation

Some employer-sponsored health plans are not subject to COBRA.

Members Requesting COBRA Information

If members, regardless of their relationship with Health Net, have questions about what COBRA requires or permits, refer them to their employer sponsor (current or former).

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, PPO, EPO, and HSP members within 120 calendar days from the date of service or in accordance with the terms of the Provider Participation Agreement (PPA).

Submit all paper claims and supporting documentation to the appropriate Health Net Claims Department (Medicare Claims, Medi-Cal claims and HMO/HSP/EPO claims).

General Billing Guidelines

Provider Type: Physicians | Hospitals

All claims must be submitted to Health Net within 120 days from the date the services were rendered. Health Net accepts claims submitted on the standard UB-04 (CMS-1450) form and computer-generated claims using these formats.

When using multi-part NCR forms, always submit the original, not second or third copies. Do not write or stamp information on the face of the claim. The physician's signature in box 13 or box 31 is acceptable. Health Net requires the following information on each claim:

- Member name
- Member identification number
- Member date of birth
- Health Net prior authorization number. Primary care physician (PCP) claims do not require prior authorization unless the services performed specifically require prior authorization
- Location where services were rendered
- ICD-10 diagnosis code
- Date of service
- Current year CPT or HCPCS code (physician) or UB-04 revenue code with narrative description (hospital)
- CMS place of service code (professional claims)
- CMS type of service code (professional claims)
- Number of days or units for each service line (professional claims)
- Billed charges
- Physician name, address, federal tax identification number, and National Provider Identifier (NPI)
- State license number of attending provider

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.

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:

- Reimbursement Amount

Reimbursement Amount

Provider Type: Physicians

The Health Net Provider Participation Agreement (PPA) specifies that contracting providers agree to accept the contract amount as payment in full for covered services. Payment is based on the rates in the PPA. Providers must use the correct codes for billing procedures, as stated in the PPA.

When a member receives covered services from a participating provider, the member is not financially responsible. The provider may not charge the member for any expenses except copayments or coinsurance or deductibles, if applicable.

The provider may not charge the member for medical services that Health Net has denied as not medically necessary, unless the member has agreed in writing to be responsible for payment of such charges prior to receiving services.

Reinsurance

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

This section includes general information on reinsurance processes.

Select any subject below:

- Hospital Reinsurance MEDICARE CMC HMO
- Shared Risk Reinsurance MEDICRE CMC HMO
- Special Risk Reinsurance HMO
- Transfer Reinsurance MEDICARE CMC HMO

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.

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.
Urodynamic Testing	CP.MP.98	To define medical necessity criteria for commonly used urodynamic studies.
Bevacizumab (Avastin)	CP.PHAR.93	To ensure patients follow selection criteria for Avastin use.

Some clinical payment policy edits may also occur as the result of a single code denial for a service that is not supported by medical necessity. When this occurs, the following explanation (ex) code is applied to the service line billed with the disallowed procedure. This ex code can be viewed on the provider's explanation of payment.

- xP: Service is denied according to a payment or coverage policy

Policy Name	Clinical Policy Number	Description
Fractional Exhaled Nitric Oxide	CP.MP.103	To clarify that testing for fractionated exhaled nitric oxide (FeNO) is investigational for diagnosing and guiding the treatment of asthma, as there is insufficient evidence proving it more than or as effective as existing standards of care.

Clinical Payment Policy Appeals

Clinical payment policy denials may be appealed on the basis of medical necessity. Providers who disagree with a claim denial based on a clinical payment policy, and who believe that the service rendered was medically necessary and clinically appropriate, may submit a written reconsideration request for the claim denial using the provider claim reconsideration/appeal/dispute or other appropriate process as defined in the health plan's provider manual. The appeal may include this type of information:

1. Statement of why the service is medically necessary.
2. Medical evidence which supports the proposed treatment.
3. How the proposed treatment will prevent illness or disability.
4. How the proposed treatment will alleviate physical, mental or developmental effects of the patient's illness.
5. How the proposed treatment will assist the patient to maintain functional capacity.
6. A review of previous treatments and results, including, based on your clinical judgment, why a new approach is necessary.
7. How the recommended service has been successful in other patients.

Compliance and Regulations

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

This section covers general information for providers on compliance and regulation requirements.

Select any subject below:

Mandatory Data Sharing Agreement

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

The state of California established the California Health and Human Services (CalHHS) Data Exchange Framework (DxF) to oversee the electronic exchange of health and social services information in California.

Entities listed below must sign a data sharing agreement (DSA). To sign the DSA, go to https://signdxf.powerappsportals.com.

Participating entities that must sign a DSA include:

- General acute care hospitals.
- Physician organizations and medical groups.
- Skilled nursing facilities.
- Clinical laboratories.
- Acute psychiatric hospitals.

The Plan may apply a corrective action plan if the agreement is not signed.

Provider Offshore Subcontracting Attestation

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

The plan requires notice of any offshore subcontracting relationship, involving members' protected health information (PHI) to ensure that the appropriate steps have been taken to address the risks involved with the use of subcontractors operating outside the United States.

An example of an offshore subcontracting relationship is a physician, laboratory, medical group, or hospital contracting with an entity to process claims, and that entity uses resources that are not located in the United

States to process the provider's claims. The provider is responsible to have processes in place that protect members' PHI.

Participating providers who use offshore subcontractors to process, handle or access member PHI in oral, written or electronic form must submit specific subcontracting information to the plan. Providers may not allow any member data to be transferred or stored offshore. Data may be accessed by an offshore entity through an onshore entity that is located in the United States.

The plan requires that participating providers who have entered into an offshore subcontracting relationship submit the following items to the plan within 20 calendar days of entering into a new offshore agreement or when revising an existing offshore agreement.

- A completed and signed copy of the attestation form (PDF) (CalViva, Community Health Plan of Imperial Valley, Wellcare By Health Net.This attests that the participating provider has taken appropriate steps to address the risks associated with the use of subcontractors operating outside the United States. Each attestation form includes the contact information for providers to return the completed form and materials.
- Providers contracting with the plan for the Medicare line of business must provide a copy of the agreement between the provider and offshore subcontractor with proprietary information removed. The plan is required to validate that the necessary contractual provisions are included in the agreement.
- A policy and procedure for ensuring and maintaining the security of members' PHI.
- A policy and procedure that documents the process used for immediate termination of the offshore subcontractor upon discovery of a significant security breach.
- A policy and procedure that documents the process used for conducting annual audits, regular monitoring and tracking results, and resolving any identified deficiencies.

Providers must submit this information for each offshore subcontractor they have engaged to perform work, regardless of whether the information was already completed for a different health plan.

Communicable Diseases Reporting

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

For more information, select any subject below:

- Primary Care Physician Responsibilities MEDI-CAL

Primary Care Physician Responsibilities

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

Primary care physicians (PCPs) are responsible for preventive care counseling and education for their assigned members. Counseling and education is documented in the medical record of each member. Health Net distributes brochures on communicable disease topics to PCP offices.

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

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
- 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).

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: Participating Physician Groups (PPG) | Hospitals | Ancillary

Refer to the Schedule of Covered Services and Copayments in the subscriber's Evidence of Coverage (EOC) 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.

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 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:

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

Denial of Investigational or Experimental Treatment for a Terminal Illness

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

For an initial review of a request for services, Health Net does the following:

- Gives 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.

Notification Delays

Provider Type: Hospitals

Financial penalties may be imposed on Health Net by regulators if specified time limits are not met. Reasonable delays include Health Net experiencing the following:

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

Health Net is 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 becomes aware that it will not meet the time requirement, whichever comes first. The provider must also be notified initially by telephone.

Required Elements for Provider Notification Letters

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

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

Health Net is 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 UM Timeliness Standards.

Eligibility

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

This section contains information on eligibility requirements and how to determine eligibility for members.

Select any subject below:

- Extension of Benefits
- Provider Responsibility for Verifying Eligibility for On-Exchange IFP Members in Delinquent Premium Grace Period
- Steps to Determine Eligibility

Extension of Benefits

Provider Type:Hospitals

Application for 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 physician 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:

1. On the date the member is no longer totally disabled.
2. 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.
3. On the date that available benefits are exhausted.
4. On the last day of the 12-month period following the date the extension began.

Refer to the member's Evidence of Coverage (EOC) for additional information, or contact the Health Net Provider Services Center.

Provider Responsibility for Verifying Eligibility for On-Exchange IFP Members in Delinquent Premium Grace Period

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

It is imperative that providers verify benefits, eligibility and cost shares each time a member is scheduled to receive services. Presentation of a member identification (ID) card is not a guarantee of eligibility. Providers must always verify eligibility on the same day services are required.

To verify eligibility providers can utilize the Health Net provider portal.

PREMIUM GRACE PERIOD FOR MEMBERS RECEIVING FEDERAL ADVANCE PREMIUM TAX CREDITS AND/OR CALIFORNIA PREMIUM SUBSIDIES

Provisions of the Affordable Care Act and California law require that Health Net allow members receiving federal Advance Premium Tax Credits (APTCs) and/or California premium subsidies a three-month grace period to pay premiums before coverage is terminated.

- Members receiving federal APTCs and/or California premium subsidies will have a federally mandated grace period of three months in which to make payment for their portion of the premium.
    - Premiums are billed and paid at the subscriber level; therefore, the grace period is applied at the subscriber level.
    - All members associated with the subscriber will inherit the enrollment status of the subscriber.
    - When providers are verifying eligibility through the secure provider portal during the first month of nonpayment of premium, the provider will receive a message that the member is

active but delinquent due to nonpayment of premium. However, claims may be submitted and Health Net will pay for covered services rendered during the first month of the grace period.
- During months two and three of the grace period, the member's eligibility status is suspended, and claims will be pended. The EX code on the explanation of payment will state: "LZ - Pend: Non-Payment of Premium."
- Coverage will remain in force during the grace period.
- If payment of all premiums due is not received from the member by the end of the three-month grace period, the member's policy will automatically terminate to the last day of the first month of the grace period.
- The member will be financially responsible for the cost of covered services received during the second and third months of the grace period, as well as any unpaid premium.
- In no event shall coverage extend beyond the date the member policy terminates.

BILLING FOR COVERED SERVICES TO MEMBERS IN SUSPENDED STATUS DURING MONTHS TWO AND THREE

For members whose eligibility is in a suspended status and seeking services from providers:

1. Providers may advise the member that providers are not obligated under their Health Net contract to provide services while the member's eligibility is in suspended status. (Status must be verified through the Health Net secure provider portal or by calling Provider Services. Providers should follow their internal policies and procedures regarding this situation.)
2. Should a provider make the decision to render services, the provider may require payment from the member. Providers may submit a claim to Health Net as well, but the claim will be contested and only paid if the member's eligibility status is returned to active status after all overdue premiums are paid in full.
3. If the member subsequently pays his or her premium and is removed from a suspended status, claims will be adjudicated by Health Net. The provider is then responsible for reconciling any payment received from the member and the payment received from Health Net. The provider may then bill the member for an underpayment or return any overpayment to the member.
4. If the member does not pay his or her premiums in full by the end of the three-month grace period and Health Net plan coverage is terminated, providers may bill the member for the full billed charges.

Verifying Eligibility for IFP Members

Providers are responsible for verifying benefits, eligibility and cost shares each time a member is scheduled to receive services. Presentation of a member identification (ID) card is not a guarantee of eligibility. Providers must always verify eligibility on the same day services are required. Member eligibility can be verified on the provider portal. For more information download Save Time Navigating the Provider Portal booklet.

When viewing eligibility of IFP members on the secure portal, providers will see a status message (PDF).

If the member's information is not found online, contact the applicable Health Net Provider Services Center.

Steps to Determine Eligibility

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

This section contains information on verifying and determining member eligibility.

Select any subject below:

- Eligibility Certification Form
- Eligibility Verification Methods
- Temporary ID Card

Eligibility Certification Form

Provider Type: Physicians | Hospitals | Ancillary

An individual 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, must be questioned by the provider to determine whether the individual is a new member. The 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 individual is determined to be a new member, he or she must sign an Eligibility Certification Form before receiving services.

Health Net Identification Card

All Health Net members are issued a Health Net identification (ID) card. This card serves as identification for medical, prescription medication and vision coverage.

The Health Net ID card should be carried by the member at all times, and must be presented to the physician, 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.

Eligibility Verification Methods

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

When an individual seeks medical attention from a participating physician group (PPG), hospital or other provider, the provider must attempt to determine eligibility with Health Net before providing care.

Member eligibility is verified at the time that the identification (ID) card is issued; however, possession of the card does not guarantee eligibility. In cases where a member has lost an ID card or where eligibility may be in question, eligibility can be verified as follows:

Eligibility Reports (applies to capitated PPGs and hospitals). Refer to Use Eligibility Report to Verify Member Information in the Monthly Eligibility Reports section for more information.

- Online: Download the Save Time Navigating the Provider Portal (PDF) booklet for step-by-step instructions.
- The interactive voice response (IVR) system for employer group EPO, HMO, HSP and PPO members to obtain information on member eligibility, copayment and claims status.
- Refer to the IVRs available for Covered California and Individual Family Plan (IFP) members to obtain information on member eligibility, copayments and claims status.
- Eligibility verification via the provider's clearinghouse. Health Net is a Phase I- and Phase II-certified entity with the Council for Affordable and Quality Healthcare (CAQH) Committee on Operating Rules (CORE) for eligibility responses. Providers must contact their vendor/ clearinghouse to submit transactions via this method using an EDI transaction or clearinghouse product.

Grace Period - Suspended Eligibility Status

A member's eligibility status may indicate that eligibility is suspended. Members who qualify for advanced premium tax credits (APTC) to subsidize his or her purchase of a health benefit plan through the Covered California marketplace are allowed an extended premium payment grace period of three months before the member's coverage is terminated. Refer to Premium Payment Grace Period for Beneficiaries Qualifying for APTC for additional information on member, provider and Health Net's rights when the member's eligibility is in suspended status during the first, second, or third month of the grace period.

Monthly Eligibility Reports

Provider Type: Participating Physician Groups (PPG) | Hospitals

Activity Analysis Report

Each month, capitated participating physician groups (PPGs) and hospitals receive an Activity Analysis Report along with the Eligibility Report. This report identifies and summarizes membership activity. It lists additions, deletions, transfers in and out of PPGs and hospitals, reinstatements, contract type changes, and plan type changes. PPGs and hospitals use this report to note new members and monitor retroactive cancellations. If a member is deleted retroactively from the Activity Analysis Report, the PPG and hospital pull the member's chart to verify whether he or she received any services. If services were provided during the time the member was determined ineligible, the PPG and hospital follow procedures for eligibility guarantee.

Use Eligibility Report to Verify Member Information

Health Net provides each capitated participating physician group (PPG) and capitated hospital with a monthly Eligibility Report listing eligible members enrolled with the PPG and capitated to the hospital per applicable PPG affiliation for the calendar month. The Eligibility Report is organized alphabetically and is sorted by member last name. The following information appears in the report:

- Member code
- Subscriber identification (ID) number
- Group number
- Contract type
- Copayment information for office visits, emergency room service and durable medical equipment (DME)
- Plan code
- Birth date
- Provider effective date
- Provider cancel date
- Physician ID number
- Coordination of benefits (COB) information

When a member requests medical services, the Eligibility Report or Health Net's eligibility verification methods are consulted by the provider to check eligibility before providing services. Because Eligibility Report lists canceled members on active contracts and canceled contracts for one month following cancellation, it is vital that the provider cancel date is reviewed on the report prior to assuming Health Net eligibility.

Temporary ID Card

Provider Type: 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 provider 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.

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

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.

Enrollment

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

This section contains general information and procedures regarding member enrollment.

Select any subject below:

- Subscriber and Member Identification Numbers

Subscriber and Member Identification Numbers

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

The plan develops unique identification (ID) numbers for all subscribers. The group subscriber ID number is formatted as an alphanumeric code, beginning with the letter "R" followed by eight digits. The individual Medicare subscriber ID number is formatted as an alphanumeric code, beginning with the letter "C" followed by eight digits.

With the exception of Medicare members, individual members of a subscriber's household are assigned the same subscriber ID number as the subscriber and a unique member code identifying the relationship of the member to the subscriber. Medicare members have one enrollee per subscriber ID number.

In compliance with California law (SB 168 (ch. 720, 2001)), the subscriber ID number replaces the member's Social Security number (SSN) on most member-oriented materials and communications, including member ID cards.

Provider-oriented materials, including eligibility reports and other health plan correspondence, include both the subscriber's ID number and SSN for identification purposes. The plan also continues to use SSNs for internal verification and administration purposes as allowed by law.

Use of Social Security Numbers

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

The plan has implemented the use of alternate identification (ID) numbers for all members to replace the member's Social Security number (SSN) as the subscriber or member ID number on most member-oriented materials and communications, including member ID cards.

The purpose of this change is to comply with SB 168 (ch. 720, 2001), which prohibits any person or agency (excluding state or local agencies) from any of the following:

- Publicly posting or displaying an individual's SSN.
- Printing a member's SSN on any card needed to access products or services, such as a member ID card.
- Requiring members to transmit their SSNs over the Internet unless the connection is secure or the SSN is encrypted.
- Requiring members to use their SSNs to access a website, unless a password or unique ID number is also required to access the website.

- Printing a member's SSN on any materials that are mailed to the member, unless required by state or federal law.

Exceptions established by SB 1730 (ch 786, 2002) include applications, forms and other documents sent by mail for the following:

- As part of an application or enrollment process.
- To establish, amend or terminate an account, contract or policy.
- To confirm the accuracy of the SSN.

These exceptions are subject to restrictions established by AB 763 (ch. 532, 2003), which prohibits the printing of the SSN, in whole or in part, on a postcard or any other type of mailer that does not require an envelope and allows the SSN to be visible without opening the mailer.

Provider-oriented materials, including eligibility reports and other health plan correspondence, includes both the member's alternate ID number and SSN for identification purposes. The plan also continues to use SSNs for internal verification and administration purposes as allowed by law.

Participating providers are subject to the same regulations.

Refer to the discussion of subscriber/member ID numbers under the Enrollment topic for more information on ID number format.

ID Cards

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

This section contains general information about member identification (ID) cards for Health Net plans, as well as sample ID cards.

Select any subject below:

- Member ID Card

Member ID Card

Provider Type: Physicians | Ancillary | Hospitals

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

- A member enrolls
- A member changes their name or physician
- A dependent is added or deleted from the policy and the group number changes
- The medical plan changes at renewal

Refer to the sample cards below to view a picture and descriptions of the fields of the Health Net member ID card.

- Identification card (Large Group PureCare HSP) (PDF)

These are sample ID cards only. The information included in them is subject to change. Providers should refer to a member's ID card when they present for services for current benefit and health plan information.

Medical Records

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

Participating providers are required to maintain member medical records in a manner that is current, detailed, complete, and organized. In addition, medical records must reflect all aspects of member care, be readily available to health care providers and provide data for statistical and quality-of-care analysis. Health Net and its participating providers must maintain active books, records, documents, and other evidence of accounting procedures and practices for 10 years. An active book, record or document is one related to current, ongoing or in-process activities and referred to on a regular basis to respond to day-to-day operational requirements.

The following retention events must also be considered in reference to the required timeframes in which medical records must be maintained by providers. These retention requirements are based on Health Net's current Corporate Records Retention Schedule:

- Pediatric medical records must be maintained for seven years after age 21
- Hospitals, acute psychiatric hospitals, skilled nursing facilities (SNFs), primary care clinics, and psychology and psychiatric clinics must maintain medical records and exposed X-rays for a minimum of seven years following patient discharge, except for minors
- Records of minors must be maintained for at least one year after a minor has reached age 18, but in no event for less than seven years

Health Net must ensure maintenance of all records and documentation (including medical records) necessary to verify information and reports required by statute, regulation or contractual obligation for five years from the end of the fiscal year in which Health Net's contract expires or is terminated with a member.

Standards for the administration of medical records by participating providers are established by the Health Net Quality Improvement Committee (HNQIC). The standards form the basis for the evaluation of medical records by Health Net. Medical records for primary care physicians (PCPs) may be selected for evaluation as part of the annual delegation oversight assessment.

Health Net requires participating providers to have a written policy in place that provides for the protection of confidential protected health information (PHI) in accordance with the Health Insurance Portability and Accountability Act (HIPAA). The policy must be kept in hard copy or electronic format and must include a functioning mechanism designed to safeguard medical records and information against loss, destruction, tampering, unauthorized access or use, and verbal discussions about member information to maintain confidentiality.

Provision of Medical Records

Participating physician groups (PPGs), physicians, hospitals and ancillary providers are required to provide Health Net with copies of medical records and accounting and administrative books and records, as they pertain to the Provider Participation Agreement (PPA).

The provider has financial responsibility to provide copies of medical records so that Health Net can make claims and benefit determinations for Health Net utilization management, quality improvement, Healthcare Effectiveness Data and Information Set (HEDIS®), and appeals and grievance programs.

Medical records may be required for regulatory reviews by the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), National Committee for Quality Assurance (NCQA), Independent Quality Review and Improvement Organization (QIO), and other regulatory bodies.

Right to Audit and Access Records, including Electronic Medical Records (EMR)

Access to Records and Audits by Health Plan

Subject only to applicable state and federal confidentiality or privacy laws, the provider must share records when Health Net or its designated representative requests access to them in order to audit, inspect, review, perform chart reviews, and duplicate such records.

For on-Exchange plans and Medicare line of business, if performed onsite, access to records for the purpose of an audit must be scheduled at mutually agreed upon times, upon at least 30 business days prior written notice by the health plan or its designated representative, but not more than 60 days following such written notice.

For Medi-Cal and Cal MediConnect, if performed onsite, access to records for the purpose of an audit must be scheduled at mutually agreed upon times, upon at least 30 business days prior written notice by Health Net or its designated representative, but not more than 60 days following such written notice. However, access to records and audits that are part of a facility site review audit, grievance visit or potential quality issue (PQI) visit can be unannounced.

EMR Access

When Health Net requests access to electronic medical records (EMR), the provider will grant the health plan access to the provider's EMR in order to effectively case manage members and capture medical record data for risk adjustment and quality reporting. There will be no other fees charged to the health plan for this access.

Written Protocols

Participating providers are required to have systems and procedures in place that provide consistent, confidential and comprehensive record-keeping practices. Written procedures must be available upon Health Net's request for:

- Confidentiality of patient information - Policy and procedure must address the protection of confidential protected health information (PHI) of the patient in accordance with the Health Information Portability and Accountability Act (HIPAA). The policy must include a written or electronic functioning mechanism designed to safeguard records and information against loss, destruction, tampering, unauthorized access or use, and additional safeguards to maintain confidentiality during verbal discussions about patient information. Information about written, electronic and verbal privacy, periodic staff training regarding confidentiality of PHI, and securely stored records that are inaccessible to unauthorized individuals must also be included

- Release of medical records and information, including faxes
- Medical record organization standards - Policy and procedure must include information about individual medical records; securely fastened medical records; medical records with member identification on each individual page; and a consistent area in the medical record designated for the member's history, allergies, problem list, medication list, preventive care, immunizations, progress notes, therapeutic, diagnostic operative, and specialty physician reports, discharge summaries, and home health information
- Filing system for records (electronic or hardcopy)
- Formal system for the availability and retrieval of medical records - Policy and procedure must allow for the ease of accessibility to medical records for scheduled member encounters within the facility or in an approved health record storage facility off the facility premises
- Filing of partial medical records - Policy and procedure must outline the process for filing partial medical records offsite, including a process that alerts authorized staff regarding the offsite filing of the partial record
- Retention of medical records in accordance with state laws and regulations (for providers who see commercial health plan patients)
- Retention of medical records in accordance with federal laws and regulations (for providers who accept Medicare patients)
- Preventive care guidelines for pediatric and adult members
- Referrals to specialists
- Accessibility of consultations, diagnostic tests, therapeutic service and operative reports, and discharge summaries to health care providers in a timely manner
- Inactive medical records - Policy and procedure must include guidelines that describe how and when a medical record becomes inactive. Member medical records may be converted to microfilm or computer disks for long-term storage. Every provider of health care services who creates, maintains, preserves, stores, abandons, or destroys medical records shall do so in a manner that preserves the confidentiality of member information

Provision of Medical Records (CalViva Health)

Participating physician groups (PPGs), physicians, hospitals, and ancillary providers are required to provide Health Net and CalViva Health with copies of medical records and accounting and administrative books and records, as they pertain to the Provider Participation Agreement (PPA).

The provider has financial responsibility to provide copies of medical records so that Health Net and CalViva Health can make claims and benefit determinations for utilization management, quality improvement, Healthcare Effectiveness Data and Information Set (HEDIS®), and appeals and grievance programs.

Medical records may be required for regulatory reviews by the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), National Committee for Quality Assurance (NCQA), Independent Quality Review and Improvement Organization (QIO), and other regulatory bodies.

Right to Audit and Access Records, including Electronic Medical Records (EMR)

Access to Records and Audits by Health Plan

Subject only to applicable state and federal confidentiality or privacy laws, the provider must share records when the health plan or its designated representative requests access to them, in order to audit, inspect, review, perform chart reviews, and duplicate such records.

If performed onsite, access to records for the purpose of an audit must be scheduled at mutually agreed upon times, upon at least 30 business days prior written notice by the health plan or its designated representative, but not more than 60 days following such written notice. However, access to records and audits that are part of a facility site review audit, grievance visit or potential quality issue (PQI) visit can be unannounced.

EMR Access

When the health plan requests access to electronic medical records (EMR), the provider will grant the health plan access to the provider's EMR in order to effectively case manage members and capture medical record data for risk adjustment and quality reporting. There will be no other fees charged to the health plan for this access.

For more information, select any subject below:

- Confidentiality of Medical Records
- Medical Record Documentation
- Medical Record Forms and Aids

Confidentiality of Medical Records

Provider Type: Physicians | 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.

Basic Principles

Protected health information (PHI) may be shared with participating providers in the same facility only, on a need-to-know basis, and may be disclosed outside the facility only to the extent necessary such release is authorized.

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), PHI, whether it is written, oral or electronic, is protected at all times and in all settings. Disclosure of PHI must have prior written member authorization. Health Net participating providers only release PHI without authorization when:

- Needed for payment
- Necessary for treatment or coordination of care
- Used for health care operations (including, but not limited to, Healthcare Effectiveness Data and Information Set (HEDIS®) reporting, appeals and grievances, utilization management, quality improvement, and disease or care management programs)

- Where permitted or required by law

Health Net and participating providers may transmit PHI to individuals or organizations, such as pharmacy or disease management vendors, who contract to provide covered services to members. PHI cannot be intentionally shared, sold or otherwise used by Health Net, its subsidiaries, participating providers, or affiliates for any purpose other than for payment, treatment or health care operations or where permitted or required by law without an authorization from the member.

AB 715 (ch. 562, 2003) supports compliance with HIPAA and applicable state laws relating to use of PHI for marketing. Marketing is defined as a communication about a product or service that encourages recipients to purchase or use the product or service. Health plans, providers, pharmaceutical benefit managers, and disease management entities are prohibited from using PHI to market a product or service unless the communication meets one of the exceptions described below:

- Written or oral communication whereby the communicator receives no compensation from a third party
- Communications made to a current member solely for the purpose of describing a provider's participation in an existing health care provider network or health plan network to which the member subscribes
- Communications made to a current member solely for the purpose of describing products, services, payment, or benefits for the health plan to which the member subscribes
- Communication to describe a plan benefit or an enhancement or replacement to a benefit
- Communications describing the availability of more cost-effective pharmaceuticals
- Compensation communications tailored to a specific individual that educate or advise them about disease management or life-threatening, chronic or seriously debilitating conditions if:
    - The member receiving the communication is notified in writing that the provider, contractor or health plan has been compensated, and identifies the source of the compensation
    - The communication must include information on how the member can opt out of receiving further communications by calling a toll-free number and must be written in 14 point font or larger. No communication can be made to a member who has opted out after 30 days from the date of the request
- Special authorization is required for uses and disclosures involving sensitive conditions, such as psychotherapy notes, AIDS or substance abuse. To release PHI regarding sensitive conditions, Health Net and participating providers must obtain written authorization from the member (or authorized representative) stating that information specific to the sensitive condition may be disclosed.

In the event the member is unable to give authorization, Health Net or the participating provider accepts the authorization of the person holding power of attorney or any other authorized representative in order to release information or have access to information about the member. Refer to the Procedure discussion for more information regarding authorized representatives.

Members may obtain their own medical records upon request. Adult members have the right to provide a written addendum to the medical record if the member believes that the record is incomplete or inaccurate. Members may request that their PHI be limited or restricted from disclosure to outside parties or may request the confidential communication of their PHI to an alternate address. Members may file a grievance with respect to any concerns they have regarding confidentiality of data.

Procedure

Participating providers, policies and procedures governing the confidentiality of medical records and the release of protected health information (PHI) must address levels of security of medical records, including the:

- Assurance that the files are secure and not accessible to unauthorized users
- Indication of who has access to the medical records
- Identification of who may execute different database functions for computerized medical records
- Assurance that staff is trained with respect to the Health Insurance Portability and Accountability Act (HIPAA), privacy requirements and related policies
- Signed confidentiality agreements on file from staff who have access to medical records
- Assurance that photocopies or printouts of the medical records are subject to the same control as the original record
- Designation of a person to destroy the medical record when required

Release of medical information guidelines must address:

- Requests for PHI via the telephone
- Demands made by subpoena duces tecum
- Timely transfer of medical records to ensure continuity of care when a Health Net member chooses a new primary care physician (PCP)
- Availability and accessibility of member medical records to Health Net and to state and federal authorities or their delegates involved in assessing quality of care or investigating enrollee grievances or other complaints
- Availability and accessibility of member medical records to the member in a timely manner in accordance with industry standards and best practices
- Requirements for medical record information between providers of care:
    - A physician or licensed behavioral health care provider making a member referral must transmit necessary medical record information to the provider receiving the member referral
    - A physician or licensed behavioral health care provider furnishing a referral service provides appropriate information back to the referring provider
    - A physician or licensed behavioral health care provider requesting information from another treating provider as necessary to provide care. Treating physicians or licensed behavioral health care providers may include those from any organization with which the member may subsequently enroll

An authorization form must be in plain language and contain the following to be HIPAA-compliant:

- A specific and meaningful description of the information to be used or disclosed
- The name of the person or entity authorized to make the requested use or disclosure
- The name of a person or entity to which the use or disclosure may be made
- A description of each purpose or use for the information. If the individual requests the authorization for their own purposes, the description here may read simply "at the request of the individual"
- An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure
- The signature of the individual and the date
- If the personal representative signs for the individual, a description of such representative's authority to act for the individual must be provided
- A statement about the individual's right to revoke the authorization at any time if the revocation is in writing, the exceptions to the revocation right, and a description of how the individual may revoke the authorization. Alternatively, the revocation statement may state the individual's right to revoke and instruct the individual to refer to the covered entity's Notice of Privacy Practices for instructions and limitations on revocation

- A statement that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining the authorization, unless a valid exception applies (such as, pre-enrollment underwriting or information needed for payment of a specific claim for benefits), but the authorization cannot require release of psychotherapy notes for either exception
- The consequences to the individual of a refusal to sign when the plan can condition enrollment in the health plan, eligibility for benefits or payment on failure to obtain such authorization
- A statement that the information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by the privacy rule

Medical Record Documentation

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

The Health Net Quality Improvement Committee (HNQIC) develops standards for the administration and evaluation of medical records. Participating providers are required to comply with all medical record documentation standards.

Health Net requires participating providers to maintain medical records in a manner that is accurate, current, detailed, complete, organized, in accordance with industry standards and best practices, and permits effective and confidential member care and quality review. Medical records must reflect all aspects of member care, be readily available to health care providers and provide data for statistical and quality-of-care analysis. Medical records may be selected for evaluation as part of the annual delegation oversight assessment.

For more information, select any subject below:

- Advance Directives
- Medical Record Documentation Standards
- Medical Record Performance Measurements

Advance Directives

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

An “Advance Health Directive” is a legal form that allows the member to designation a representative; a person they want make decisions on their behalf or if loose the capacity to make decisions. Additionally, the member can also name people that they do not want to make decisions on their behalf, if they lose the capability to speak or loose the capacity make decision for themselves. The member can ask a family member or a primary care physician or someone they trust to help fill out the form. Members have certain rights regarding a “Advance Health Directive”: The right to learn about changes to the law regarding Advance Health Directives; The right to have their Advance Health Directive be placed in their medical record; and The right to change or cancel their Advance Health Directive at any time.

Medical Record Documentation Standards

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

Participating providers are required to meet Health Net medical record documentation standards. The following documentation guidelines must be followed and all of the elements must be included in the medical records of members.

- Format - The primary language and linguistic service needs of non- or limited-English proficient (LEP) or hearing impaired persons, individual personal biographical information, emergency contact, and identification of the member's assigned primary care physician (PCP)
- Documentation - Medical record entries and corrections must be documented in accordance with acceptable legal medical documentation standards; allergies, chronic problems, and ongoing and continuous medications must be documented in a consistent and prominent location; all signed consent forms and the ofference of advance health care directive information and education to members ages 18 and older must be included
- Routine record keeping - Department of Managed Health Care (DMHC) regulations require that the refusal of interpreter services for a Health Net member must be documented in the medical record. Department of Insurance (CDI) regulations also require that, when a minor, or friend or family member interprets at a member's request, even when a qualified interpreter is offered and available at no charge, the offer and the refusal at each visit it occurs shall be documented in the member's medical record
- Coordination of care - Notation of missed appointments, follow-up care and outreach efforts, practitioner review of diagnostic tests and consultations, history of present illness, progress and resolution of unresolved problems at subsequent visits, and consistent diagnosis and treatment plans
- Preventive care
    - Adult preventive care - Notation of periodic health evaluations according to the United States Preventive Services Task Force (USPSTF); assessment of immunization status and the year of the immunization(s); tuberculosis screenings and testing; blood pressure and cholesterol screenings; Chlamydia screenings for sexually active females to age 25 or at risk; and mammograms and Pap tests for females
    - Pediatric preventive care - Notation of age-appropriate physical exams according to the American Academy of Pediatrics (AAP); immunizations specified and within AAP and Healthcare Effectiveness Data and Information Set (HEDIS®) requirements; anticipatory guidance for age-appropriate levels; vision, hearing, lead, and tuberculosis screenings and testing; and nutrition and dental assessments
    - Perinatal preventive care - Notation of prenatal care visits according to the most recent American Congress of Obstetrics and Gynecology (ACOG) standards, including a timely prenatal visit within the first trimester; postpartum visit three to eight weeks after delivery - this interval may be modified according to the needs of teh patient, such as HEDIS timlines of 21-56 days after delivery; domestic violence and abuse screenings; HIV, alpha fetoprotein (AFP) and genetic screenings; and assessments of infant feeding status

Medical Record Performance Measurements

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

Health Net monitors medical record documentation through a variety of measures, which includes, but is not limited to, various quality initiatives, data collection by way of primary care physician (PCP) medical record audits, and records collected through the Healthcare Effectiveness Data and Information Set (HEDIS®) process. Data is aggregated and analyzed at least annually. Opportunities for improvement are identified and appropriate interventions are implemented based on compliance levels established for each individual activity. Interventions may include sending providers updates, educational or reference materials, creating template medical record forms, and provider and staff education and training. Participating providers are required to obtain a performance level of at least 80% on the medical record performance measures for a conditional pass.

Medical Record Forms and Aids

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

This section contains references and links to a variety of forms and aids for use and reference to help providers meet medical record documentation standards and requirements.

Select any subject below:

- Medical Record Forms and Aids

Medical Record Forms and Aids

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

Health Net has various medical record documentation forms and aids for participating providers.

- Advance Directive Labels (PDF)
- Adult Health Maintenance Checklist with Standards (PDF)
- Annual Care for Older Adults (COA)/Advance Care Planning (ACP) Form (PDF)
- Audiometric Screening form (PDF)
- Chronic Problem List (PDF)
- History Form - English (PDF)
- History Form -Spanish (PDF)
- Initial Health Appointment (IHA) Tickler Log (PDF)
- Language Labels (PDF)

- Medication and Chronic Problem Summary (PDF)
- Message Log (PDF)
- Preventive Care Forms (PDF)
- Referral Log (PDF)
- Signature Page (PDF)

Member Rights and Responsibilities

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

This section contains general information on member rights and responsibilities.

Select any subject below:

- Advance Directives
- Member Rights and Responsibilities

Advance Directives

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

Providers should consider discussing advance directives during routine office visits with Health Net members, instead of waiting until a member is acutely ill.

Health Net and its participating providers are required to comply with the PSDA for all new and renewing members. Health Net's policy is that any adult member has the right to make an advance directive concerning health issues. Additionally, in accordance with Title 22 of the California Code of Regulations and 422.128(b)(1)(ii)(E) of the Code of Federal Regulations, providers must document in a prominent place in the member's medical records (adult members only), whether the member has been informed of, or has executed, an advance directive.

An advance directive is a written document signed by a member, such as a durable power of attorney for health care (DPAHC), a declaration pursuant to the Natural Death Act, or a living will that explains the member's wish concerning a given course of medical care should a situation arise where they is unable to make these wishes known. The member may specify guidelines for care or delegate the decision-making authority to a family member, close friend, or other representative.

According to AB 2805 (ch.579, 2006), a written advance health care directive is legally sufficient if all the following requirements are satisfied:

- The advance directive contains the date of its execution
- The advance directive is signed either by the member or in the member's name by another adult in the member's presence and at the member's direction
- The advance directive is either acknowledged before a notary public or signed by at least two witnesses who satisfy the requirements of Sections 4674 and 4675 of the California Probate Code

- If the advance directive is acknowledged before a notary public, and a digital signature is used, the digital signature must meet all of the following requirements:
  - It either meets the requirements of Section 16.5 of the Government Code and Chapter 10 (commencing with Section 22000) of Division 7 of Title 2 of the California Code of Regulations, or the digital signature uses an algorithm approved by the National Institute of Standards and Technology
  - It is unique to the person using it
  - It is capable of verification
  - It is under the sole control of the person using it
  - It is linked to data in such a manner that if the data are changed, the digital signature is invalidated
  - It persists with the document and not by association in separate files
  - It is bound to a digital certificate

For more information, select any subject below:

- Provider Responsibilities and Procedures

Provider Responsibilities and Procedures

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

Participating providers must establish procedures ensuring that any advance directive is brought to the attending provider's immediate attention if, in the opinion of that provider, the member is unable to make health care decisions. If any adult Health Net member has such a directive in force, the following must occur:

- Each health care provider must honor advance directives to the fullest extent permitted under California and federal law
- Primary care physicians (PCPs) must be open to any discussion with a member and provide medical advice if the member desires guidance or assistance regarding this matter. Direct inquiries to the regional office or the Health Net Provider Services Center
- In no event may the participating provider refuse to treat a member or otherwise discriminate against a member because the member has completed an advance directive

For additional information on Advance Directive, refer to the member's Evidence of Coverage (EOC).

Member Rights and Responsibilities

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

Members have the right to expect a certain level of service from their health care providers. Members are also responsible for cooperating with providers in obtaining health care services. Health Net developed member rights and responsibilities statements in accordance with the National Committee for Quality Assurance (NCQA) and the Centers for Medicare and Medicaid Services (CMS). These member rights and responsibilities

apply to member's relationships with Health Net, and all participating providers responsible for member care. In addition to member rights and responsibilities, medical services must be provided in a culturally competent manner without regard to race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, health status, physical or mental handicap, or disability.

Health Net members are notified annually of their rights and responsibilities via the member's Evidence of Coverage (EOC) or Certificate of Insurance (COI) and are listed below for reference. The actual statements of member rights and responsibilities may vary slightly from what is included in the EOC or COI. Health Net members with questions regarding their rights and responsibilities should be directed to their specific member materials.

Members have the right to:

- Receive information about Health Net, its services, its providers and member rights and responsibilities.
- Be treated with respect and recognition of their dignity and right to privacy;
- Participate with providers in making decisions about their health care;
- A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage;
- Use interpreters who are not your family members or friends;
- File a grievance in your preferred language by using the interpreter service or by completing the translated grievance form that is available on www.healthnet.com;
- File a complaint if your language needs are not met;
- Voice complaints or appeals about the organization or the care it provides; and
- Make recommendations regarding the organization's member rights and responsibilities policies.

Members have the responsibility to:

- Supply information (to the extent possible) that the organization and its providers need in order to provide care;
- Follow plans and instructions for care that they have agreed on with their providers;
- Be aware of their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible; and
- Refrain from submitting false, fraudulent, or misleading claims or information to Health Net or your providers.

Prescription Drug Program

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

This section contains general member benefit information on the prescription drug program.

Select any subject below:

- Compounded Medications
- Diabetic Supplies
- Exclusions and Limitations
- Generic Medications
- Off-Label Medication Use

Exclusions and Limitations

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

The following list of exclusions and limitations (benefits vary by plan) applies to the Health Net prescription drug program:

- Medications prescribed by a non-participating physician are not covered except when the physician's services have been authorized because of a medical emergency, illness or injury, or the physician is the authorized referring physician.
- Allergy serum.
- Appetite suppressants or medications for body weight reduction, unless medically necessary for morbid obesity, require prior authorization.
- Blood.
- Compounded medications - Prescription orders that are combined or manufactured by the pharmacist and placed in an ointment, capsule, tablet, solution, suppository, cream or other form using Food and Drug Administration (FDA)-approved medications, are covered at the Level III copayment. Coverage for compounded medications is subject to prior authorization by the plan and medical necessity. Compounded medications are not covered if there is a similar proprietary product available.
- Devices other than diaphragms.
- Dietary or nutritional supplements - Medications used as dietary or nutritional supplements, including vitamins and herbal remedies, are limited to medications that are listed in the Recommended Drug List (RDL). Phenylketonuria (PKU) is covered under the medical benefit.
- Medications prescribed for cosmetic purposes - Medications that are prescribed for the following non-medical conditions are not covered: hair loss, sexual performance, athletic performance, anti-aging, and mental performance. Examples of medications that are excluded when prescribed for such conditions include, but are not limited to Penlac®, Renova™ , Retin-A®, Vaniqua®, Propecia®, and Lustra.™
- Supply amounts (for any number of days), which exceed the Food and Drug Administration's (FDA's) or Health Net's usage recommendations.
- Hypodermic syringes and needles - Hypodermic syringes and needles are limited to disposable insulin needles and syringes and reusable pen devices.
- Medications prescribed for non-FDA-approved use.
- Medications prescribed for non-covered services.
- Lost, stolen or damaged medications.
- Prescriptions from non-participating pharmacies.
- Non-prescription (over-the-counter) medications, equipment and supplies (except insulin, diabetic supplies and as required under preventive care coverage).
- Oxygen.

Compounded Medications

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

Most Health Net pharmacy benefit plans cover medically necessary and appropriate compounded prescriptions that meet all of the following conditions:

- Includes at least one federal legend medication listed on the Health Net Recommended Drug List (RDL) as one of its main compounded ingredients.
- There is scientific evidence and peer-reviewed literature demonstrating safety and effectiveness for the specific medical condition.
- There is no acceptable proprietary alternative medication.

Diabetic Supplies

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

Health Net covers specific brands of blood glucose meters at no charge and test strips at Tier II of the Recommended Drug List (RDL). The selected brands meet the needs of the majority of members and physicians. The following blood glucose meters and test strips are available with a primary care physician (PCP) prescription at participating pharmacies:

- OneTouch® Verio® IQ meter and test strips
- OneTouch® Ultra® Mini meter
- OneTouch® Ultra® 2 meter
- One Touch® Ultra® Blue test strips
- FreeStyle® test strips
- Freestyle Lite® meter and test strips
- Freestyle InsuLinx ® meter and test strips
- Precision Xtra® meter and test strips

No other meters or test strips are covered at Tier II on the Health Net RDL.

Test strips are available in packages of 50 and 100 and may be prescribed to allow for up to a 30-day supply. Prior authorization is required if more than 200 test strips per month are prescribed.

Most members have coverage for diabetic supplies under their pharmacy benefit. Insulin-dependent and noninsulin-dependent diabetics are eligible for blood glucose monitoring supplies.

Insulin needles and syringes are covered under the Health Net Prescription Drug Program.

Generic Medications

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

A generic-equivalent medication is the pharmaceutical equivalent of a brand-name medication for which the brand-name medication's patent has expired. The Food and Drug Administration (FDA) must approve the generic medication as meeting the same standards of safety, purity, strength, and effectiveness as the brand-name medication.

Generic Substitution Program

If a generic product cannot be used due to medical necessity, a prescriber may:

1. Clearly indicate on the prescription "do not substitute" (DNS) or "dispense as written" (DAW). The pharmacist must make the indication on the prescription claim, and the member may be charged the higher copayment, or
2. Request prior authorization for the brand-name medication documenting failure or clinically significant adverse effects to the generic equivalent.

Off-Label Medication Use

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

A medication prescribed for a use that is not stated in the indications and usage information published by the manufacturer is covered only if the medication is:

- Approved by the Food and Drug Administration (FDA).
- On the Recommended Drug List (RDL) and prescribed or administered by a participating licensed health care professional for the treatment of:
    - A life-threatening condition
    - A chronic and seriously debilitating condition for which the medication is determined to be medically necessary to treat such condition
- Recognized for treatment of the life-threatening or chronic and seriously debilitating condition by one of the following:
    - The American Hospital Formulary Service (AHFS) Drug Information.
    - One of the following compendia, if recognized by the federal Centers for Medicare & Medicaid Services (CMS) as part of an anticancer therapeutic regimen:
        - Elsevier Gold Standard's Clinical Pharmacology..
        - National Comprehensive Cancer Network Drug and Biologics Compendium.
        - Thomson Micromedex DrugDex.
- Two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.

The following definitions apply to the terms mentioned in this provision only.

Life-threatening means either or both of the following:

- Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.
- Diseases or conditions with potentially fatal outcomes, where the end-point of clinical intervention is survival.

Chronic and seriously debilitating refers to:

- Diseases or conditions that require ongoing treatment to maintain remission or prevent deterioration and cause significant long-term morbidity

Participating Pharmacy

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

Members are required to obtain medications from Health Net participating pharmacies, with a few exceptions. Health Net contracts with many major pharmacy chains, supermarket-based pharmacies and independently owned neighborhood pharmacies.

For a complete and up-to-date list of participating pharmacies, contact the Health Net Provider Services Center (Commercial, or Medicare), or go to ProviderSearch.

Physician Self-Treatment

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

Health Net does not cover physician self-treatment rendered in a non-emergency. This includes treatment of immediate family members. Physician self-treatment occurs when physicians provide their own medical services, including prescribing their own medication, ordering their own laboratory tests and self-referring for their own services. Claims for emergency self-treatment are subject to review by Health Net.

Prescription Mail-Order Program

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

A prescription mail-order program is available to Health Net members. Members are required to pay their mail-order copayments for up to a 90-day supply of medication depending on their plan. The member copayment applies to a 90-consecutive-calendar-day supply of maintenance medications (prescription medications used to

manage chronic or long-term conditions when members respond positively to medication treatment and dosage adjustments are either no longer required or made infrequently) and each refill allowed by that order when prescribed by a Health Net participating physician or an authorized specialist. The 90-day-supply maximum is subject to the physician's judgment, the Food and Drug Administration (FDA) and Health Net's recommendations for use. In cases where a 90-day supply is not recommended by the FDA, the prescriber or Health Net, the mail order pharmacy dispenses the correct quantity. Prescriptions filled through the mail-order program should be written for a 90-day supply whenever possible.

- **For members with Commercial HMO and PPO products:** New prescription medication requests may be mailed by the member to the mail order pharmacy CVS Caremark Pharmacy, or faxed or e-prescribed to the mail order pharmacy by the prescribing physician. The member's Health Net identification (ID) number, date of birth, phone number including area code, and Health Net should appear on the prescription request to ensure it is processed correctly. If available, a generic equivalent medication is automatically substituted unless the prescriber indicates DAW (dispense as written) or DNS (do not substitute). Members are charged a higher copayment. Specialty drugs are not available through mail order.
- **For members with Ambetter HMO or Ambetter PPO:** New prescription medication requests may be mailed by the member to Express Scripts® Pharmacy, faxed to Express Scripts Pharmacy by the prescribing physician at 800-837-0959, or e-prescribed by the prescribing physician to Express Scripts Pharmacy. Members can request mail order service for prescription medications and refills from Express Scripts Pharmacy by phone, mail or online at express-scripts.com/rx. The member's Health Net ID number, date of birth, phone number including area code, and Health Net should appear on the prescription request to ensure it is processed correctly. If available, a generic equivalent medication is automatically substituted unless the prescriber indicates DAW or DNS. Members are charged a higher copayment. Specialty drugs are not available through mail order.

Prior Authorization Process

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

Prior authorization is needed for prescription medications when:

- A medication is listed on the Health Net Drug List (Formulary) as needing prior authorization.
- A medication is not listed on the Formulary.
- A step therapy exception is requested.

There are three options for submitting a prior authorization form:

1. Submit the prior authorization electronically through CoverMyMeds.
2. Complete the Prescription Drug Prior Authorization or Step Therapy Exception Request Form (PDF) and submit to Pharmacy Services.
3. Contact Pharmacy Services directly via telephone.

When using the Prescription Drug Prior Authorization or Step Therapy Exception Request Form (PDF) it must be electronically submitted, faxed to Pharmacy Services or submitted by any reasonable means of transmission. Faxes are accepted 24 hours a day, and each request is tracked to ensure efficient handling of inquiries from physicians and members. Requests for prior authorization may also be called into Pharmacy Services. Requests are processed within 24 hours for urgent requests and 72 hours for standard requests. If a

health care service plan, contracted physician group or utilization review organization fails to notify a prescribing provider of its coverage determination within 72 hours for nonurgent requests, or within 24 hours if exigent circumstances exist, upon receipt of a completed prior authorization or step therapy exception request, the prior authorization or step therapy exception request shall be deemed approved for the duration of the prescription, including refills.

Pharmacy Services will respond via fax to advise providers the status of the request.

The Prescription Drug Prior Authorization or Step Therapy Exception Request Form (PDF) and medication-use guidelines are also available through Pharmacy Services fax-back system: select option 2, for commercial claim form.

Exigent Requests

Exigent circumstances take place when a member is suffering from a serious health condition that may jeopardize their life, health or ability to regain maximum functions, or is undergoing a current course of treatment using a non-formulary medication.

Providers may request an expedited medication review based on exigent circumstances by contacting Pharmacy Services. The request must include an oral or written statement, which includes the following:

- An exigency exists and the basis for the exigency.
- A justification supporting the need for the non-formulary medication to treat the member's condition, including a statement that covered formulary medications on any tier would not be as effective as the non-formulary medication, or would have adverse effects.

Health Net makes a coverage determination and notifies the member and prescribing physician or other prescriber, as appropriate, of the determination no later than 24 hours after receiving the request or any additional information requested by Health Net that is reasonably necessary to make the determination. If approved, Health Net continues to provide the requested medication throughout the duration of the member's health condition.

Participating physician group (PPG) step therapy and exception process

For PPGs delegated as financially responsible through capitation or other financial arrangement, or for which medical management (medical necessity review) is done by other than the health plan, the utilization review organization must comply with state law[1] relating to self-injectable medications and self-injectable step therapy exception determinations and procedures.

[1]Health and Safety Code Sections 1367.206 and 1367.241.

- The provider may appeal a denial of an exception request for coverage of a nonformulary drug, prior authorization request or step therapy exception request consistent with the plan’s current utilization management processes. The law requires the provider to submit justification and supporting clinical documentation supporting the provider’s determination that the required prescription drug is inconsistent with good professional practice for provision of medically necessary covered services.
- PPGs that do their own utilization review on behalf of the plan, or between the plan and another contracted entity, are required to comply with the specified provisions of state law relating to step therapy determinations and procedures. Denial of step therapy exception requests require a notification to the prescribing provider and member on the external appeal process through the plan

(independent medical review) or request additional or clinical documentation to make a coverage determination. In addition, notification of an incomplete or missing clinical documentation step therapy exception request requires notification to the prescribing provider.

PPGs must ensure that they have this process in place.

As a result, a financially responsible PPG **cannot deny, as standard practice:**

- PA for a nonformulary drug only because the member has not tried and failed with a formulary drug, and
- PA for a step therapy exception only because the member has not tried and failed with a preferred drug in the step therapy process.
- **Denial or approval must be based on the medically necessary documentation provided with the PA.**

Quantity of Medication to Be Prescribed

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

Maintenance medication should be prescribed for a 30-day supply unless the member wants to use the Health Net mail-order program; then a 90-day supply of maintenance medication should be prescribed.

Up to a 30-day supply is covered for medications that come in specific quantities, such as inhalers or insulin vials. In some cases, this may be less than a 30-day supply.

For acute treatment, a standard course of therapy should be prescribed. Medications that are used as needed or come packed in small quantities, such as Imitrex®, should be prescribed for the smallest package size. The Health Net Recommended Drug List (RDL) indicates quantity limits on specific medications. Quantities larger than a 30-day supply or dosing greater than that approved by the Food and Drug Administration (FDA) or Health Net's medication usage guidelines require prior authorization.

Copayments are charged per 30-day supply for maintenance medications and per course of therapy or individual package for acute medications. Some medications have a specific quantity per copayment. Refer to the RDL for specific quantity limitations.

Recommended Drug List

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

The Health Net Recommended Drug List (RDL) is the approved list of covered medications. In addition, they identify whether a generic version of a brand-name medication exists and whether prior authorization is required.

Medications that are listed in the RDL are covered if the member has a prescription benefit plan; however, the prescription medication must be dispensed for a condition, illness or injury that is covered by Health Net. Some medications may require prior authorization from Health Net in order to be covered.

The Health Net RDL is available for review or download from the provider portal.

Prior Authorizations

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

This section contains general information on prior authorizations requirements.

Select any subject below:

- How to Secure Prior Authorization on Health Net Provider Portal
- NIA - Prior Authorization
- Prior Authorization Process for Direct Network Practitioners

How to Secure Prior Authorization on the Provider Portal

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

To obtain step-by-step guidance on how to determine whether services require prior authorization and how to secure prior authorization on Health Net's provider portal, download the Save Time Navigating the Provider Portal (PDF), Save Time Navigating the Provider Portal – Community Health Plan of Imperial Valley (PDF), Save Time Navigating the Provider Portal – CalViva (PDF) or Save Time Navigating the Provider Portal – WellCare by Health Net booklet.

NIA - Prior Authorization

Provider Type: Physicians

Health Net partners with Evolent Specialty Services, Inc. to provide utilization management (UM) services, including prior authorization determinations for certain advanced and cardiac imaging for fee-for-service (FFS) members.

Go to the Health Net provider website for more information.

Prior Authorization Process for Direct Network Providers

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

Selected specialty and outpatient services that cannot be provided in a primary care physician's (PCP's) or specialist's office require prior authorization as outlined in the Commercial Prior Authorization Requirements or the Medicare Prior Authorization Requirements.

PCPs and specialists must fax requests for prior authorization to the Health Net Medical Management Department using the appropriate form listed below:

- Inpatient California Health Net Commercial Prior Authorization (PDF)
- Outpatient California Health Net Commercial Prior Authorization (PDF)
- Inpatient California Health Net Medicare Authorization (PDF)
- Outpatient California Health Net Medicare Authorization (PDF)

The Health Net Medical Management Department accepts prior authorization requests for elective and urgent services by fax only.

To initiate the prior authorization process, PCPs and specialists must:

- Verify member eligibility and benefit coverage by accessing the Health Net provider portal or by contacting the Health Net Provider Services Center.
- Complete the prior authorization form, including CPT codes and sufficient clinical information to support the medical necessity of the request. Incomplete forms or forms with insufficient information at the time of submission delay processing (some surgical requests, such as requests for reconstructive surgery or repair require submission of non-returnable color photos, models or X-rays).

Contact the Health Net Medical Management Department or visit the Health Net provider website to obtain the status of an authorization.

Allow 14 calendar days for routine organization determinations and 72 hours for expedited organization determinations.

Emergency services do not require prior authorization.

Prior Authorization Requirements

California
Commercial

Effective January 1, 2025

The services, procedures, equipment and outpatient pharmaceuticals below apply to:

- Direct Network[1] HMO (including Ambetter HMO) and Point of Service (POS) Tier 1
- POS Tiers 2 and 3 (Elect, Select and Open Access)
- Ambetter (Amb.) HMO participating physician groups (PPGs)
- PPO (including Amb.) and out-of-state PPO

These are subject to prior authorization (PA) requirements (unless noted as "notification" required only) if an “X” is included under the applicable line of business. If “X” is not present, PA may not be required or the service, procedure, equipment or outpatient pharmaceutical may not be a covered benefit. PA is guaranteed only as of the time of access to this prior authorization requirements page.

Member questions – If members have questions regarding the PA list or requirements, refer to the member services number listed on their identification card.

Pre-Auth Check Tool for individual plans – To confirm whether a specific code requires authorization, go to: IFP Ambetter HMO or IFP Ambetter PPO and follow the prompts.

Medical necessity – Medical necessity must exist for any plan benefit to be a covered service whether a PA is required or not.

Services that require PA vs. covered services – This PA list is not intended to be a list of covered services. The member’s *Evidence of Coverage (EOC)* provides a complete list of covered services. *EOCs* may be available online to members on the Health Net website (IFP, Small Group, Large Employer Groups) or by requesting them from the Health Net Provider Services Center.

Eligibility rules and limitations – Refer to the member’s Health Net identification (ID) card to confirm product type before proving care. Then verify member eligibility through the Health Net Provider Services Center. Even if a service or supply is authorized, eligibility rules and benefit limitations will still apply – all services, procedures, equipment and outpatient pharmaceuticals are subject to benefit plan coverage limitations.

Submit a PA request –

- Send the request via fax or online to Health Net unless stated differently in requirements listed below.
- The Health Net Request for Prior Authorization form must be completed in its entirety.
- Attach pertinent medical records, treatment plans, test results, and evidence of conservative treatment to support the medical appropriateness of the request.
- For more submission instructions, see *'Avoid Processing Delays for Prior Authorization Requests with These Guidelines.' (PDF)*
- Out-of-state PPO plans or PPO plans with travel benefits should verify member eligibility and confirm the process to submit a request for authorization through the Health Net Provider Services Center before providing care.

PA Timelines –

If the request is for …	Submit prior authorization request:
An **elective** in patient or outpatient services or procedures.	As soon as the need for service is identified.

If the request is for …	Submit prior authorization request:
A **routine** request or procedure.	At least five business days before a scheduled procedure.
An **urgent** request or procedure.	72 hours before a scheduled procedure. Emergency services do not require prior authorization.

[1]Direct Network refers to Health Net's directly contracting network for HMO, Ambetter HMO and POS Tier 1 products.**CARE –** Services provided pursuant to a CARE agreement or CARE plan approved by a court do not require prior authorization.

Services outside of California – PPO plans that include travel benefits and out-of-state PPO plans: Inpatient services, medical oncology and transplant services require prior authorization. Verify member eligibility through the Health Net Provider Services Center prior to providing care. Services provided within California follow the requirements and directions below.

Select lines of business are abbreviated as follows: Ambetter HMO PPGs is Amb. HMO PPGs, POS Tiers 1, 2 and 3 are POS T1, POS T2, POS T3. Ambetter HMO utilizes the CommunityCare network. Data about Data:

Inpatient Services

Submit a prior authorization request to Health Net unless stated differently in requirements listed below.

Inpatient Service	HMO, POS T1	Amb. HMO PPGs	POS T2, POS T3	PPO
Behavioral health or substance abuse facility • Authorized by the Behavioral Health Team • Includes: ◦ Inpatient acute psychiatric ◦ Inpatient detoxification ◦ Residential treatment (mental health and	X	X	X	X

Inpatient Service	HMO, POS T1	Amb. HMO PPGs	POS T2, POS T3	PPO
chemical dependency)				
Hospice	X	X	X	X
Hospital • Acute inpatient admission, inpatient rehabilitation, Long-Term Acute Care Hospital (LTAC) • Musculoskeletal procedures authorized by TurningPoint Healthcare Solutions, LLC • PPO, OOS PPO Only: Cardiac Procedures and Ear Nose Throat Procedures authorized by TurningPoint Healthcare Solutions, LLC	X	X	X	X
Skilled nursing facility	X	X	X	X

Inpatient Service	HMO, POS T1	Amb. HMO PPGs	POS T2, POS T3	PPO
Urgent/emergent admission • **Notification required only**, as soon as possible, but no later than 24 hours or by the next business day • Send notification to Hospital Notification Unit	X	X	X	X

Outpatient Services

Submit a prior authorization request to Health Net unless stated differently in requirements listed below.

Outpatient Service	HMO, POS T1	Amb. HMO PPGs	POS T2, POS T3	PPO
Ablative techniques for treating Barrett's esophagus and for treatment of primary and metastatic liver malignancies	X	X	X	X
Ambulance	X	X*	X	X

Outpatient Service	HMO, POS T1	Amb. HMO PPGs	POS T2, POS T3	PPO
• Non-emergency air transportation • Non-emergency ground transportation				
Bariatric procedures • Surgical procedure • Bariatric surgeries must be performed through Health Net's designated bariatric specialty network	X	X*	X	X
Behavioral health and substance abuse Authorized by the Behavioral Health Team other than office visits including: • Applied behavioral analysis (ABA) and other forms of	X	X	X	X

Outpatient Service	HMO, POS T1	Amb. HMO PPGs	POS T2, POS T3	PPO
• behavioral health treatment (BHT) for autism and pervasive developmental disorders • Electroconvulsive therapy (ECT) • Intensive outpatient program (IOP) • Neuropsychological testing • Partial hospital program (PHP) full or half day • Psychological testing • Transcranial magnetic stimulation (TMS)				
Bronchial thermoplasty	X		X	X
Capsule endoscopy	X	X*	X	X
Cardiovascular procedures Authorized by TurningPoint Healthcare Solutions, LLC.				X

Outpatient Service	HMO, POS T1	Amb. HMO PPGs	POS T2, POS T3	PPO
Includes: • Arterial procedures • Coronary angioplasty/ stenting • Coronary artery bypass grafting • Implantable cardioverter defibrillator (ICD) • ICD revision or removal • Leadless pacemaker • Left atrial appendage (LAA) occluders • Loop recorder • Non-coronary angioplasty/ stenting • Pacemaker • Pacemaker revision or removal • Valve replacement • Wearable cardiac defibrillator (WCD)				

Outpatient Service	HMO, POS T1	Amb. HMO PPGs	POS T2, POS T3	PPO
Chiropractic care and Acupuncture visits • Authorization not required for initial evaluation • Contact American Specialty Health Plans, Inc. (ASH Plans)	X	X	X	X
Clinical trials	X	X	X	X
Dermatology (in-office procedures) Includes: • Chemical exfoliation, electrolysis • Dermabrasion/ chemical peel • Laser treatment • Skin injections and implants	X	X*	X	X
Diagnostic procedures	X	X	X	X

Outpatient Service	HMO, POS T1	Amb. HMO PPGs	POS T2, POS T3	PPO
Authorized by Evolent Specialty Services, Inc. (Evolent) **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				

Outpatient Service	HMO, POS T1	Amb. HMO PPGs	POS T2, POS T3	PPO
Drug testing PA required for all quantitative tests for drugs of abuse	X		X	X
Durable medical equipment (DME) Includes: • BiLevel positive airway pressure (BiPAP); refer members to Apria Healthcare • Bone growth stimulator • Continuous glucose monitoring • Continuous positive airway pressure (CPAP); refer members to Apria Healthcare • Custom-made items including custom wheelchairs	X	X	X	X

Outpatient Service	HMO, POS T1	Amb. HMO PPGs	POS T2, POS T3	PPO
• Hospital beds and mattresses • Power wheelchairs • Scooters • Ventilators				
Ear, nose, throat (ENT) services Authorized by TurningPoint Healthcare Solutions, LLC Includes: • Choanal atresia • Cochlear device (hearing) • Fistula repair • Laryngoscopy, laryngoplasty • Nasal, sinus endoscopy • Polyp excision • Rhinoplasty, septoplasty, vestibular stenosis repair • Thyroidectomy, parathyroidectomy • Tonsillectomy, adenoidectomy • Tympanostomy, tympanoplasty, myringotomy				X

Outpatient Service	HMO, POS T1	Amb. HMO PPGs	POS T2, POS T3	PPO
Ear, nose, throat (ENT) services Authorized by Health Net Includes: • Balloon sinuplasty • Cochlear implants • Nasal surgery, such as rhinoplasty or septoplasty	X	X*	X	
Enhanced external counterpulsation (EECP)	X	X*	X	X
Experimental/ investigational services and new technologies Includes, but is not limited to, those listed in the Investigational Procedures List	X	X	X	X
Gender reassignment services (Transgender services)	X	X*	X	X

Outpatient Service	HMO, POS T1	Amb. HMO PPGs	POS T2, POS T3	PPO
Genetic testing Includes counseling	X	X*	X	X
Implantable pain pumps Authorized by TurningPoint Healthcare Solutions, LLC	X	X*	X	X
Joint surgeries Authorized by TurningPoint Healthcare Solutions, LLC	X	X*	X	X
Maternity **Notification required only** at time of first prenatal visit	X	X	X	X
Neuro and spinal cord stimulators Authorized by TurningPoint Healthcare Solutions, LLC	X	X*	X	X
Neuropsychological testing Authorized by Health Net when related to a medical	X	X*	X	X

Outpatient Service	HMO, POS T1	Amb. HMO PPGs	POS T2, POS T3	PPO
procedure; otherwise, refer to the Behavioral Health Team				
Orthognathic procedures Includes: • TMJ treatment • Surgical procedure	X	X*	X	X
Orthotics Custom-made orthotics	X	X	X	X
Proprietary laboratory analyses Includes the following CPT® codes: 0457U, 0459U, 0462U, 0468U, 0472U	X	X	X	X
Prosthetics Applies to items exceeding $2,500 in billed charges	X	X	X	X
Radiation therapy **For HMO, PPO** – Authorized by	X	X*	X	X

Outpatient Service	HMO, POS T1	Amb. HMO PPGs	POS T2, POS T3	PPO
eviCore healthcare **For POS T1, T2, T3** – Authorized by Health Net; limited to: • Intensity modulated radiation therapy (IMRT) • Neutron beam therapy • Proton beam therapy • Stereotactic radiosurgery and stereotactic body radiotherapy (SBRT)				
Reconstructive and cosmetic surgery, services and supplies Surgery, services, and supplies, including, but not limited to: • Bone alteration or reshaping, such as osteoplasty	X	X*	X	X

Outpatient Service	HMO, POS T1	Amb. HMO PPGs	POS T2, POS T3	PPO
• Breast reduction and augmentation except when following a mastectomy (includes for gynecomastia or macromastia) • Dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate • Excision, excessive skin and subcutaneous tissue (including lipectomy and panniculectomy) of the abdomen,				

Outpatient Service	HMO, POS T1	Amb. HMO PPGs	POS T2, POS T3	PPO
thighs, hips, legs, buttocks, forearms, arms, hands, submental fat pad, and other areas • Eye or brow procedures, such as blepharoplasty, brow ptosis or canthoplasty • Gynecologic or urology procedures, such as clitoroplasty, labioplasty, vaginal rejuvenation, scrotoplasty, testicular prosthesis, and vulvectomy • Hair electrolysis, transplantation or laser removal • Lift, such as arm, body, face, neck, thigh • Liposuction • Otoplasty • Penile implant				

Outpatient Service	HMO, POS T1	Amb. HMO PPGs	POS T2, POS T3	PPO
• Treatment of varicose veins • Vermilionectomy with mucosal advancement				
Referrals to nonparticipating providers	X	X		
Sleep studies Authorized by eviCore healthcare	X	X*		X
Spinal surgery • Includes, but is not limited to, laminotomy, fusion, diskectomy, vertebroplasty, nucleoplasty, stabilization, and X-Stop • Authorized by TurningPoint Healthcare Solutions, LLC	X	X*	X	X
Therapy	X	X*	X	X

Outpatient Service	HMO, POS T1	Amb. HMO PPGs	POS T2, POS T3	PPO
Requires PA after 12 combined visits, including home setting • Physical therapy • Occupational therapy • Speech therapy				
Transplant • Fax requests to the Transplant Team • All transplant evaluations and procedures, including, but not limited to, evaluation, transplant consult visits, donor search, and transplant procedure • Transplants must be performed through Health Net's designated transplantation	X	X	X	X

Outpatient Service	HMO, POS T1	Amb. HMO PPGs	POS T2, POS T3	PPO
specialty network				
Trigger point and sacroiliac (SI) joint injections	X	X*	X	X
Uvulopalatopharyngoplasty (UPPP) and laser-assisted UPPP Surgical procedure	X	X*	X	X
Vestibuloplasty Surgical procedure	X	X*	X	X
Wound care Including but not limited to: • Negative pressure wound treatment, low-frequency ultrasound • Skin substitutes and biologicals • Wound debridement – authorization required after 12	X	X*	X	X

Outpatient Service	HMO, POS T1	Amb. HMO PPGs	POS T2, POS T3	PPO
sessions per year				

*Subject to PA from the Health Net CommunityCare PPG.

Outpatient Pharmaceuticals (Submitted Under Medical Benefit)

Medications

- Authorized by Health Net Pharmacy Services
- Outpatient pharmaceuticals require prior authorization for all commercial lines of business: HMO, POS T1, POS T2, POS T3, Amb. HMO PPGs, and PPO

Outpatient Pharmaceuticals (Submitted under medical benefit)	
Hemophilia factors	AcariaHealth™ is Health Net's preferred provider
Medications newly approved by the U.S. Food and Drug Administration (FDA)	May require prior authorization – Contact Health Net Pharmacy Services to confirm
Self-injectables	For a list of self-injectables, refer to the DOFR crosswalk
Testosterone therapy	

- Authorized by Health Net Pharmacy Services
- Coram is Health Net's preferred infusion provider

Outpatient Pharmaceuticals (Submitted Under Medical Benefit)	
DRUG/THERAPY CLASS	
Gene therapy, includes CAR-T therapy	Examples include: • Abecma®*, Adstiladrin®, Breyanzi®*, Carvykti®*, Elevidys™, Hemgenix®, Imlygic®, Kymriah™*, Luxturna™,

Outpatient Pharmaceuticals (Submitted Under Medical Benefit)	
	Skysona®, Tecartus™*, Yescarta™*, Zynteglo®, Zolgensma® *CAR-T therapy
GnRH agonists	Examples include: • Eligard®, Fensolvi®, Lupron Depot®, Lupron Depot-Ped®, Triptodur®, Zoladex® Authorization required for non-oncology/non-urology only: • Eligard, Lupron Depot, Zoladex
Hereditary angioedema (HAE) agents	Examples include: • Berinert®, Cinryze®, Firazyr®, Haegarda®, Kalbitor®, Ruconest®, Takhzyro® • Preferred: Firazyr and Haegarda. See self-injectables
Intravenous (IV) iron agents	Examples include: • Injectafer®, Monoferric®, Triferic®/Triferic AVNU
Immune globulin agents	Examples include: • Intravenous immunoglobulin (IVIG), Asceniv®, Bivigam®, Cuvitru®, Flebogamma®, Gammagard® Liquid, Gammagard® S/D, Gammaked™, Gammaplex®, Gamunex®-C, Hizentra®, HyQvia®, Octagam®, Panzyga®, Privigen®, Xembify®
Lysosomal storage disorders	Examples include:

Outpatient Pharmaceuticals (Submitted Under Medical Benefit)	
	• Aldurazyme®, Brineura™, Cerezyme®, Elaprase®, Elelyso®, Fabrazyme®, Kanuma®, Lumizyme®, Mepsevii™, Naglazyme®, Vimizim®, Vpriv®
PD-1/PD-L1 inhibitors	Examples include: • Bavencio®, Imfinzi®, Jemperli®, Keytruda®, Libtayo®, Loqtorzi™, Opdivo®, Opdualag™, Tecentriq®, Tevimbra®, Zynyz®
Pemetrexed agents	Examples include: • Alimta® (no PA for generic), Pemfexy™, Pemrydi RTU®, and other generic
Pulmonary arterial hypertension (PAH) agents	Examples include: • PDE-5 inhibitors: Revatio® • Prostacylin analogues/receptor agonist injection: Flolan®, Remodulin®, Veletri® • Prostacylin analogues (PCA) inhalation: Tyvaso®, Ventavis®
Ranibizumab agents	Examples include: • Byooviz™, Cimerli™, Lucentis®, Susvimo™
Viscosupplementation agents	Examples include: • Euflexxa®, Gelsyn-3™, GenVisc® 850, Hyalgan®, Supartz FX ™, Synojoynt ™, Triluron ™, TriVisc ™, VISCO-3 ™, Durolane, Gel-One®, Hymovis®,

Outpatient Pharmaceuticals (Submitted Under Medical Benefit)	
	Orthovisc®, Monovisc®, Synvisc®, Synvisc One®

- The following medications require prior authorization from the Health Net Pharmacy Services
- For the reference product, all generics or biosimilar drugs will require a prior authorization

Outpatient Pharmaceuticals (Submitted Under Medical Benefit)				
Abrilada™	Elrexfio™	Lumoxiti®	Revcovi™	Uplizna®
Actemra®	Elzonris®	Lunsimo™	Rybrevant™	Vabysmo®
Adakveo®	Empaveli™	Lutathera®	Rylaze™	Valstar®
Adcetris®	Empliciti®	Lyfgenia™	Ryplazim®	Vectibix®
Adzynma™	Enjaymo™	Macugen®	Rystiggo®	Veopoz™
Akynzeo®	Entyvio™	Margenza™	Sandostatin® LAR kit	Vidaza®
Aliqopa™	Epkinly™	Marqibo®	Saphnelo™	Viltepso®
Amondys 45™	Erbitux®	Monjuvi®	Sarclisa®	Visudyne®
Amvuttra®	Evenity®	Mozobil®	Scenesse®	Vyepti™
Anktiva®	Evkeeza™	Mylotarg™	Sculptra®	Vyjuvek®
Aphexda®	Exondys 51™	Myobloc®	Signifor® LAR	Vyondys 53®
Aralast®	Eylea®/Eylea HD	Myozyme®	Simponi Aria®	Vyvgart®
Arzerra®	Fasenra™	Novantrone®	Sinuva®	Vyvgart Hytrulo
Asparlas™	Faslodex®	Nplate®	Skyrizi®	Wezlana™
Azedra®	Folotyn®	Nucala	Soliris®	Xeomin®
Beleodaq®	Fyarro™	Nulibry™	Somatuline® Depot	Xgeva®/Wyost®
Benlysta®	Gamifant®	Ocrevus™	Sotradecol®	Xiaflex®
Beovu®	Givlaari	Omvoh™	Spevigo®	Xipere®
Beqvez™	Glassia™	Oncaspar®	Spinraza™	Xolair®
	H.P. Acthar® Gel	Onpattro™		

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Outpatient Pharmaceuticals (Submitted Under Medical Benefit)				
Besponsa®	Halaven®	Orencia®	Spravato™	Yervoy®
Bkemv™	iDose®TR (implant)	Oxlumo™	Stelara®	Yutiq™
Blincyto®	Ilaris®	Ozurdex®	Sunlenca®	Zaltrap®
Botox®	Ilumya®	Padcev®	Sustol®	Zemaira®
Briumvi®	Iluvien®	Panhematin®	Syfovre™	Zemdri™
Cablivi®	Imdelltra™	Parsabiv®	Synagis®	Zepzelca™
Casgevy™	Imjudo®	Pepaxto®	Synribo®	Zilretta™
Cimzia®	Izervay™	Perjeta®	Talvey™	Zinplava™
Cinqair®	Jelmyto™	Phesgo®	Tecvayli™	Zulresso™
Columvi™	Jesduvroq™	Polivy™	Tepezza®	Zynlonta®
Cortrophin®	Jevtana®	Poteligeo®	Testopel®	
Cosela™	Ketalar®	Prevymis™	Tezspire®	
Cosentyx®	Kimmtrak®	Prolastin®	Tivdak™	
Crysvita®	Kisunla®	Prolia®/Jubbonti®	Tofidence™	
Cyramza®	Krystexxa®	Provenge®	Trodelvy®	
Danyelza®	Kyprolis®	Qalsody™	Trogarzo™	
Darzalex®/ Darzalex Faspro®	Lemtrada®	Radicava™	Tyenne®	
Daxxify®	Lenmeldy™	Radiesse®	Tyruko®	
Dupixent®	Leqembi™	Reblozyl®	Tysabri®	
Durysta™	Leqvio®	Rebyota™	Tzield™	
Dysport®	Leukine®	Retisert®	Ultomiris™	
Elahere™	Levoleucovorin (Fusilev®, Khapzory™)		Unituxin®	

- **Biosimilars require prior authorization**
- Preferred biosimilars are required in lieu of branded drugs
- Authorized by Health Net Pharmacy Services
- Must try preferred products prior to non preferred approval. Please refer to the drug specific policy for complete list of preferred products

OUTPATIENT PHARMACEUTICALS - BIOSIMILARS	
NON-PREFERRED	PREFERRED
Bevacizumab agents – Alymsys®, Avastin®, Vegzelma® (no longer requires PA for ophthalmologists)	Mvasi®, Zirabev™ (no PA required for ophthalmologists)
Erythropoiesis-stimulating agents (ESA) – Aranesp®, Epogen®, Mircera®, Procrit®	Retacrit™ (PA not required for Retacrit when administered/provided under the medical benefit)
Filgrastim agents – Granix®, Neupogen®, Releuko®	• Nivestym® • Zarxio® (PA not required for Zarxio when administered/provided under the medical benefit)
Infliximab agents – Avsola®, Remicade®	Inflectra®, Renflexis®
Pegfilgrastim agents – Fulphila®, Fylnetra®, Neulasta®, Neulasta Onpro®, Rolvedon™, Ryzneuta TM, Stimufend®, Ziextenzo®	Nyvepria®, Udenyca®, Udenyca Onbody
Rituximab agents – Riabni®, Rituxan®, Rituxan Hycela™	Ruxience®, Truxima® (no PA required for hematology/oncology indications)
Trastuzumab agents – Enhertu®, Herceptin®, Herceptin Hylecta™, Herzuma®, Kadcyla®, Ontruzant®	Kanjinti®, Ogivri®, Trazimera™

Prior Authorization Requirements

California
Wellcare By Health Net Medicare Advantage

Effective August 1, 2024

The services, procedures, equipment and outpatient pharmaceutics below apply to:

- Wellcare By Health Net Medicare Advantage (MA) PPO and HMO Direct Network[1]

These are subject to prior authorization (PA) requirements (unless noted as "notification" required only) and guaranteed only as of the time of access to this prior authorization requirements page. For MA PPO plans, PA is recommended, but not required, for out-of-network coverage only.

Member questions – If members have questions regarding the PA list or requirements, refer to the member services number listed on their identification card.

Pre-Auth Check Tool – Confirm whether a specific code requires authorization on the Medicare Pre-Auth page.

Medical necessity – Medical necessity must exist for any plan benefit to be a covered service whether a PA is required or not.

Services that require PA vs. covered services – This PA list is not intended to be a list of covered services. The member's *Evidence of Coverage (EOC)* provides a complete list of covered services. *EOCs* are available to members on the member portal or in hard copy on request. Providers may obtain a copy of a member's *EOC* by requesting it from Provider Services. Data about Data:

Eligibility rules and limitations – Providers are responsible for verifying member eligibility through the Provider Services prior to providing care. Even if a service or supply is authorized, eligibility rules and benefit limitations will still apply – all services, procedures, and equipment are subject to benefit plan coverage limitations.

Submit a PA request –

- Send the request via fax or online to Wellcare By Health Net unless stated differently in requirements listed below.
- The Health Net Request for Prior Authorization form must be completed in its entirety.
- Attach pertinent medical records, treatment plans, test results, and evidence of conservative treatment to support the medical appropriateness of the request.
- For more submission instructions, see *Avoid Processing Delays for Prior Authorization Requests with These Guidelines.*

PA timelines –

If the request is for …	Submit prior authorization request:
Elective inpatient or outpatient services	As soon as the need for service is identified.

If the request is for …	Submit prior authorization request:
A **routine** request	At least five business days before a scheduled procedure.
An **urgent** request	72 hours before a scheduled procedure. Emergency services do not require prior authorization.

[1] Direct Network refers to the directly contracted network.

Inpatient Services

Submit a prior authorization request to Wellcare By Health Net unless stated differently in the requirements listed below.

INPATIENT SERVICES	COMMENTS
Behavioral health or substance abuse facility	Authorized by the Behavioral Health Team
Hospice	**Notification required only.** Covered under Original Medicare
Hospital	Acute inpatient admission, inpatient rehabilitation, Long-Term Acute Care Hospital (LTAC)
Skilled nursing facility	
Urgent/emergent admission	• **Notification required only,** as soon as possible, but no later than 24 hours or by the next business day • Send notification to Hospital Notification Unit

Outpatient Procedures, Services or Equipment

Submit a prior authorization request to Wellcare By Health Net unless stated differently in the requirements listed below.

OUTPATIENT PROCEDURES, SERVICES OR EQUIPMENT	COMMENTS
Ablative techniques for treating Barrett's esophagus and for treatment of primary and metastatic liver malignancies	
Abortion	
Ambulance	Non-emergency air transportation
Anesthesia	For spine manipulation or closed procedure
Bariatric procedures	• Surgical procedure • Bariatric surgeries must be performed through the Wellcare By Health Net's designated bariatric specialty network
Behavioral health and substance abuse	Authorized by the Behavioral Health Team PA not required for office visits Includes: • Day treatment • Electroconvulsive therapy (ECT) • Intensive outpatient therapy (IOP) • Neuropsych testing ordered by a psychiatrist • Partial hospitalization • Psychological testing • Substance use disorder • Transcranial magnetic stimulation (TMS) • Treatment/rehabilitation
Bronchial thermoplasty	

OUTPATIENT PROCEDURES, SERVICES OR EQUIPMENT	COMMENTS
Cardiac	• Artificial heart • Cardiac monitor insertion • Endovenous ablation • Endovascular revascularization • Intracardiac catheter ablation • Pacemaker, leadless • Pulmonary artery pressure sensor • Unlisted vascular surgery • Vascular embolization and occlusion
Chiropractic care and Acupuncture visits	• Authorization not required for initial evaluation • Contact American Specialty Health Plans, Inc. (ASH Plans)
Chondrocyte implants	
Clinical trials	**Notification required only**. Covered under Original Medicare
Cochlear implants	
Dermatology (in-office procedures)	Includes: • Benign lesion excision • Chemical exfoliation, electrolysis • Dermabrasion/chemical peel • Laser treatment • Skin injections and implants
Diagnostic procedures	**Radiology:** • Radiopharmaceutical localization of tumor • Unlisted procedure

OUTPATIENT PROCEDURES, SERVICES OR EQUIPMENT	COMMENTS
	Advanced imaging: • Computed tomography (CT)/computed tomography angiography (CTA) • Magnetic resonance imaging (MRI)/ magnetic resonance angiography (MRA) • MRI guided high intensity focused ultrasound • 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)
Drug testing	PA required for all quantitative tests for drugs of abuse
Durable medical equipment (DME) and supplies	Includes: • BiLevel positive airway pressure (BiPAP); refer members to Apria Healthcare • Bone growth stimulator • Continuous positive airway pressure (CPAP); refer members to Apria Healthcare • Custom-made items, including custom wheelchairs • Enteral nutrition • Hospital beds, mattresses and accessories • Infusion pumps • Lift devices, including Hoyer • Lymphedema pumps and supplies • Nerve stimulators • Oxygen concentrators • Patient lifts

OUTPATIENT PROCEDURES, SERVICES OR EQUIPMENT	COMMENTS
	• Power wheelchairs, power operated vehicles and accessories • TENS units • Vagus nerve stimulator • Ventilators • Certain procedure codes; call or use the Online Prior Authorization Validation Tool to determine if authorization is required
Ear, nose and throat (ENT)	• Nasal/sinus endoscopy • Osseointegrated implant • Sinus procedures • Unlisted ENT procedure
Enhanced external counterpulsation (EECP)	
Experimental/investigational services and new technologies	Includes, but is not limited to, those listed in the Investigational Procedures List
Gastroenterology	• Capsule endoscopy • Cholecystectomy • Exploratory laparotomy • Laparoscopy procedures • Transoral lower esophageal myotomy • Unlisted procedures
Gender reassignment services (Transgender services)	
Genetic testing	Includes counseling
Hearing aid	
Hernia repair	

OUTPATIENT PROCEDURES, SERVICES OR EQUIPMENT	COMMENTS
Home health services	Includes: • Home health aide • Home IV infusion • Occupational therapy • Physical therapy • Skilled nursing visits • Social work visits • Speech therapy
Hospice	**Notification required only**; covered under Original Medicare
Hyperbaric oxygen therapy	
Infertility	Includes drug therapy, testing and treatment
Joint surgeries	
Laboratory	• Chronic HCV assay • Engraftment analysis • Genetic analysis procedures • Proprietary Laboratory Analysis (PLA) Codes
Maternity	**Notification required only** at time of first prenatal visit
Neuro and spinal cord stimulators	
Neurology	• Electroencephalogram (EEG) or Video EEG (VEEG) • Neuroplasty procedures • Neurostimulators proceduring

OUTPATIENT PROCEDURES, SERVICES OR EQUIPMENT	COMMENTS
	• Stereotactic lesion procedure
Neuropsychological testing	Authorized by MHN for behavioral health services or Wellcare By Health Net for medical services.
Occupational and speech therapy	• Visits exceeding 12 • Includes home setting
Ophthalmology	• Cataract procedures • Corneal procedures/transplant • Glaucoma procedures/surgery • Repair procedures of eye • Unlisted ophthalmological service/ procedure
Orthognathic procedures	• Includes TMJ treatment • Surgical procedure
Orthopedic	• Endoscopy (foot, wrist) • Orthopedic computer assisted surgical navigation • Procedures of the foot or toes • Procedures of lower extremities • Procedures of upper extremities • Unlisted procedures
Orthotics	Design, construction, and attachment of artificial limbs or other systems
Pain management	Includes: • Epidural injections

OUTPATIENT PROCEDURES, SERVICES OR EQUIPMENT	COMMENTS
	• Facet injections • Median branch block • Radio frequency ablation • Trigger point • Sacroiliac joint injection (SI)
Palliative care	Applies to D-SNP members only
Physical therapy	• Visits exceeding 12 • Includes home setting
Proprietary laboratory analyses	Includes the following CPT® codes: 0457U, 0459U, 0462U, 0468U, 0472U
Prosthetics	Design, construction, and attachment of artificial limbs or other systems
Pulmonology	• Drug Induced Sleep Endoscopy (DISE) • Unlisted pulmonary service
Radiation therapy	Limited to: • Intensity modulated radiation therapy (IMRT) • Neutron beam therapy • Proton beam therapy • Stereotactic radiosurgery and stereotactic body radiotherapy (SBRT)
Reconstructive and cosmetic surgery, services and supplies	Surgery, services and supplies, including, but not limited to: • Bone alteration or reshaping, such as osteoplasty

OUTPATIENT PROCEDURES, SERVICES OR EQUIPMENT	COMMENTS
	• Breast reduction and augmentation except when following a mastectomy (includes for gynecomastia or macromastia) • Dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate. • Excision, excessive skin and subcutaneous tissue (including lipectomy and panniculectomy) of the abdomen, thighs, hips, legs, buttocks, forearms, arms, hands, submental fat pad, and other areas. • Eye or brow procedures, such as blepharoplasty, brow ptosis or canthoplasty • Hair electrolysis, transplantation or laser removal • Lift, such as arm, body, face, neck, thigh • Liposuction • Nasal surgery, such as rhinoplasty or septoplasty • Otoplasty • Treatment of varicose veins
Referrals to nonparticipating providers	Applies to MA HMO only
Sacral nerve neuromodulation	
Skin substitutes and biologicals	
Sleep studies	Surgery and treatment; facility-based sleep studies
Spinal surgery	Includes, but is not limited to, laminotomy, fusion, diskectomy, vertebroplasty, nucleoplasty, stabilization, and X-Stop

OUTPATIENT PROCEDURES, SERVICES OR EQUIPMENT	COMMENTS
Transcatheter implantation of wireless pulmonary artery pressure sensor	
Transplant	• Fax request to the Transplant Team • All transplant evaluations and procedures, including, but not limited to, evaluation, transplant consult visits, donor search, and transplant procedure • Transplants must be performed through Wellcare By Health Net's designated transplantation specialty network
Unlisted procedures	Unlisted special service, procedure or report
Urology	• Laparoscopy surgery (prostate) • Penile prosthesis • Prostate procedure
Uvulopalatopharyngoplasty (UPPP) and laser-assisted UPPP	Surgical procedure
Wound care	Including, but not limited to: • Negative pressure wound treatment, low-frequency ultrasound • Wound debridement – authorization required after 12 sessions per year

Outpatient Pharmaceuticals (Part B Medications)

Medications

- Part B Medications are authorized by Pharmacy Services

OUTPATIENT PHARMACEUTICALS (PART B MEDICATIONS)	
Biosimilars are required to be used in lieu of branded drugs	
Medications newly approved by the U.S. Food and Drug Administration (FDA)	• Newly approved medications may require PA • Contact Pharmacy Services to confirm whether a specific new medication requires PA
New Medicare Part B medication codes issued by the Centers for Medicare & Medicaid Services (CMS)	• Newly issued codes for part B medications may require PA • Contact Pharmacy Services to confirm whether a specific new medication requires PA
Part B Medications	• To confirm whether a Part B medication requires PA or step therapy, refer to the Prior Authorization Requirements online validation tool • Coram is the preferred infusion provider

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:

- PureCare HSP (Large Group)

PureCare HSP (Large Group)

Provider Type: Physicians | Hospitals | Ancillary

The PureCare Health Care Services Plan (HSP) requires members to access benefits through participating PureCare HSP providers. Out-of-network services are not covered unless authorized by the plan. Refer to the member's PureCare HSP identification (ID) card for more information.

PCPs and Self-Referrals

Members enrolled in PureCare HSP are required to select a primary care physician (PCP) or Essential Community Providers (ESP clinics). The clinic is listed as the member's PCP instead of the physician's name. PureCare HSP members may self-refer within the PureCare HSP service area for services that do not require prior authorization. The PCP or clinic is listed on the member's ID card.

Acupuncture services are administered by American Specialty Health Plans of California, Inc. (ASH). Mental health, behavioral health and substance abuse services are administered by MHN Services.

Provider Oversight

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

This section contains general information on provider oversight requirements and monitoring.

Select any subject below:

- Fraud, Waste and Abuse
- Monitoring Provider Exclusions
- Contractual Financial and Administrative Requirements
- Facility and Physician Additions, Changes and Deletions
- Service and Quality Requirements

Fraud, Waste and Abuse

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

Fraud is intentional misrepresentation or deception for the purpose of obtaining payment or other benefits not otherwise due. Abuse includes those practices that are inconsistent with accepted sound fiscal, business or medical practices. The following are examples of fraud and abuse:

- Intentional misrepresentation of services rendered.

- Deliberate application for duplicate reimbursement.
- Intentional improper billing practices.
- Failure to maintain adequate records to substantiate services.
- Failure to provide services that meet professionally recognized standards of health care.
- Provision of unnecessary services .

Health Net is responsible for reporting to the state its findings of suspected fraud and abuse by participating providers or vendors under its Medi-Cal plans. Suspected fraud and abuse is identified through various sources that include aggregate data analysis, review of high-cost providers, review of CPT-4 codes with potential for over-use, members, the state, law enforcement agencies, other providers, and associates.

Providers and their office staff are legally required to report suspected cases of fraud and abuse to Health Net. Reports of suspected fraud may be made anonymously to the Health Net Fraud Hotline.

Monitoring Provider Exclusions

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

The Centers for Medicare & Medicaid Services (CMS) requires contractors and their first-tier, downstream and related entities (FDRs) to monitor federal and state exclusion lists. The parties or entities on these lists are excluded from various activities, including rendering services to Medicare enrollees (unless in the case of an emergency, as stated in 42 CFR §1001.1901), and employing or contracting with excluded parties to provide services to Medicare enrollees. Health Net requires that its participating physician groups (PPGs), hospitals, ancillary providers, and practitioners continuously monitor federal and state exclusion lists.

Monitoring for Excluded Parties

The names of parties that have been excluded from participation in federal health programs are published in the Office of the Inspector General U.S. Department of Health and Human Services (OIG-HHS) List of Excluded Individuals and Entities (LEIE), CMS Preclusion List, Medi-Cal Suspended and Ineligible Provider List (SIPL), Office of Personnel Management (OPM) under the Federal Employee Health Benefit Plan (FEHBP) and on the General Services Administration's (GSA) Exclusions Extract Data Package (EEDP) (or Excluded Parties List System (EPLS), which was replaced by the EEDP), as referenced through the System for Award Management (SAM) website.

Medicare Advantage organizations (MAOs) and their FDRs must abide by the regulations documented in the Social Security Act 1862(e)(1)(B),), 5 CFR §890.1043(a)(b)(c), 42 CFR §422.503(b)(4)(vi)(F), 422.752(a)(8), 423.504(b)(4)(vi)(F), 423.752(a)(6), 422.222, 422.224 and 1001.1901. These federal exclusion requirements are further interpreted and communicated as guidance by CMS in Medicare Manual, Volume 100-16, Chapters 9 and 21 §50.6.8.

Additional regulations that require sponsors to include CMS requirements in their contracts, as well as monitor their FDRs, are available in 42 CFR §422.504(i)(4)(B)(v) and 423.505(i)(3)(v).

Health Net and Provider Responsibilities

Health Net is required to monitor federal and state exclusion lists to ensure that Health Net is not hiring, contracting or paying excluded parties or entities for services rendered to enrollees in Health Net's Medicare (MA and MA-PD) plans. Health Net's FDRs must check the LEIE, CMS Preclusion List, SIPL, FEHBP and EEDP federal exclusion lists prior to hiring or contracting with any new employee, temporary employee, volunteer, consultant, governing body member, or FDR for Part C- and Part D-related activities. MAOs and their FDRs must continuously monitor these lists at least monthly to ensure parties or entities that were previously screened have not become excluded later.

LEIE

The OIG-HHS imposes exclusions under the authority of sections 1128 and 1156 of the Social Security Act. A list of all exclusions and their statutory authority is available on the Exclusion Authority website.

The current LEIE is available on the OIG-HHS website. Refer to Frequently asked questions (FAQs) for additional information about the LEIE.

Providers on the OIG list will be terminated from all products, federal and non-federal.

FEHBP

The OPM, under the OIG-HHS, imposes suspension and debarment actions for entities contracted with the FEHBP. The current FEHBP suspended and debarred report is available by contacting your plan representative.

Providers on the FEHBP list will be terminated from all products, federal and non-federal. Additionally, a 12-month claims look-back review must occur for all identified participating and non-participating providers. Federal Employee Health Benefit Plan members identified through the claims review must receive notification that the provider is no longer available to receive services from.

Resctricted Provider Database (RPD)

The RPD is published by DHCS to identify providers placed under a payment suspension while under investigation based upon a credible allegation of fraud (Title 42, Code of Federal Regulations (CFR) section 455.23 and Welfare and Institution Code (WIC) section 14107.11. Search Part 455 of the CFR. Search the WIC. The sanction action is specific to the individual rendering provider's National Provider Identifier and/or Tax Identification Number as listed on the database file. Subcontractors and delegated entities may continue contractual relationships with providers on the RPD that are listed under a "payment suspension only"; however, reimbursements for Medi-Cal covered services must be withheld. Contracts must be terminated with providers on the RPD that are not listed under a "payment suspension only." Subcontractors and delegated entities choosing to terminate a provider's contract must notify Health Net per the language in the *Provider Participation Agreement* (*PPA*) and within the required advance notification turnaround times included in the Medi-Cal provider operations manual under Provider Oversight > Facility and Physician Additions, Changes and Deletions > Closure and Termination available in the Provider Library online. Providers under a payment suspension will be indicated as such under the "comment" column of the database file. If you would like a copy of the latest RPD data file, subcontractors and delegated entities should submit a request to Health Net at ProvServicesOps@healthnet.com.

EEDP

The GSA's EEDP is a government-wide compilation of various federal agency exclusions, and replaces the Excluded Parties List System (EPLS). Exclusions contained in the EEDP are governed by each agency's regulatory or legal authority. The EEDP also includes parties and entities from other federal exclusion databases. All parties or entities listed on the EEDP are subject to exclusion from Medicare participation. The current EEDP is available on the SAM website.

Providers on the EEDP list will be terminated from all products, federal and non-federal.

SIPL

The SIPL is published by DHCS to identify suspended and otherwise ineligible providers. It is updated monthly and available on the DHCS Medi-Cal website > References > Suspended & Ineligible Provider List. Additional information about the list is located in the Medi-Cal Suspended and Ineligible Provider List introduction.

Providers on the SIPL will be terminated from all products, federal and non-federal.

CMS Preclusion List

The CMS Preclusion List is published by CMS to identify precluded providers. It is updated monthly and available on the Healthnet.com site, after logging on, under the regulatory section.

Providers on the CMS Preclusion List will be terminated from all products, federal and non-federal.

CLAIMS PAYMENT FOR EXCLUDED PARTIES

Health Net, its PPGs, hospitals, and ancillary providers cannot pay participating and nonparticipating parties or entities included on these lists for any services using federal funds, except as documented in the CMS Internet Only Manual, publication 100-16, Chapter 6 - Relationships with Providers, which states, "The OIG has a limited exception that permits payment for emergency services provided by excluded providers under certain circumstances. See 42 CFR §1001.1901." FDRs contracting with Health Net must have a documented process in place to ensure compliance with these guidelines, and notify enrollees who obtain services from excluded parties and make claims payments as allowed under these exceptions. This documentation

Contractual Financial and Administrative Requirements

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

This section contains general information on contractual financial and administrative requirements.

Select any subject below:

- Financial Statements
- Use of Performance Data

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
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.

Use of Performance Data

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

Health Net is subject to various statutory, regulatory and accreditation requirements, and must ensure that all agreements comply with any such mandates. Accreditation from the National Committee for Quality Assurance (NCQA) is critical to both the health plan and network providers, and ensures that Health Net meets the highest possible standards of excellence and care.

One of the requirements of NCQA is that Health Net may use practitioner performance data for quality improvement activities. Therefore, Health Net's contract templates have been updated with the following language:

Provider agrees to cooperate with quality management and improvement (QI) activities; maintain the confidentiality of member information and records pursuant to this agreement; and allow Health Net to use provider's performance data.

Facility and Physician Additions, Changes and Deletions

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

This section includes information on requirements for adding or removing a participating provider.

Select any subject below:

Overview

Provider Type: Hospitals | Ancillary

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 Provider Participation Agreement (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 and ancillary providers 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 and directs the facility to make any changes required in order to meet the requirements. Health Net requires hospitals and ancillary providers 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 and ancillary providers 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 and ancillary providers must also provide Health Net a list of the names, locations and federal tax identification numbers (TINs) of all of its participating providers.

Hospitals and ancillary providers 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 and ancillary provider a list of the physicians or subcontractors Health Net shows as active and under contract with the participating provider. Hospitals and ancillary providers are required to review this list and notify Health Net of any additions or deletions. At least monthly, hospitals and ancillary providers must provide Health Net with a list of additions, deletions and address changes, as well as a complete listing annually.

Hospitals and ancillary providers must furnish Health Net copies of any amendments to a contract with a participating provider within 20 days of execution.

Facility and Satellites

Provider Type: 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 Health Net in writing at least 90 days before the addition. Health Net has the right, in its sole discretion, to determine whether the new or satellite facilities or the new member physicians are acceptable to Health Net.

Facility Terminations

Facilities 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 terminates its relationship with the facility.

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 Terminations

Provider Type: Physicians | Hospitals

Participating providers 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.

Service and Quality Requirements

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

This section includes information on requirements for adding or removing a participating provider.

Select any subject below:

- Access to Care and Availability Standards

- Quality Improvement Problem Resolution

Access to Care and Availability Standards

Provider Type: Physicians | 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) 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 must demonstrate 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 statues and regulations, primary care physician (PCP) and specialty care practitioner (SCP) office hours must be reasonable, convenient and sufficient to ensure that they do not discriminate against members and members are able to access care within established time-elapsed access standards. PCP and SCP office hours must be posted in the provider's office. Health Net requires a PCP practice to be open at least 20 hours per week and a SCP practice to be open at least 16 hours per week for members to schedule appointments within established appointment access standards. During evenings, weekends and holidays, or whenever the office is closed, an answering service or answering machine should be utilized to provide members with clear and simple instructions on after-hours access to medical care.

After-Hours Access Guidelines

As required by applicable statutes, participating providers must ensure that, when medically necessary, they have medical services available and accessible to members 24 hours a day, seven days a week, and PCPs are required to have appropriately licensed professional back-up for absences. Participating physician groups (PPGs) and PCPs who do not have services available 24 hours a day may use an answering service or answering machine to provide members with clear and simple instruction on after-hours access to medical care (urgent/emergency medical care).

PCPs (or on-call physicians) must return telephone calls and pages within 30 minutes and be available 24 hours a day, seven days a week. The PCP or on-call physician designee must provide urgent and emergency care. The member must be transferred to an urgent care center or hospital emergency room, as medically necessary.

Additionally, Health Net provides triage and screening services 24 hours a day, seven days a week through medical/nurse advice lines. Refer to the Triage and Screening Services/Nurse Advice Lines section below for further information.

Note: Although Health Net does not delegate triage and screening services, PCPs are still required to comply with these after-hours requirements since medically necessary services are required to be available and accessible 24 hours a day, seven days a week.

After-Hours 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 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. Health Net's after-hours scripts provide easy to use messaging examples on how to direct members to emergency care services and who they need to talk to when they need urgent medical advice.

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, on a holiday 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, and question the member according to the PCP's or PPG's established instructions (who, what, when, and where) to assess the nature and extent of the problem.
- Contact the on-call physician with the facts as stated by the member.
- After office hours, physicians are required to return telephone calls and pages within 30 minutes. If an on-call physician cannot be reached, direct the member to a medical facility where emergency or urgent care treatment can be given. This is considered authorization, which is binding and cannot be retracted.
- In the event of a hospitalization, the PPG or hospital must contact 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 and does not replace the PCP's instruction, assessment and advice. According to community access-to-care standards, all

PCPs must provide 24-hour telephone service for urgent/emergent instructions, medical condition assessment and advice. The Member Services Department coordinates member access to the service, if necessary.

The program allows registered nurses (RNs) and other applicable licensed health care professionals to assess a member's medical condition and, through conversation with the caller, take further action, and provide instruction on home and care techniques and general health information.

Health Net ensures that telephone triage or screening services are provided in a timely manner appropriate for the member's condition, and the triage or screening wait time does not exceed 30 minutes. Health Net provides triage or screening services through contracted medical/nurse advice lines. Health Net members can access these services by contacting the Nurse Advice Line telephone number on the back of their ID cards.

Facility Access for the Disabled

Health Net and its participating providers 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 are to reasonably accommodate members and ensure that programs and services are as accessible (including physical and geographic access) to members with disabilities as they are to members without disabilities. Providers must have written policies and procedures to ensure appropriate access, including ensuring physical, communication and programmatic barriers do not inhibit members with disabilities from obtaining all covered services.

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. If a member has not selected a PCP, Health Net assigns one. The PCP is responsible for coordinating all specialty care referrals 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).
- Self-refer to a behavioral health practitioner, 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. 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 new 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 shortened or 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.

Advances 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, 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 his or her practice.

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.

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 processes all prior authorization requests 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.

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 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 Availability Corrective Action section below for further information.

Health Net's performance goals for access-related, time-elapsed provider criteria are available for providers' reference.

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Health Net HSP Plans Medical Appointment Access Standards

ACCESS MEASURE	STANDARD	PERFORMANCE GOAL
Non-urgent appointments for primary care - regular and routine care (PCP)	Appointment within 10 business days of request	70%
Urgent care (PCP) services that do not require prior authorization	Appointment within 48 hours of request	70%
Non-urgent appointments with specialist (SCP)	Appointment within 15 business days of request	70%
Urgent care services (SCP and other) that require prior authorization	Appointment within 96 hours of request	70%
After-hours care (PCP)	Ability to contact on-call physician after hours within 30 minutes for urgent issues Appropriate after hours emergency instructions	90%
Non-urgent ancillary services for MRI/mammogram/physical therapy	Appointment within 15 business days of request	70%
In-office wait time for scheduled appointments (PCP and SCP)	Not to exceed 15 minutes	70%

Compliance is measured by results from the Provider Appointment Availability Survey (PAAS) and Provider After-Hours Availability Survey (PAHAS) conducted via telephone by Health Net and the Consumer Assessment of Health Care Providers & Systems (CAHPS®[1]) survey.

1 CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

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 HSP 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	

Availability Standards	Performance Threshold
Member to full time equivalent (FTE) PCP ratio	2,000:1
Member to FTE physician	1,200:1
Member to SCP ratio	1,200:1
Member to 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 all lines of businesses appointment access policy and procedure (CA.NM.05), is not met.

Health Net uses the following criteria for identifying PPGs with patterns of noncompliance and will issue a corrective action plan (CAP) when one or more metrics are noted as being noncompliant:

- Appointment access - PPGs that do not meet Health Net's 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.
- The PPG is to return the signed Provider Notification of Timely Access Results Attestation that attests that the PPG has notified their providers of their individual results and of their responsibilities of compliance related to timely access.
- Providers and PPGs deemed non-compliant will be encouraged to attend a Timely Access Training session as part of the CAP process. Health Net will notify all non-compliant providers/PPGs of the training schedule and will suggest that the provider/PPG sign up for one session. Attendance at the training will be documented. A "Timely Access Provider Training" certificate must be completed after attending the training.

CAP Follow-Up Process

- If the PPG fails to return a completed IP within the prescribed time frame, the Provider Network Management (PNM) Department is asked to intercede.
- PPGs demonstrating a pattern of noncompliance with access regulations and standards are subject to an in-office audit and may be referred to PNM and the Contracting departments for further action.

Quality Improvement Problem Resolution

Provider Type: Physicians | Hospitals | Ancillary

Under the quality improvement (QI) standards, all participating providers are required to:

- Initiate research, within two business days, 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:

- Language Assistance Program and Cultural Competency
- Quality Improvement Program

Language Assistance Program and Cultural Competency

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

This section contains general information on Health Net's cultural and linguistic services.

Select any subject below:

- Language Assistance Program and Cultural Competency
- Language Assistance Program and Cultural Competency (Hospitals only)

Language Assistance Program and Cultural Competency

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

The Health Care Language Assistance Regulations require all health plans to provide language assistance and culturally responsive services to members with limited English proficiency (LEP), limited reading skills, who are deaf or have a hearing impairment, or who have diverse cultural and ethnic backgrounds. To comply with this requirement, Health Net created the Language Assistance Program (LAP). Health Net's LAP offers interpreter services to members to ensure that Health Net members with LEP are able to obtain language assistance while accessing health care services. Health Net's LAP supports Health Net members' linguistic and cultural needs. Additionally, Health Net offers interpreter support and requires all participating providers to take evidence-based cultural competency courses. Providers are encouraged to take courses through the U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH) as part of their continuing education. For more information, refer to OMH Think Cultural Health.

Health Net participating providers must comply with Health Net's LAP as defined in this section.

Compliance Requirements

Health Net participating providers, including case management and utilization management (UM)-delegated providers, are required to comply with Health Net's LAP by using the following:

- Interpreter services - Use qualified interpreters for members with LEP. Interpreter services are provided by Health Net at no cost to providers or members. Interpretation services include face-to-face (in-person), telephone, video remote, sign language (including American Sign Language and tactile), and closed captioning interpretation. Please request interpretation services at least 5-10 days before the scheduled appointment.
    - Telephone interpreters are available in more than 150 languages. Advance notice for telephone interpreters is not required.
- Translation services - Provide Health Net, upon request and in a timely manner, with the documents sent to members. If a Health Net member requests translation or an alternative format of an English document that was produced by a delegated PPG on Health Net's behalf, the provider must refer the member to the Health Net Member Services phone number listed on the member's identification (ID) card. When Member Services receives the request from the member, Health Net contacts the provider requesting a copy of the specific English document for translation or alternative format. The provider must submit the document within 48 hours of Health Net's request. Translation is only available in threshold languages
- Tagline and non-discrimination notice - Include a Health Net-specific tagline and non-discrimination notice with all member informing materials going to Health Net members.

Commercial	CalViva Health	Community Health Plan of Imperial Valley	Medi-Cal
Commercial Non-discrimination Notice (PDF)	Non-discrimination Notice CalViva Health (English) (PDF)	Non-discrimination Notice Community Health Plan of Imperial Valley (English) (PDF)	Non-discrimination Notice Medi-Cal (English) (PDF)
	Non-discrimination Notice CalViva Health (Hmong) (PDF)	Non-discrimination Notice Community Health Plan of Imperial Valley (Spanish) (PDF)	Non-discrimination Notice Medi-Cal (Arabic) (PDF)
	Non-discrimination Notice CalViva Health (Spanish) (PDF)		Non-discrimination Notice Medi-Cal (Armenian) (PDF)
			Non-discrimination Notice Medi-Cal (Cambodian) (PDF)
			Non-discrimination Notice Medi-Cal (Chinese) (PDF)
			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)

Commercial	CalViva Health	Community Health Plan of Imperial Valley	Medi-Cal
			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

Provider Type: Physicians | Hospitals | Ancillary

The Health Net Quality Improvement (QI) program manages improvement of the quality of care and service provided to Health Net members. It encompasses all providers, including all medical, behavioral health and ancillary providers, contracting with Health Net. The QI program includes the development and implementation of standards for clinical care and service, the measurement of adherence to the standards and the implementation of actions to improve performance. The scope of the program includes:

- Wellness is a component of the Decision Power® whole-person approach to care.
- Practice guidelines for prevention and chronic care.
- Monitoring and evaluating care and services provided in all health care delivery settings, including behavioral health services and long-term services and supports (LTSS) in coordination with other medical conditions.
- Clinical quality and safety of care.
- Member, practitioner and provider satisfaction.
- Hospital quality comparison reports.
- Practitioner and provider site and facility inspections.
- Medical record and documentation standards.
- Practitioner and provider qualifications and selection.
- Organizational performance.
- Support for cultural and linguistic services.
- Continuity and coordination of care.
- Maintaining compliance with the QI requirements of regulatory agencies, such as the Centers for Medicare & Medicaid Services (CMS), the Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC), and the California Department of Insurance (CDI).

Health Net has developed quality management systems that extend across the entire continuum of care, with special emphasis on preventive services and managing chronic conditions. All program components are evaluated on their measurable effect on Health Net's populations.

Participating providers, hospitals and ancillary providers are required to comply with the standards and requirements set forth in Health Net's operations manuals.

Health Net regularly communicates information about Health Net's QI program goals, processes and outcomes as they relate to member care through provider updates, Online News articles and other forums. QI program information is also available to providers on request through Health Net's Provider Services Center.

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 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. .

Referrals

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

This section contains general information on referrals.

Select any subject below:

- Investigational and Experimental Treatment
- Out-of-Network Providers
- PureCare HSP (large group) Referral Process

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.

Out-of-Network Providers

Provider Type: Physicians

PureCare HSP (large group) members should obtain services from any participating provider in Health Net's PureCare HSP (large group) provider network. If these services are not available within the participating network, Health Net authorizes services to a qualified non-participating provider in accordance with the Health Net prior authorization procedures below, except in emergencies or as otherwise required by law.

1. Determine whether an out-of-network provider is necessary and request prior authorization.
2. Complete and fax the Request for Prior Authorization form to the Health Net Medical Management Department listed on the form.
3. Allow five business days for Health Net to process elective requests and 72 hours for urgent requests.

PureCare (Large Group) HSP Referral Process

Provider Type: Physicians | Hospitals | Ancillary

PureCare Health Care Service Plan (HSP) members are required to select a primary care physician (PCP); however, HSP members may self-refer to any participating provider in Health Net's PureCare HSP provider network without a referral from their PCPs.

PureCare HSP members who obtain services from providers outside of the PureCare HSP network are responsible for payment, except in the case of emergency or urgent care, or services approved by Health Net.

Third-Party Liability

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

This section contains general information on third-party liability responsibilities.

Select any subject below:

- Coverage Explanation

Coverage Explanation

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

If a subscriber or member is injured through an act or omission of another person, the participating provider must provide benefits in accordance with the Evidence of Coverage (EOC) or Certificate of Insurance (COI). If the injured member is entitled to recovery, the plan and the participating provider rendering services to the member are entitled to recover and retain the value of the services provided from any amounts received by the member from third-party sources.

When the plan pays a claim with an injury or trauma diagnosis code that may be related to a motor vehicle accident, employment or possible other third-party liability, the plan may use an outside vendor, the Rawlings Company, to investigate for determination of other coverage liability. Rawlings' expertise and automated system capabilities are used to identify claims where a third party may be responsible for payment. Rawlings may directly correspond with providers requesting refunds when another liability coverage is determined to be primary. If a provider receives a refund request letter from the Rawlings Company that includes the primary coverage insurance information in the event that the provider has not already been provided the other coverage information by the member or billed the primary carrier, the provider is expected to bill the other coverage and refund the plan, via the Rawlings Company, within a reasonable time period. Failure to comply with timely filing guidelines when overpayment situations are the result of another carrier being responsible does not release the participating provider from liability.

Reimbursement to the plan or the participating provider under this lien is based on the value of the services the member receives and the costs of perfecting the lien. The value of the services depends on how the participating provider was paid and the lien amount is determined as permitted by law. Unless the money that the member receives comes from a workers' compensation claim, the following applies:

- The amount of the reimbursement that the member owes the plan or the participating provider is reduced by the percentage that the member's recovery is reduced if a judge, jury or arbitrator determines that the member was responsible for some portion of the member's injuries.
    - For plans subject to state law, when the member is represented by an attorney: the lien will be the lesser of a *pro rata* reduction for the member's reasonable attorney fees and costs

paid by the member from the money received in the underlying third-party case, or one-third of the member's recovery.
    - For plans subject to state law, when the member is not represented by an attorney: the lien will be the lesser of the full amount of the lien otherwise due or one-half of the member's recovery.

Provider and Member and Responsibilities

Provider Responsibility

The participating provider must question the member for possible third-party liability (TPL) in injury cases. Often, the member does not mention that this liability exists, having received complete care without charge from the participating provider and may not feel that it is necessary. The participating provider must check for this liability where treatment is being provided. The participating provider must develop procedures to identify these TPL cases. After TPL has been established, the participating provider must provide the plan with the information using the Authorization to Treat a Member form or other correspondence.

Submit Itemized Charges and Member's Statement of Liability for Reimbursement

When the participating provider seeks reimbursement from the third-party payer, it must do so by filing an appropriate lien. This may be done by submitting an itemized statement for paid claims or value of services rendered, whichever is appropriate, and a member's statement of third-party liability to any person or entity which may receive payments made in a settlement or judgment in the TPL case.

Lien Coordination

The participating provider must coordinate with any participating providers that assert a lien and ensure that all communication received by the member in this regard is consistent. In the event that the PPG is assigned recovery of a hospital lien, the plan must be advised promptly.

Calculation of Lien Amount

The participating providers' staff is responsible for remaining current on legal developments regarding TPL recoveries. In determining the amount of the lien, follow guidelines prepared by counsel. Recoveries for coordination of benefits (COB), duplicate payments and the like should be reconciled promptly. Where the participating provider asserts the contractual lien based on Evidence of Coverage (EOC) or Certificate of Insurance (COI), it is subject to:

- A reduction by the percentage that the member's recovery is reduced if a judge, jury or arbitrator determines the member is responsible for some portion of the member's injuries.
    - For plans subject to state law, when the member is represented by an attorney: the lien will be lesser of a pro ratareduction for the member's reasonable attorney fees and costs paid by

the member from the money received in the underlying third-party case, or one-third of the member's recovery.
    - For plans subject to state law, when the member is not represented by an attorney: the lien will be the lesser of the full amount of the lien otherwise due or one-half of the member's recovery.

It is the participating provider's responsibility to act reasonably in pursuing a lien.

Member Responsibility

An injured member entitled to recovery is required to:

- Inform the plan and participating providers of the name and address of the third party, if known, the name and address of the member's attorney, if using an attorney, and describe how the injuries were caused.
- Complete any paperwork that the plan or the participating providers may reasonably require to assist in enforcing the lien.
- Promptly respond to inquiries from lien holders about the status of the case and any settlement discussions.
- Notify lien holders immediately upon the member or the member's attorney receiving any money from third parties or their insurance companies.
- Hold any money that the member or the member's attorney receives from third parties or their insurance companies in trust, and reimburse the plan and the participating providers for the amount of the lien as soon as the member is paid by the third party.

Utilization Management

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

This section describes Health Net's utilization management program and processes.

Select any subject below:

- Care Management
- Continuity of Care
- Economic Profiling
- Hospital Discharge Planning
- Medical Data Management System
- Medical Management
- Notification of Hospital Admissions
- Separation of Medical Decisions and Financial Concerns
- Utilization Management Goal

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

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 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.

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.
- **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 care management activities.

NICU Levels of Care Criteria

Provider Type: Physicians | Hospitals

Health Net's neonatal intensive care unit (NICU) levels of care criteria (PDF) is used by contracting vendors and concurrent review staff when assessing, documenting and authorizing NICU care.

Continuity of Care

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

Health Net provides for continuity of care (COC) for new and existing members due to termination of prior coverage and any health plan withdrawn from any portion of the market for a currently enrolled Health Net member. Health Net members who have been receiving care that meets certain criteria may continue with their existing out-of-network providers for up to 12 months.

A current member may also request COC to complete care with a departing Health Net provider after that provider leaves Health Net's network. Covered services are provided for the period of time necessary to complete a course of treatment and to arrange for safe transition of care to another provider. Health Net makes the decision in consultation with the member and the terminated provider or nonparticipating provider, and consistent with good professional practice.

Continuity of Care

Member requests for COC assistance must meet certain criteria:

- There are no documented quality-of-care issues, or state or federal exclusion requirements where Health Net has determined the provider is ineligible to continue providing services to Health Net members.
- Compensated rates and methods of payment are the same as those currently used by Health Net or the participating physician group (PPG) unless a letter of agreement or letter of understanding is executed.
- Copayments, deductibles or other cost-sharing components during the period of completion of covered services with a terminated provider or a nonparticipating provider are the same the member would pay if receiving care from a provider currently contracting with Health Net.

Types of clinical criteria where a member may be eligible for COC

- Acute condition – a sudden onset of symptoms due to an illness, injury, or other medical problem.

- Serious chronic condition – a medical condition due to a disease, illness, or other medical problem or medical disorder, not to exceed 12 months from the member's effective date of coverage.
- Pregnancy – for the duration of the pregnancy and the immediate postpartum period.
    - A maternal mental health condition is a mental health condition that can impact a woman during pregnancy, peri- or post-partum, or that arises during pregnancy, in the peri- or post-partum period, up to one year after delivery.
- Terminal illness – an incurable or irreversible condition that has a high probability of causing death within one year or less. COC applies for the duration for the terminal illness.
- Newborn care – birth to 36 months, not to exceed 12 months from the member's effective date of coverage under the plan.
- Performance of a surgery or other procedure that has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered enrollee.
- Behavioral health conditions – all acute, serious or chronic mental health conditions, including treatment for children diagnosed with autism spectrum disorder (ASD). These services include applied behavioral analysis (ABA) – for up to 12 months.

Exceptions

Some of the circumstances where COC is not available are:

- Services that are not a covered benefit of the plan.
- Out-of-network provider does not agree to Health Net's utilization management (UM) policies and payment rates.
- Provider type or service is for durable medical equipment (DME), transportation, other ancillary services, or carved-out services.

Requesting Continuity of Care

New and existing members, their authorized representatives on file with Health Net, or their providers may request COC directly from Health Net. Refer to the Health Net Member Services Department for assistance.

Health Net reviews and completes COC requests within five business days after receipt of the request. When additional clinical information is necessary to make a decision, the COC request can be pended for an additional 45 days. The pend letter for the required information is generated and faxed to the requested provider. A hard copy will follow by mail to the provider and the member.

If there is an imminent and serious threat to the member's health, requests are completed within three calendar days.

Upon completion of the COC review, the provider and the member will be notified of the decision within 24 hours of the decision.

Applies to EPO and PPO members only: Health Net accepts and approves retroactive requests for COC that meet all requirements. The services must have occurred after the member's enrollment in the plan and Health Net must have the ability to demonstrate that there was an existing relationship between the member and provider prior to the member's enrollment into the plan.

Out-of-network providers cannot refer the member to another out-of-network provider without authorization from Health Net or a delegated PPG.

PPG Process

Health Net forwards the COC request to the delegated PPG's UM department if the PPG termed the requested provider. The delegated PPG:

- Works with the out-of-network provider to secure a care plan for the member
- Makes the decision whether to extend the COC services, or to redirect the services in-network.
- Works with the out-of-network provider to make sure they are willing to work with the PPG and Health Net.

Economic Profiling

Provider Type: Physicians

Economic profiling is defined as any evaluation of a provider based in whole or in part on the economic costs or use of services associated with medical care provided or authorized by the provider.

Hospital and Inpatient Facility Discharge Planning

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

Participating providers are required to work with hospitals and inpatient facilities (general acute care hospitals, long-term acute care hospitals and skilled nursing facilities) to create an appropriate discharge plan and care transition protocol for members, including post-hospital care and member notification of patient rights within seven days of post-hospitalization. For any concurrent authorization that is denied, care cannot be discontinued until the treating provider has been notified and agreed to an appropriate discharge or transition of care plan.

Each hospital or inpatient facility must have a written discharge planning policy and process that includes:

- Counseling for the member or family members to prepare them for post-hospital or post-inpatient facility care, if needed.
- A transfer summary that accompanies the member upon transfer to a skilled nursing facility (SNF), intermediate-care facility, or a part-skilled nursing or intermediate care service unit of the hospital.
- Information regarding each medication dispensed must be given to the member upon discharge.

The Transitional Care Services program is designed to aid in the transitional period immediately after hospital discharge, focusing on critical post-discharge follow-up appointments.

Members have the right to:

- Be informed of continuing health care requirements following discharge from the hospital or inpatient facility.
- Be informed that, if the member authorizes, a friend or family member may be provided information about the member's continuing health care requirements following discharge from the hospital or inpatient facility.
- Actively participate in decisions regarding medical care. To the extent permitted by law, participation includes the right to refuse treatment.
- Appropriate pain assessment and treatment.

Electronic medical records or administrative system (Medi-Cal providers only)

In accordance with the Provider Participating Agreement (PPA) and Federal regulation 42 CFR 482.24 section (d), hospitals and facilities must ensure compliance and prompt electronic notification of patient discharges and transfers. The following organizations have been designated as qualified health information organizations (QHIOs) and are available to assist with Data Exchange Framework (DxF) requirements:

- Los Angeles Network for Enhanced Services (LANES)
- Manifest MedEx
- SacValley MedShare
- San Diego Health Connect
- Applied Research Works, Inc.
- Health Gorilla, Inc.
- Long Health, Inc.
- Orange County Partners in Health-Health Information Exchange (OCPH-HIE)
- Serving Communities Health Information Organization (SCHIO)

Medical Data Management System

Provider Type: Physicians

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.

Medical Management

Provider Type: Physicians | Hospitals | Ancillary

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. MHN is required to use approved scientifically based criteria. Health Net national medical policy statements are currently available on the Health Net provider website under Resources for Your. Medical policy statements and other clinical criteria, such as InterQual and Hayes Technology Assessments, are available by calling the Health Net Provider Services Center.

Concurrent Review

Health Net's concurrent review staff perform clinical reviews for HSP members. 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 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 monitor the member's care, and coordinate transfers and any needed post-discharge services with the HSP provider.

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. A denial letter contains the basis for the denial and information on the appeals and grievance process, as required by state and federal law.

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 participating) HSP providers. Following review by a Health Net medical director, authorization is approved or denied and communicated in writing to the 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 utilize the Inpatient California Health Net Commercial Prior Authorization (PDF) or Outpatient California Health Net Commercial Prior Authorization (PDF) forms, or refer to the Prior Authorization topic for additional information.

- Prior written authorization request for hospitalization which is submitted by the primary care physician (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.

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

Separation of Medical Decisions and Financial Concerns

Provider Type: Physicians | Ancillary | Hospitals

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.

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

Contacts in Alphabetical Order

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

A

- AcariaHealth
- Access to Interpreter Services
- American Specialty Health Plans
- Animas Diabetes Care, LLC
- Apria Healthcare, Inc
- ATG Rehab Specialists, Inc

B

Behavioral Health Provider Services

C

- Case Management Department
- Connect Hearing, Inc
- Coram
- Custom Rehab Network

D

Department of Managed Health Care

E

- Electronic Claims Clearinghouse Information
- EviCore Healthcare

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 Decision Power Referral Fax
- Health Net Delegation Oversight Department
- Health Net EDI Claims Department
- Health Net Elect Claims
- Health Net Fraud Hotline
- Health Net Health Equity Department
- Health Net Hospital Notification Unit
- Health Net Mail Order Prescription Drug Program
- Health Net Member Appeals and Grievances Department
- Health Net Member Services Department
- Health Net Provider Communications Department
- Health Net PPO Claims Submission
- Health Net Prior Authorization Department
- Health Net Program Accreditation Department
- Health Net Provider Services Center
- Health Net Quality Improvement Department
- Health Net's Regional Medical Directors
- Health Net Transplant Care Manager
- Health Net Utilization Management Department
- Health Net Wellness and Prevention Department
- Hoveround, Inc

I

J

K

Kick It California

L

Linkia, LLC

M

- Matria Health Care, Inc
- MiniMed Distribution Corp, Inc
- Modivcare

N

- National Imaging Associates, Inc
- National Seating and Mobility
- Nurse Advice Line

O

P

- Pharmacy Services
- Provider Disputes and Appeals - Commercial
- Pumping Essentials

Q

Quest Diagnostics

R

Roche

S

Smiths Medical, Inc

T

Transplant Team

U

V

W

X

Y

Z

Glossary

PDF Forms and References in Alphabetical Order

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

A

- AAP Recommendations for the Preventive Pediatric Health Care (PDF)
- Adult AIDS/HIV Confidential Case Report (PDF)
- After-Hours Sample Script - Arabic (PDF)
- After-Hours Sample Script - Armenian (PDF)
- After-Hours Sample Script - Chinese (PDF)
- After-Hours Sample Script - English (PDF)
- After-Hours Sample Script - Farsi (PDF)
- After-Hours Sample Script - Hmong (PDF)
- After-Hours Sample Script - Khmer (Cambodian) (PDF)
- After-Hours Sample Script - Korean (PDF)
- After-Hours Sample Script - Russian (PDF)
- After-Hours Sample Script - Spanish (PDF)
- After-Hours Sample Script - Tagalog (PDF)
- After-Hours Sample Script - Vietnamese (PDF)
- Autoclave Log (PDF)

B

Bariatric Surgery Performance Centers (PDF)

C

- Certification for Contracts Grants, loans, and Cooperative Agreements (PDF)
- Clinical Payment Policy CP.MP.152 - Measurement of Serum 1 25-dihydroxyvitamin D (PDF)
- Clinical Payment Policy CP.MP.153 - Helicobacter Pylori Serology Testing (PDF)
- Clinical Payment Policy CP.MP.154 - Thyroid Hormones and Insulin Testing in Pediatrics (PDF)
- Clinical Payment Policy, CCP.MP.155 - EEG in the Evaluation of Headache (PDF)
- Clinical Payment Policy CP.MP.156 - Cardiac Biomarker Testing for Acute Myocardial In farction (PDF)
- Clinical Payment Policy CP.MP.157 - 25-hydroxyvitamin D Testing in Children and Adolescents (PDF)

- Clinical Payment Policy CP.MP.38 - Ultrasound in Pregnancy (PDF)
- Confidential Morbidity Report (PDF)

D

- Decision Power Referral Fax Form - Commercial and Medicare (PDF)
- Directory Removal for At-Risk Providers Form (PDF)
- Disclosure of Lobbying Activities Form and Disclosure Form Instructions (PDF)
- Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Coding Policies (PDF)

E

- Edinburgh Perinatal/Postnatal Depression Scale (EPDS) Questionnaire (PDF)
- Eligibility Report Field Descriptions (PDF)

F

G

H

Hepatitis B Vaccination Declination (PDF)

I

- ICD-10-CM Codes for Abortion-Related Services (PDF)
- Identification card (Large group PureCare HSP) (PDF)
- Individual Family Plan member eligibility status displayed on the secure provider portal (PDF)
- Industry Collaboration Effort (ICE): Provider Tools to Care for Diverse Populations (PDF)
- Inpatient California Health Net Commercial Prior Authorization (PDF)
- Interpreter Service Quick Reference Card (PDF)

J

K

L

Language Identification Poster (PDF)

M

- Medical Record - Adult Health Maintenance Checklist With Standards (PDF)
- Medical Record - Advance Directive Labels (PDF)
- Medical Record - Audiometric Screening (PDF)
- Medical Record - History Spanish (PDF)
- Medical Record - Medication and Chronic Problem Summary (PDF)
- Medical Record - Signature Page (PDF)
- Medical/Behavioral Comanagement/Coordination of Care Form (PDF)
- Member Grievance Form (PDF)

N

- NICU Level of Care Criteria (PDF)
- Nondiscrimination Notice and Taglines (PDF)

O

- Offshore Subcontracting Attestation: Participating Provider (PDF)
- Order of Benefits for Dependent Children (PDF)
- Out-of-Pocket Maximum - Back (PDF)
- Out-of-Pocket Maximum - Front (PDF)
- Out-of-Pocket Maximum Copayment Example (PDF)
- Outpatient California Health Net Commercial Prior Authorization (PDF)

P

- Palliative Care Providers (contracted)
- Physical or Speech Therapy (PDF)

- Potential Quality Issue Referral Form (PDF)
- Prescription Drug Prior Authorization or Step Therapy Exception Form (PDF)
- Provider Dispute Resolution Request - Commercial and Medi-Cal (PDF)
- Provider Dispute Resolution Request - IFP (PDF)

Q

Quick Reference Guide (PDF)

R

- Reportable Diseases (PDF)
- Request for Confidential Communication Form (PDF)

S

- Sample - Hospital Refusal Letter (PDF)
- Subscriber OOPM Notification Letter (PDF)

T

Transplant Performance Centers (PDF)

U

- Urgent Request for Continuing Home Health Services (PDF)
- Urgent Request for Continuing Occupational, Physical or Speech Therapy (PDF)

V

Verifying Eligibility (IFP) (PDF)

W

X

Y

Z

نص نموذجي لما بعد ساعات الدوام

يمكن استخدام أحد النصوص التالية من قبل الأطباء والمجموعات الطبية كأساس لضمان حصول أعضاء Health Net على الرعاية الطبية السريعة بعد ساعات الدوام أو عندما تكون عياداتكم مغلقة.

هام: خدمات الهاتف الفعالة بعد ساعات الدوام تضمن للمتصلين الاتصال بشخص أو جهاز تسجيل صوتي خلال 30 ثانية.

1. المكالمات التي يرد عليها شخص (مثل خدمات الرد على المكالمات أو مراكز الرعاية المركزية):

إذا شعر الشخص المتصل بأنه يواجه مشكلة صحية طارئة، انصح المتصل بإقفال الخط والاتصال فوراً بالرقم 911 أو التوجه إلى أقرب عيادة أو منشأة طوارئ.

إذا شعر الشخص المتصل أن الوضع يتطلب المعالجة العاجلة أو الحاجة لبحث الأمر مع طبيب أو منشأة طبية، قم بالاتصال بالطبيب عن طريق القيام بواحدة أو أكثر من الإجراءات التالية:

- ضع الشخص المتصل في وضع الانتظار للحظة ومن ثم قم بوصله بالطبيب المناوب
- اطلب من الشخص المتصل تزويدك برقم هاتفه وأخبره بأن الطبيب سيتصل به خلال 30 دقيقة (قم فوراً بإرسال رسالة للطبيب لإعلامه عن ذلك)
- أعطي الشخص المتصل رقم البيجر (جهاز الإخطار) وأخبره أن الطبيب سيتصل به خلال 30 دقيقة أو قم بتوجيه الشخص المتصل إلى أقرب مركز للرعاية العاجلة (urgent care).
- إذا عبر المتصل عن حاجته لخدمات مترجم، قم بتأمين مترجم عن طريق الاتصال بخدمات الترجمة

أمثلة:

مرحباً، لقد اتصلت بـ <خدمات الرد على المكالمات/مركز الرعاية المركزية> للدكتور <اسم العائلة>. إذا كانت هذه حالة طبية طارئة، رجاء أن تقفل الخط واتصل فوراً بالرقم 911 أو توجه إلى أقرب عيادة طوارئ. إذا كنت تريد التكلم مع الطبيب المناوب، رجاء أن تبقى على الخط وسوف أصلك به.

مرحباً، لقد اتصلت بـ <خدمات الرد على المكالمات/مركز الرعاية المركزية> للدكتور <اسم العائلة>. إذا كانت هذه حالة طبية طارئة، رجاء أن تقفل الخط واتصل فوراً بالرقم 911 أو توجه إلى أقرب عيادة طوارئ. إذا كنت تريد التكلم مع الطبيب المناوب، يستطيع الدكتور <اسم العائلة> مساعدتك. رجاء أن تتصل بالطبيب عن طريق البيجر (جهاز الإخطار) على الرقم <هاتف>. يمكنك ترقب استلام مكالمة منه خلال 30 دقيقة.

2. المكالمات التي يرد عليها جهاز التسجيل (مسجلة):

مرحباً، لقد اتصلت بـ <أدخل اسم الطبيب/المجموعة الطبية> إذا كانت هذه حالة طارئة، رجاء أن تقفل الخط واتصل فوراً بالرقم 911 أو توجه إلى أقرب عيادة طوارئ. إذا كنت تريد التكلم مع الطبيب المناوب، (اختر الخيار المناسب):

- رجاء أن تبقى على الخط وسوف أصلك بالدكتور <اسم العائلة>
- *يمكنك الاتصال بالطبيب المناوب مباشرة عن طريق الاتصال بالرقم <هاتف>*
- *اضغط على <رقم> للتحويل إلى مركزنا للرعاية العاجلة. يقع مركزنا للرعاية العاجلة في <عنوان مركز الرعاية العاجلة> (يجب تزويد خيارات اللغة المناسبة للموقع).*
- *اضغط على <رقم> لإخطار الطبيب المناوب. يمكنك توقع استلام مكالمة من الطبيب خلال 30 دقيقة.*

أمثلة:

مرحباً، لقد اتصلت بـ <اسم الطبيب/المجموعة الطبية> للدكتور <اسم العائلة>. إذا كانت هذه حالة طارئة، رجاء أن تقفل الخط واتصل فوراً بالرقم 911 أو توجه إلى أقرب عيادة طوارئ. إذا كنت تريد التكلم مع الطبيب المناوب، رجاء أن تترك رسالة صوتية مع ذكر اسمك ورقم هاتفك وسبب اتصالك ويمكنك ترقب استلام رسالة من الطبيب خلال 30 دقيقة.

مرحباً، لقد اتصلت بـ <أدخل اسم الطبيب/المجموعة الطبية>. إذا كانت هذه حالة طبية طارئة، رجاء أن تقفل الخط واتصل فوراً بالرقم 911 أو توجه إلى أقرب عيادة طوارئ. إذا كنت تريد التكلم مع الطبيب المناوب، يمكنك الاتصال به مباشرة عن طريق الاتصال بالرقم <هاتف> أو اضغط على <رقم> لإخطار الطبيب المناوب. يمكنك توقع استلام مكالمة من الطبيب خلال 30 دقيقة.

ԱՇԽԱՏԱՆՔԱՅԻՆ ԺԱՄԵՐԻՑ ՀԵՏՈ ՏԵՔՍՏԻ ՆՄՈՒՇ

Հետևյալ տեքստերից որևէ մեկը որպես կաղապար կարող է օգտագործվել բժիշկների և բժշկական խմբերի կողմից, երաշխավորելու համար, որ բժշկական խնամքը իր ժամանակին մատչելի կդառնա Health Net-ի անդամներին՝ աշխատանքային ժամերից հետո կամ երբ ձեր գրասենյակները փակ են:

ԿԱՐԵՎՈՐ՝ Աշխատանքային ժամերից հետո արդյունավետ հեռախոսային սպասարկումը կերաշխավորի, որ զանգահարողները կարողանան 30 վայրկյանի ընթացքում միանալ պատասխանող անձի կամ սարքի:

I. ԱՆՁԻ ԿՈՂՄԻՑ ՊԱՏԱՍԽԱՆՎՈՂ ՀԵՌԱԽՈՍԱԿԱՆՉԵՐ (ինչպես՝ պատասխանող ծառայությունը կամ կենտրոնացված զտման համակարգը)՝

Եթե զանգահարողը հավատացած է, որ գտնվում է բժշկական արտակարգ վիճակում, զանգահարողին խորհուրդ տվեք հեռախոսն անջատել և անմիջապես զանգահարել 911 կամ շարժվել դեպի ամենամոտիկ շտապ օգնության կայանը կամ բժշկական հաստատությունը:

Եթե զանգահարողը հավատացած է, որ կացությունը հրատապ է կամ նշի, որ հարկավոր է խոսել բժշկի հետ, հեշտացրեք բժշկի հետ կապի հաստատումը, կատարելով հետևյալներից մեկը կամ ավելին՝

- Զանգահարողից խնդրեք սպասել մի պահ և զանգահարողին միացրեք հերթապահ բժշկին
- Վերցրեք զանգահարողի հեռախոսի համարը և նրան խորհուրդ տվեք, որ բժիշկը հեռախոսականչին կպատասխանի 30 րոպեի ընթացքում (անմիջապես պատգամ ուղարկեք բժշկին)
- Զանգահարողին տվեք հերթապահ բժշկի փեյջերի համարը և զանգահարողին խորհուրդ տվեք, որ բժիշկը անդամին կզանգահարի 30 րոպեի ընթացքում, կամ զանգահարողին ուղարկեք ամենամոտիկ շտապ խնամքի կենտրոնի վայրը
- Եթե զանգահարողը նշի կարիքը բանավոր թարգմանության ծառայությունների, հեշտացրեք կապը՝ ձեռք բերելով բանավոր թարգմանչական ծառայությունները

Օրինակներ՝

Բարև, դուք հասել եք բժիշկ <Ազգանուն>-ի <պատասխանող ծառայություն/կենտրոնացված զտման համակարգ>: Եթե սա բժշկական արտակարգ վիճակ է, խնդրում ենք հեռախոսն անջատել և անմիջապես զանգահարել 911 կամ գնալ ամենամոտիկ շտապ օգնության կայանը: Եթե ուզում եք հերթապահ բժշկի հետ խոսել, խնդրում եմ գծի վրա սպասել և ես ձեզ կմիացնեմ նրան:

Բարև, դուք միացել եք բժիշկ <Ազգանուն>-ի համար <պատասխանող ծառայության/կենտրոնացված զտման համակարգ>-ին: Եթե սա բժշկական արտակարգ վիճակ է, խնդրում ենք հեռախոսն անջատել և անմիջապես զանգահարել 911 կամ գնալ ամենամոտիկ շտապ օգնության կայանը: Եթե ուզում եք հերթապահ բժշկի հետ խոսել, բժիշկ <ազգանուն>-ը կարող է ձեզ օգնել: Խնդրում ենք նրան <փեյջ անել/զանգահարել> <հեռախոսի համար> համարով: Պատասխան հեռախոսականչի սպասեք 30 րոպեի ընթացքում:

II. ՊԱՏԱՍԽԱՆՈՂ ՍԱՐՔԻ ՄԻՋՈՑՈՎ ՊԱՏԱՍԽԱՆՎԱԾ ՀԵՌԱԽՈՍԱԿԱՆՉԵՐ

Բարև, դուք միացել եք <տեղադրեք Բժշկի/Բժշկական խմբի անունը>: Եթե սա բժշկական արտակարգ վիճակ է, խնդրում ենք հեռախոսն անջատել և անմիջապես զանգահարել 911 կամ գնալ ամենամոտիկ շտապ օգնության կայանը: Եթե ուզում եք հերթապահ բժշկի հետ խոսել (կատարեք համապատասխան ընտրությունը)՝

- *Խնդրում ենք սպասել և ձեզ կմիացնեն բժիշկ <Ազգանուն>-ին*
- *Հերթապահ բժշկին կարող եք միանալ ուղղակի զանգահարելով <հեռախոսի համար>*

- *Սեղմեք <թվանշան> մեր հրատապ խնամքի կենտրոն փոխանցվելու համար: Մեր հրատապ խնամքի կենտրոնը գտնվում է <հրատապ խնամքի կենտրոնի հասցե> (Վայրի համար հարկավոր է ընծայել լեզվական համապատասխան ընտրանքներ)*
- *Սեղմեք <թվանշան> հերթապահ բշկին փեյջ անելու համար: Պատասխան հեռախոսականչի սպասեք 30 րոպեի ընթացքում:*

Օրինակներ՝

Բարև, դուք միացել եք բժիշկ <Ազգանուն>-ի համար <Բժշկի անուն/Բժշկական խումբ>-ին: Եթե սա բժշկական արտակարգ վիճակ է, խնդրում ենք հեռախոսն անջատել և անմիջապես զանգահարել 911 կամ գնալ ամենամոտիկ շտապ օգնության կայանը: Եթե ուզում եք հերթապահ բժշկի հետ խոսել, խնդրում ենք պատգամ թողնել նշելով ձեր անունը, հեռախոսի համարը և զանգահարման պատճառը, և կարող եք պատասխան կանչ սպասել 30 րոպեի ընթացքում:

Բարև, դուք միացել եք <Բժշկի անուն/Բժշկական խումբ>-ին: Եթե սա բժշկական արտակարգ վիճակ է, խնդրում ենք հեռախոսն անջատել և անմիջապես զանգահարել 911 կամ գնալ ամենամոտիկ շտապ օգնության կայանը: Եթե ուզում եք հերթապահ բժշկի հետ խոսել, նրան կարող եք միանալ ուղղակի զանգահարելով <հեռախոսի համար> կամ սեղմելով <թվանշան>, որպեսզի միանաք հերթապահ բժշկի փեյջերին: Պատասխան հեռախոսականչի սպասեք 30 րոպեի ընթացքում:

AFTER HOURS SAMPLE SCRIPT

One of the following scripts may be used by physicians and medical groups as a template to ensure Health Net members have access to timely medical care after business hours or when your offices are closed.

IMPORTANT: Effective telephone service after business hours ensures callers are able to reach a live voice or answering machine within 30 seconds.

I. CALLS ANSWERED BY A LIVE VOICE (such as an answering service or centralized triage):

If the caller believes that he or she is experiencing a medical emergency, advise the caller to hang up and call 911 immediately or proceed to the nearest emergency room/medical facility.

If the caller believes the situation is urgent or indicates a need to speak with a physician, facilitate contact with the physician by doing one or more of the following:

- Put the caller on hold momentarily and then connect the caller to the on-call physician
- Get the caller's number and advise him or her that a physician will return the call within 30 minutes (immediately send a message to physician)
- Give the caller the pager number for the on-call physician and advise the caller that the physician will call the member within 30 minutes, or direct the caller to the nearest urgent care center location
- If a caller indicates a need for interpreter services, facilitate the contact by accessing interpreter services

Examples:

Hello, you have reached the <answering service/centralized triage> for Dr. <Last Name>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the on-call physician, please stay on the line and I will connect you.

Hello, you have reached the <answering service/centralized triage> for Dr. <Last name>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the on-call physician, Dr. <Last Name> can assist you. Please <page/call> him/her at <telephone number>.You may expect a call back within 30 minutes.

II. CALLS ANSWERED BY AN ANSWERING MACHINE:

Hello, you have reached <insert Name of Doctor/Medical Group>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the physician on call (select appropriate option):

- *Please hold and you will be connected to Dr. <Last Name>*
- *You may reach the physician on call directly by calling <telephone number>*
- *Press <number> to transfer to our urgent care center. Our urgent care center is located at <urgent care center address> (Appropriate language options should be provided for the location.)*
- *Press <number> to page the physician on call. You may expect a return call within 30 minutes*

Examples:

Hello, you have reached the <Name of Doctor/Medical Group> for Dr. <Last Name>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the physician on call, please leave a message with your name, telephone number and reason for calling, and you may expect a call back within 30 minutes.

Hello, you have reached <Name of Doctor/Medical Group>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the physician on call, you may reach him/her directly by calling <telephone number> or press <number> to page the physician on call. You may expect a call back within 30 minutes.

متن نمونه برای بعد از ساعات کاری

یکی از متن های زیر توسط پزشکان و گروه های پزشکی به عنوان الگو استفاده خواهد شد تا اطمینان حاصل شود که اعضای Health Net به مراقبت پزشکی بموقع بعد از ساعات کاری یا هنگام تعطیلی مطب ها دسترسی داشته باشند.

نکته مهم: خدمات تلفنی مؤثر بعد از ساعات کاری تضمین می کند که تماس گیرندگان بتوانند با یک صدای زنده یا ماشین پیامگیر در ظرف 30 ثانیه صحبت کنند.

I. تماس هایی که توسط یک صدای زنده جواب داده می شوند (از قبیل خدمات پاسخگوئی یا تریاژ مرکزی شده):

اگر تماس گیرنده تصور می کند که مشکلی دارد که اورژانس پزشکی است، به تماس گیرنده توصیه نمائید که گوشی را گذاشته و فوراً شماره 911 را بگیرد یا به نزدیک ترین بخش اورژانس/مرکز پزشکی برود.

اگر تماس گیرنده تصور می کند که در وضعیت فوری است یا بیان می کند که می خواهد با یک پزشک صحبت کند، یکی از اقدامات زیر را برای تسهیل تماس با پزشک انجام دهید:

- تماس گیرنده را برای یک لحظه منتظر نگه داشته و سپس تماس گیرنده را به پزشک کشیک وصل کنید.
- شماره تلفن تماس گیرنده را گرفته و به وی بگوئید که پزشک در ظرف 30 دقیقه با وی تماس خواهد گرفت (فوراً یک پیغام را برای پزشک ارسال کنید)
- شماره پیجر پزشک کشیک را به تماس گیرنده بدهید و به وی بگوئید که پزشک در ظرف 30 دقیقه با عضو تماس خواهد گرفت، یا تماس گیرنده را به نزدیک ترین مرکز مراقبت فوری هدایت کنید.
- اگر تماس گیرنده اشاره کند که به خدمات مترجم شفاهی نیاز دارد، تماس را توسط دسترسی به خدمات مترجم شفاهی تسهیل کنید

مثال ها:

سلام، شما با <خدمات پاسخگوئی/تریاژ مرکزی شده> برای دکتر <نام خانوادگی> تماس گرفته اید. اگر این یک موقعیت اورژانس است، لطفاً گوشی را گذاشته و فوراً شماره 911 را بگیرید یا به نزدیک ترین بخش اورژانس بروید. اگر مایلید که با پزشک کشیک صحبت کنید، لطفاً گوشی را نگه دارید و شما را به وی وصل خواهم کرد.

سلام، شما با <خدمات پاسخگوئی/تریاژ مرکزی شده> برای دکتر <نام خانوادگی> تماس گرفته اید. اگر این یک موقعیت اورژانس است، لطفاً گوشی را گذاشته و فوراً شماره 911 را بگیرید یا به نزدیک ترین بخش اورژانس بروید. اگر مایلید که با پزشک کشیک صحبت کنید، دکتر <نام خانوادگی> می تواند به شما کمک کند. لطفاً با وی به شمارهٔ <شماره تلفن> <پیج/تماس> بگیرید. می توانید انتظار داشته باشید که در ظرف 30 دقیقه با شما تماس گرفته شود.

II. تماس هایی که توسط ماشین پیامگیر جواب داده می شوند:

سلام.، شما با <نام پزشک/گروه پزشکی را وارد کنید> تماس گرفته اید. اگر این یک موقعیت اورژانس است، لطفاً گوشی را گذاشته و فوراً شماره 911 را بگیرید یا به نزدیک ترین بخش اورژانس بروید. اگر مایلید که با پزشک کشیک صحبت کنید (گزینه مناسب را انتخاب کنید):

- *لطفاً گوشی را نگه داشته و شما را در تماس با دکتر<نام خانوادگی> قرار خواهیم داد*
- *می توانید توسط تماس با شمارهٔ <شماره تلفن> مستقیماً با پزشک کشیک تماس بگیرید.*
- *شمارهٔ <شماره> را برای انتقال به مرکز مراقبت فوری ما فشار دهید. مرکز مراقبت فوری ما در <نشانی مرکز مراقبت فوری> واقع شده است (گزینه های زبان مناسب بایستی برای این مرکز ارائه شود.)*
- *شمارهٔ <شماره> را برای پیج کردن پزشک کشیک فشار دهید. می توانید انتظار داشته باشید که در ظرف 30 دقیقه با شما تماس گرفته شود.*

مثال ها:

سلام، شما با <نام پزشک/گروه پزشکی> برای دکتر <نام خانوادگی> تماس گرفته اید. اگر این یک موقعیت اورژانس است، لطفاً گوشی را گذاشته و فوراً شماره 911 را بگیرید یا به نزدیک ترین بخش اورژانس بروید. اگر مایلید که با پزشک کشیک صحبت کنید، لطفاً پیغام بگذارید که شامل نام، شماره تلفن و دلیل تماس شما می شود و می توانید انتظار داشته باشید که در ظرف 30 دقیقه با شما تماس گرفته شود.

سلام.، شما با <نام پزشک/گروه پزشکی> تماس گرفته اید. اگر این یک موقعیت اورژانس است، لطفاً گوشی را گذاشته و فوراً شماره 911 را بگیرید یا به نزدیک ترین بخش اورژانس بروید. اگر مایلید که با پزشک کشیک صحبت کنید، می توانید توسط تماس با شمارهٔ <شماره تلفن> و فشردن شمارهٔ <شماره> برای پیج کردن پزشک کشیک، مستقیماً با وی تماس بگیرید. می توانید انتظار داشته باشید که در ظرف 30 دقیقه با شما تماس گرفته شود.

PIV TXWV TXOG COV LUS KAW CIA THAUM COV SIJHAWM KAWS

Cov kws kho mob thiab pab pawg kho mob siv tau cov lus uas lawv qab ntawm no los pab kom cov tswv cuab mus txais tau kev kho mob tom qab cov sijhawm tsis ua haujlwm lossis thaum koj lub chaw haujlwm kaws.

TSEEM CEEB: Txoj kev pab teb xov tooj tom qab cov sijhawm kaws yuav pab tau cov neeg hu tuaj txais tau ib tug neeg lub suab lossis lub tshuab teb xovtooj ua ntej 30 second.

I. COV XOVTOOJ UAS IB TUG NEEG LUB SUAB TEB (xws li lub chaw teb xovtooj/chaw kho mob):

Yog tus neeg hu tuaj ntseeg tias nws muaj ib yam mob xwm txheej ceev, qhia rau tus neeg hu tuaj kom nws khwb lub xovtooj thiab hu 911 tamsid lossis mus rau tom lub chaw kho mob xwm txheej ceev/lub chaw kho mob uas nyob ze tshaj rau ntawm nws.

Yog tus neeg hu tuaj ntseeg tias nws muaj ib yam mob nrawm lossis xav nrog ib tug kws kho mob tham, pab kom nws tham tau nrog ib tug kws kho mob thaum koj ua ib qho lossis ntau tshaj raws li cov lawv qab ntawm no:

- Muab tus neeg hu tuaj tsab xovtooj tso tos tib pliag ces txuas tus neeg hu tuaj mus rau tus kws kho mob uas ua haujlwm rau lub sijhawm tamsim nov
- Nug tus neeg hu tuaj rau nws tus xovtooj thiab qhia rau nws tias tus kws kho mob mam li rov qab hu tuaj rau nws ua ntej 30 feeb (hu tso lus tamsid rau tus kws kho mob)
- Muab tus kws kho mob uas ua haujlwm rau lub sijhawm tamsim tus xovtooj ntawm nws lub pager rau tus neeg hu tuaj thiab qhia rau tus neeg hu tuaj tias tus kws kho mob mam li hu rau the tswv cuab ua ntej 30 feeb, lossis qhia kom tus neeg hu tuaj cia li mus rau lub chaw kho mob nrawm uas nyob ze tshaj rau ntawm nws
- Yog tias tus neeg hu tuaj hais tias lawv xav tau kev pab txhais lus, pab kom nws tham tau nrog ib tug kws txhais lus

Cov piv txwv:
Nyob zoo, koj tau hu tuaj rau <lub chaw teb xovtooj/chaw kho mob> rau tus kws kho mob Dr. <Lub Xeem>. Yog tias qhov no yog ib yam kev mob xwm txheej ceev, thov khwb lub xovtooj thiab ntau 911 tamsid lossis mus rau tom lub chaw kho mob xwm txheej ceev uas nyob ze tshaj rau ntawm koj. Yog tias koj xav tham nrog tus kws kho mob uas ua haujlwm rau lub sijhawm tamsim nov, thov mloog twj ywm ces kuv mam li txuas koj tsab xovtooj mus.

Nyob zoo, koj tau hu tuaj rau <lub chaw teb xovtooj/chaw kho mob> rau tus kws kho mob Dr. <Lub xeem>. Yog tias qhov no yog ib yam kev mob xwm txheej ceev, thov khwb lub xovtooj thiab ntau 911 tamsid lossis mus rau tom lub chaw kho mob xwm txheej ceev uas nyob ze tshaj rau ntawm koj. Yog tias koj xav tham nrog tus kws kho mob uas ua haujlwm rau lub sijhawm tamsim nov, tus kws kho mob Dr. <Lub Xeem> yuav pab tau koj. Thov <nias tso koj tus xovtooj/hu> nws ntawm <xovtooj>. Koj yuav txais ib tsab xovtooj hu rov qab tuaj rau koj ua ntej 30 feeb.

II. TSAB XOVTOOJ UAS LUB TSHUAB KAW LUS TEB:

Nyob zoo, koj tau hu tuaj rau <hais tus Kws Kho Mob/Pab Pawg Kho Mob lub npe>. Yog tias qhov no yog ib yam kev mob xwm txheej ceev, thov khwb lub xovtooj thiab ntau 911 tamsid lossis mus rau tom lub chaw kho mob xwm txheej ceev uas nyob ze tshaj rau ntawm koj. Yog tias koj xav tham nrog tus kws kho mob uas ua haujlwm rau lub sijhawm tamsim nov (xaiv qhov haum rau koj):

- *Thov tos mentsis ces koj tsab xovtooj mam li txuas mus rau tus kws kho mob Dr. <Lub Xeem>*
- *Koj cia li hu mus cuag tus kws kho mob uas ua haujlwm rau lub sijhawm tamsim nov thaum koj hu rau <xovtooj>*
- *Nias <tus lej> kom txuas tau koj tsab xovtooj mus rau qhov chaw kho mob nrawm. Peb lub chaw kho mob nrawm nyob ntawm <lub chaw kho mob nrawm qhov chaw nyob> (Koj yuav tsum muaj ib txoj kev los xaiv kom siv tau nws hom lus los qhia txog qhov chaw kho mob.)*

- *Nias <tus lej> kom tso tau koj tus xovtooj rau tus kws kho mob uas ua haujlwm rau lub sijhawm tamsim nov. Koj yuav txais ib tsab xovtooj hu rov qab tuaj rau koj ua ntej 30 feeb*

Cov piv txwv:
Nyob zoo, koj tau hu tuaj rau <Tus Kws Kho Mob/Pab Pawg Kho Mob lub Npe> rau tus kws kho mob Dr. <Lub Xeem>. Yog tias qhov no yog ib yam kev mob xwm txheej ceev, thov khwb lub xovtooj thiab ntau 911 tamsid lossis mus rau tom lub chaw kho mob xwm txheej ceev uas nyob ze tshaj rau ntawm koj. Yog tias koj xav tham nrog tus kws kho mob uas ua haujlwm rau lub sijhawm tamsim nov, thov kaws lus cia nrog koj lub npe, xovtooj thiab qhia vim li cas koj hu tuaj, ces koj yuav txais ib tsab xovtooj hu rov qab tuaj rau koj ua ntej 30 feeb.

Nyob zoo, koj tau hu tuaj rau <Tus Kws Kho Mob/Pab Pawg Kho Mob lub Npe>. Yog tias qhov no yog ib yam kev mob xwm txheej ceev, thov khwb lub xovtooj thiab ntau 911 tamsid lossis mus rau tom lub chaw kho mob xwm txheej ceev uas nyob ze tshaj rau ntawm koj. Yog tias koj xav tham nrog tus kws kho mob uas ua haujlwm rau lub sijhawm tamsim nov, koj cia li hu ncaj nraim mus tau rau nws ntawm <xovtooj> lossis nias <tus lej> kom tso tau koj tus xovtooj cia rau tus kws kho mob uas ua haujlwm rau lub sijhawm tamsim nov. Koj yuav txais ib tsab xovtooj hu rov qab tuaj rau koj ua ntej 30 feeb.

គំរូលំនាំ បនញាប់ពីម៉ោងធេ ិការ

លំនាំមួយនៅខាងក្រោម អាចនឹងបានប្រើដោយវេជ្ជបណ្ឌិត និងក្រុមពេទ្យ ធ្វើជាគំរូដើម្បីធ្វើឲ្យប្រាកដថាសមាជិក Health Net មានសមត្ថភាពទទួលការថែទាំសុខភាពទាន់ពេលវេលា បន្ទាប់ពីម៉ោងធ្វើការ ឬនៅពេលការិយាល័យវេជ្ជបណ្ឌិតរបស់អ្នកបិទ។

សារៈសំខាន់ ៖ ប្រសិទ្ធិភាពនៃសេវាតាមទូរស័ព្ទបន្ទាប់ពីម៉ោងធ្វើការ ធ្វើឲ្យប្រាកដថាអ្នកទូរស័ព្ទមក អាចទាក់ទងមកសំឡេងរស់រវើក ឬម៉ាស៊ីនឆ្លើយ ក្នុងពេល 30 វិនាទី។

I. ការទូរស័ពព្ទមកបានឆ្លើយដោយសំឡេងរស់រវើក (ដូចជាម៉ាស៊ីនឆ្លើយ ឬមជ្ឈដ្ឋានស្នាក់ការ) ៖

បើអ្នកទូរស័ព្ទមក ជឿថាគាត់មានអាសន្នខាងសុខភាព ត្រូវប្រាប់អ្នកទូរស័ព្ទមកឲ្យដាក់ចុះ និងហៅលេខ 911 ជាប្រញាប់ ឬធ្វើដំណើរទៅបន្ទប់សង្គ្រោះអាសន្ន/មន្ទីរពេទ្យ ដែលស្ថិតនៅជិតបំផុត។

បើអ្នកទូរស័ព្ទមក ជឿថាស្ថានការណ៍គឺជាបន្ទាន់ ឬបើគាត់ប្រាប់ថាត្រូវការនិយាយជាមួយនឹងវេជ្ជបណ្ឌិត ត្រូវសំរបសំរួលការទាក់ទងជាមួយនឹងវេជ្ជបណ្ឌិត ដោយធ្វើការមួយ ឬច្រើនយ៉ាងនៅខាងក្រោម ៖

- ប្រាប់អ្នកទូរស័ព្ទមក ឲ្យចាំមួយភ្លែត ហើយបន្ទាប់មកតភ្ជាប់អ្នកទូរស័ព្ទមក ទៅវេជ្ជបណ្ឌិតប្រចាំការ
- យកលេខទូរស័ព្ទរបស់អ្នកទូរស័ព្ទមក ហើយប្រាប់គាត់ថាវេជ្ជបណ្ឌិតនឹងទូរស័ព្ទទៅវិញ ក្នុងពេល 30 នាទី (បញ្ជូនសារទៅវេជ្ជបណ្ឌិត ភ្លាមៗ)
- ឲ្យលេខកោះហៅរបស់វេជ្ជបណ្ឌិតប្រចាំការ ទៅអ្នកទូរស័ព្ទមក និងប្រាប់អ្នកទូរស័ព្ទមក ថាវេជ្ជបណ្ឌិតនឹងទូរស័ព្ទទៅសមាជិកវិញ ក្នុងពេល 30 នាទី ឬណែនាំអ្នកទូរស័ព្ទមក ឲ្យទៅកន្លែងមណ្ឌលថែទាំជាបន្ទាន់ ដែលស្ថិតនៅជិតបំផុត
- បើអ្នកទូរស័ព្ទមក ប្រាប់ថាត្រូវការសេវាពីអ្នកបកប្រែ ត្រូវសំរបសំរួលការទាក់ទង ដោយទាក់ទងទៅសេវាពីអ្នកបកប្រែ

ឧទាហរណ៍ ៖

សួស្តី អ្នកបានទាក់ទងមក <សេវាខាងការឆ្លើយ/មជ្ឈដ្ឋានស្នាក់ការ> សំរាប់វេជ្ជបណ្ឌិត <នាមត្រកូល>។ បើនេះជាអាសន្នខាងសុខភាព សូមដាក់ទូរស័ព្ទចុះ ហើយហៅលេខ 911 ជាប្រញាប់ ឬទៅបន្ទប់សង្គ្រោះអាសន្នដែលស្ថិតនៅជិតបំផុត។ បើអ្នកចង់និយាយជាមួយនឹងវេជ្ជបណ្ឌិតប្រចាំការ សូមរង់ចាំសិន ហើយខ្ញុំនឹងតភ្ជាប់អ្នក។

សួស្តី អ្នកបានទាក់ទងមក <សេវាខាងការឆ្លើយ/មជ្ឈដ្ឋានស្នាក់ការ> សំរាប់វេជ្ជបណ្ឌិត <នាមត្រកូល>។ បើនេះជាអាសន្នខាងសុខភាព សូមដាក់ទូរស័ព្ទចុះ ហើយហៅលេខ 911 ជាប្រញាប់ ឬទៅបន្ទប់សង្គ្រោះអាសន្នដែលស្ថិត នៅជិតបំផុត។ បើអ្នកចង់និយាយជាមួយនឹងវេជ្ជបណ្ឌិតប្រចាំការ វេជ្ជបណ្ឌិត <នាមត្រកូល> អាចជួយអ្នកបាន។ សូម <កោះហៅ/ហៅ> ទៅគាត់តាមលេខ <លេខទូរស័ព្ទ>។ គាត់នឹងទូរស័ព្ទមកអ្នកវិញក្នុងពេល 30 នាទី។

II. ការទូរស័ពព្ទមក បានឆ្លើយដោយម្ចាស៊ីនឆ្លើយ ៖

សួស្តី អ្នកបានទាក់ទងមក <បញ្ចូលឈ្មោះវេជ្ជបណ្ឌិត/ក្រុមពេទ្យ>។ បើនេះជាអាសន្នខាងសុខភាព សូមដាក់ទូរស័ព្ទចុះ ហើយហៅលេខ 911 ជាប្រញាប់ ឬទៅបន្ទប់សង្គ្រោះអាសន្នដែលស្ថិតនៅជិតបំផុត។ បើអ្នកចង់និយាយជាមួយនឹងវេជ្ជបណ្ឌិតប្រចាំការ (ជ្រើសរើសជំរើសត្រឹមត្រូវ) ៖

- *សូមរង់ចាំសិន ហើយខ្ញុំនឹងតភ្ជាប់អ្នក ទៅវេជ្ជបណ្ឌិត <នាមត្រកូល>*
- *អ្នកអាចទាក់ទងវេជ្ជបណ្ឌិតប្រចាំការផ្ទាល់ ដោយទូរស័ព្ទទៅលេខ <លេខទូរស័ព្ទ>*
- *ចុចលេខ <លេខ> ដើម្បីបញ្ជូនទៅមណ្ឌលថែទាំជាបន្ទាន់។ មណ្ឌលថែទាំជាបន្ទាន់របស់យើងបិតនៅវា <អាសយដ្ឋានមណ្ឌលថែទាំជាបន្ទាន់> (ជំរើសអាសាត្រឹមត្រូវ គួរតែបានផ្តល់សំរាប់ទីកន្លែង)។*
- *ចុចលេខ <លេខ> ដើម្បីកោះហៅវេជ្ជបណ្ឌិតប្រចាំការ។ គាត់នឹងទូរស័ព្ទមកអ្នកវិញក្នុងពេល 30 នាទី។*

ឧទាហរណ៍ :

សួស្តី អ្នកបានទាក់ទងមក <ឈ្មោះវេជ្ជបណ្ឌិត/ក្រុមពេទ្យ> សំរាប់វេជ្ជបណ្ឌិត <នាមត្រកូល>។ បើនេះជាអាសន្នខាងសុខភាព សូមដាក់ទូរស័ព្ទចុះ ហើយហៅលេខ 911 ជាប្រញាប់ ឬទៅបន្ទប់សង្រ្គោះអាសន្នដែលស្ថិតនៅជិតបំផុត។
បើអ្នកចង់និយាយជាមួយនឹងវេជ្ជបណ្ឌិតប្រចាំការ សូមទុកសំឡេង ដោយមានឈ្មោះ និងលេខទូរស័ព្ទរបស់អ្នក ព្រមទាំងមូលហេតុនៃការទូរស័ព្ទមក ហើយគាត់នឹងទូរស័ព្ទមកអ្នកវិញក្នុងពេល 30 នាទី។

សួស្តី អ្នកបានទាក់ទងមក <ឈ្មោះវេជ្ជបណ្ឌិត/ក្រុមពេទ្យ>។ បើនេះជាអាសន្នខាងសុខភាព សូមដាក់ទូរស័ព្ទចុះ ហើយហៅលេខ 911 ជាប្រញាប់ ឬទៅបន្ទប់សង្រ្គោះអាសន្នដែលស្ថិតនៅជិតបំផុត។ បើអ្នកចង់និយាយជាមួយនឹង វេជ្ជបណ្ឌិតប្រចាំការ អ្នកអាចទាក់ទងទៅគាត់ដោយផ្ទាល់ ដោយទូរស័ព្ទទៅលេខ <លេខទូរស័ព្ទ> ឬចុចលេខ <លេខ> ដើម្បីកោះហៅវេជ្ជបណ្ឌិតប្រចាំការ។ គាត់នឹងទូរស័ព្ទមកអ្នកវិញក្នុងពេល 30 នាទី។

업무시간 후 샘플 스크립트

*의사 및 메디컬 그룹은 병원 업무 시간 후 또는 병원이 문을 닫은 경우 **Health Net** 회원들이 적절한 시간에 의료 서비스를 받으실 수 있도록 다음 스트립트 중 하나를 템플릿으로 이용할 수 있습니다.*

중요사항: 병원 업무 시간 후 효과적인 전화 서비스는 전화하신 분들에게 실제 음성 또는 자동 응답 서비스를 30초 이내에 제공합니다.

I. 실제 음성 전화 응답 (자동 응답 또는 중앙 분류 등)

전화를 건 사람이 의료 응급상황이라고 생각하는 경우, 전화를 끊고 즉시 911로 전화하거나 가장 가까운 응급실이나 병원을 찾아가도록 조언합니다.

전화를 건 사람이 긴급한 상황이라고 생각하거나 의사와 상담이 필요한 경우, 다음 중 하나 이상의 조치를 취해 의사와 연락을 원활히 할 수 있습니다.

- 전화를 잠시 대기하고 당직 의사에게 전화를 건 사람을 연결합니다
- 전화를 건 사람의 전화번호를 받고 의사가 30 분 이내에 전화를 할 것이라고 알려줍니다 (즉시 의사에게 메시지 전송)
- 전화를 건 사람에게 당직 의사의 호출 번호를 알려주고 의사가 30 분 이내에 전화를 할 것이라고 알려 주거나 전화를 건 사람에게 가장 가까운 긴급 치료 센터 위치를 알려줍니다
- 전화를 건 사람이 통역 서비스가 필요한 경우, 통역 서비스에 연락하여 문의를 원활하게 할 수 있도록 해 줍니다

예시:
안녕하십니까? Dr. <성>의 <자동 응답 서비스/중앙 분류 서비스>입니다. 의료 응급상황인 경우, 전화를 끊고 즉시 911에 전화하시거나 가장 가까운 응급실을 방문하십시오. 당직 의사와 상담을 원하시면, 잠시 전화를 끊지 말고 기다려 주시면 제가 당직 의사와 연결해 드리겠습니다.

안녕하십니까? Dr. <성>의 <자동 응답 서비스/중앙 분류 서비스>입니다. 의료 응급상황인 경우, 전화를 끊고 즉시 911에 전화하시거나 가장 가까운 응급실을 방문하십시오. 당직 의사와 상담을 원하시면 Dr. <성>가 도와드릴 것입니다. <전화번호>번으로 <호출/전화>하십시오. 30분 이내에 전화를 받을 수 있을 것입니다.

II. 자동 응답기가 답변하는 전화:

안녕하십니까? <의사/메디컬 그룹 이름 삽입 >에 전화해 주셔서 감사합니다. 의료 응급상황인 경우, 전화를 끊고 즉시 911에 전화하시거나 가장 가까운 응급실을 방문하십시오. 당직 의사와 상담을 원하시면 (적당한 옵션 선택하십시오):

- *잠시 전화를 끊지 말고 기다리시면 Dr. <성>과 연결해 드리겠습니다*
- *<전화번호>번으로 전화하여 직접 당직 의사와 통화할 수 있습니다*
- *<번호>를 누르시면 긴급 치료 센터와 연결됩니다 긴급 치료 센터는 <긴급 치료 센터 주소>에 있습니다 (위치에 대한 적당한 언어 옵션이 제공되어야 합니다.)*
- *<번호>를 눌러 당직 의사를 호출합니다. 30분 이내에 전화를 받을 수 있을 것입니다*

예시:
안녕하십니까? <의사/메디컬 그룹 이름>의 Dr. <성>입니다. 의료 응급상황인 경우, 전화를 끊고 즉시 911에 전화하시거나 가장 가까운 응급실을 방문하십시오. 당직 의사와 상담을 원하시면 귀하의 이름과 전화번호, 전화를 한 이유에 대해 메시지를 남겨주십시오. 30분 이내에 전화 드리겠습니다.

안녕하십니까? <의사/메디컬 그룹 이름>입니다. 의료 응급상황인 경우, 전화를 끊고 즉시 911에 전화하시거나 가장 가까운 응급실을 방문하십시오. 당직 의사와 상담을 원하시면 직접 <전화번호>로 전화하거나 <번호>로 호출하여 당직 의사와 상담할 수 있습니다. 30분 이내에 전화를 받을 수 있을 것입니다.

ОБРАЗЕЦ ОПРОСНОГО ЛИСТА ПО ОБСЛУЖИВАНИЮ В НЕРАБОЧИЕ ЧАСЫ

Врачи и медицинские группы могут использовать один из приведенных ниже опросных листов в качестве шаблона, чтобы убедиться в том, что участники Health Net имеют доступ к своевременной медицинской помощи в нерабочее часы, либо когда ваши офисы закрыты.

ВАЖНОЕ ПРИМЕЧАНИЕ: эффективное телефонное обслуживание в нерабочие часы подразумевает, что в течение 30 секунд после начала звонка позвонившему ответил оператор или автоответчик.

I. ЗВОНКИ, НА КОТОРЫЕ ОТВЕЧАЕТ ОПЕРАТОР (служба телефонных ответов или централизованное распределение звонков):

Если позвонивший считает, что ему или ей необходима неотложная медицинская помощь, посоветуйте позвонившему повесить трубку и немедленно позвонить по номеру 911, либо направьте его в ближайшее приемное отделение неотложной медицинской помощи/медицинское учреждение.

Если позвонивший полагает, что его ситуация не терпит отлагательства, либо же он выражает потребность поговорить с врачом, обеспечьте ему связь с врачом при помощи одного или нескольких из следующих действий:

- Немедленно переведите позвонившего в режим ожидания, а затем соедините его с дежурным врачом
- Возьмите номер телефона у позвонившего, и сообщите ему или ей, что врач перезвонит ему в течение 30 минут (немедленно пошлите сообщение врачу)
- Дайте позвонившему номер пейджера дежурного врача, и сообщите позвонившему, что врач позвонит ему в течение 30 минут, либо направьте его в ближайший центр оказания неотложной помощи
- Если позвонивший нуждается в помощи переводчика, обеспечьте ему связь при помощи переводческих услуг.

Примеры:
Здравствуйте, вы позвонили в <служба телефонных ответов/централизованное распределение звонков> доктору <Фамилия>. Если у вас неотложное медицинское состояние, пожалуйста, повесьте трубку и немедленно позвоните по номеру 911, либо обратитесь в ближайшее к вам приемное отделение неотложной медицинской помощи. Если вы хотите поговорить с дежурным врачом, пожалуйста, оставайтесь на линии и я соединю вас.

Здравствуйте, вы позвонили в <служба телефонных ответов/централизованное распределение звонков> доктору <Фамилия>. Если у вас неотложное медицинское состояние, пожалуйста, повесьте трубку и немедленно позвоните по номеру 911, либо обратитесь в ближайшее к вам приемное отделение неотложной медицинской помощи. Если вы хотите поговорить с дежурным врачом, вам поможет доктор <Фамилия>. Пожалуйста <отошлите сообщение на пейджер/позвоните> ему/ее по <телефону>. Вам перезвонят в течение 30 минут.

II. ЗВОНКИ НА АВТООТВЕТЧИК:

Здравствуйте, вы позвонили, <вставьте имя доктора/название медицинской группы>. Если у вас неотложное медицинское состояние, пожалуйста, повесьте трубку и немедленно позвоните по номеру 911, либо обратитесь в ближайшее к вам приемное отделение неотложной медицинской помощи. Если вы хотите поговорить с дежурным врачом, то (выберите подходящий вариант):

- *Пожалуйста, оставайтесь на линии, и вас соединят с доктором <Фамилия>*

- *Вы можете напрямую позвонить дежурному врачу по телефону <номер телефона>*
- *Нажмите <номер> , чтобы соединиться с нашим центром экстренной медицинской помощи. Наш центр экстренной медицинской помощи расположен по адресу: <адрес центра экстренной медицинской помощи> (необходимо обеспечить по данному адресу возможность языкового выбора)*
- *Нажмите <номер> , чтобы отправить сообщение на пейджер дежурного врача. Вам перезвонят в течение 30 минут.*

Примеры:
Здравствуйте, вы позвонили <имя доктора/название медицинское группы> доктору <Фамилия>. Если у вас неотложное медицинское состояние, пожалуйста, повесьте трубку и немедленной позвоните по номеру 911, либо обратитесь в ближайшее приемное отделение неотложное медицинской помощи. Если вы хотите поговорить с дежурным врачом, пожалуйста, оставьте сообщение с вашим именем, номером телефона и причиной звонка. Вам перезвонят в течение 30 минут.

Здравствуйте, вы позвонили <имя доктора/название медицинской группы>. Если у вас неотложное медицинское состояние, пожалуйста, повесьте трубку и немедленно позвоните по номеру 911, или обратитесь в ближайшее приемное отделение неотложной медицинской помощи. Если вы хотите поговорить с дежурным врачом, то вы можете связаться с ним/нею напрямую, позвонив по номеру <номер телефона> или нажмите <номер>, чтобы отправить сообщение на пейджер дежурного врача. Вам перезвонят в течение 30 минут.

SAMPLE NA SCRIPT PAGKATAPOS NG ORAS NA MAY PASOK

Magagamit ng mga manggagamot at medikal na pangkat ang isa sa mga sumusunod na script bilang template upang matiyak na may access ang mga miyembro ng Health Net sa napapanahong pangangalagang medikal pagkatapos ng oras ng negosyo o kapag sarado ang inyong mga tanggapan.

MAHALAGA: Tinitiyak ng mabisang serbisyo ng telepono pagkatapos ng oras ng negosyo na magagawang abutin ng mga tumatawag ang isang live na boses o answering machine sa loob ng 30 segundo.

I. MGA TAWAG NA SINASAGOT NG ISANG LIVE NA BOSES (gaya ng isang serbisyo sa pagsagot o centralized na triage):

Kung pinaniniwalaan ng tumatawag na siya ay nakakaranas ng isang medikal na emergency, payuhan ang tumatawag na mag-hang up at agad na tumawag sa 911 o pumunta sa pinakamalapit na emergency room/medikal na pasilidad.

Kung pinaniniwalaan ng tumatawag na agaran ang sitwasyon o nagsaad ng pangangailangang makipag-usap sa isang manggagamot, ayusin ang pakikipag-ugnay sa manggagamot sa pamamagitan ng paggawa sa isa o higit pa sa sumusunod:

- I-hold nang ilang sandali ang tumatawag at pagkatapos ay ikonekta ang tumatawag sa on-call na manggagamot
- Kunin ang numero ng tumatawag at payuhan siya na tatawag sa kanya ang isang manggagamot sa loob ng 30 minuto (agad na magpadala ng mensahe sa manggagamot)
- Ibigay sa tumatawag ang numero sa pager ng on-call na manggagamot at payuhan ang tumatawag na tatawagan ng manggagamot ang miyembro sa loob ng 30 minuto, o idirekta ang tumatawag sa pinakamalapit na lokasyon ng center ng agarang pangangalaga
- Kung isinaad ng tumatawag ang pangangailangan para sa mga serbisyo ng tagasalin ng wika, ayusin ang pakikipag-ugnay sa pamamagitan ng pag-access sa mga serbisyo ng tagasalin ng wika

Mga Halimbawa:

Kamusta, naabot mo ang <answering service/centralized na triage> para kay Doktor <Last Name>. Kung isa itong medikal na emergency, mangyaring mag-hang up at i-dial agad ang 911 o pumunta sa pinakamalapit na emergency room. Kung nais mong makipag-usap sa on-call na manggagamot, mangyaring manatili sa linya at ikokonekta kita.

Kamusta, naabot mo ang <answering service/centralized na triage> para kay Doktor <Last Name>. Kung isa itong medikal na emergency, mangyaring mag-hang up at i-dial agad ang 911 o pumunta sa pinakamalapit na emergency room. Kung nais mong makipag-usap sa on-call na manggagamot, matutulungan ka ni Doktor <Last Name>. Mangyaring <i-page/tawagan> siya sa <numero ng telepono>.Maaari mong asahan ang isang tugon na tawag sa loob ng 30 minuto.

II. MGA TAWAG NA SINASAGOT NG ISANG ANSWERING MACHINE:

Kamusta, naabot mo ang <ipasok ang Pangalan ng Doktor/Medikal na Pangkat>. Kung isa itong medikal na emergency, mangyaring mag-hang up at i-dial agad ang 911 o pumunta sa pinakamalapit na emergency room. Kung nais mong makipag-usap sa manggagamot na on-call (piliin ang naaangkop na pagpipilian):

- *Mangyaring maghintay at ikokonekta ka kay Doktor <Apelyido>*
- *Maaari mong direktang maabot ang manggagamot na on-call sa pamamagitan ng pagtawag sa <numero ng telepono>*
- *Pindutin ang <numero> upang lumipat sa aming center ng agarang pangangalaga. Matatagpuan ang aming center ng agarang pangangalaga sa <address ng center ng agarang pangangalaga> (Dapat ibigay ang mga naaangkop na pagpipilian sa wika para sa lokasyon.)*
- *Pindutin ang <numero> upang i-page ang manggagamot na on-call. Maaari mong asahan ang isang tugon na tawag sa loob ng 30 minuto*

Mga Halimbawa:

Kamusta, naabot mo ang <answering service/centralized na triage> para kay Doktor <Last Name>. Kung isa itong medikal na emergency, mangyaring mag-hang up at i-dial agad ang 911 o pumunta sa pinakamalapit na emergency room. Kung nais mong makipag-usap sa manggagamot na on-call, mangyaring mag-iwan ng mensahe kasama ang iyong pangalan, numero ng telepono at dahilan ng pagtawag, at maaari mong asahan ang isang tugon na tawag sa loob ng 30 minuto.

Kamusta, naabot mo ang <ipasok ang Pangalan ng Doktor/Medikal na Pangkat>. Kung isa itong medikal na emergency, mangyaring mag-hang up at i-dial agad ang 911 o pumunta sa pinakamalapit na emergency room. Kung nais mong makipag-usap sa manggagamot na on-call, maaabot mo siya nang direkta sa pamamagitan ng pagtawag sa <numero ng telepono> o pindutin ang <numero> upang i-page ang manggagamot na on-call. Maaari mong asahan ang isang tugon na tawag sa loob ng 30 minuto

BẢN MẪU TRẢ LỜI ĐIỆN THOẠI SAU GIỜ LÀM VIỆC

Một trong những bản mẫu trả lời điện thoại sau đây có thể được bác sĩ và các nhóm y khoa dùng để trả lời điện thoại, nhằm giúp cho Hội viên Health Net được giúp đỡ đúng lúc về các vấn đề y tế sau giờ làm việc hoặc khi văn phòng bác sĩ hay văn phòng nhóm y khoa, đóng cửa.

LƯU Ý QUAN TRỌNG: Dịch vụ trả lời điện thoại hữu hiệu sau giờ làm việc sẽ bảo đảm cho người gọi được nói chuyện trực tiếp với nhân viên, hoặc được trả lời bằng máy nhắn tin, trong vòng 30 giây.

I. ĐIỆN THOẠI GỌI VÀO ĐƯỢC NHÂN VIÊN ĐẠI DIỆN TRỰC TIẾP TRẢ LỜI (như nhân viên văn phòng dịch vụ trả lời điện thoại, hoặc văn phòng cứu xét mức độ nguy cấp để chữa trị):

Nếu người gọi nghĩ là họ đang trong tình trạng cấp cứu y tế, hãy bảo họ gác máy và gọi 911 ngay lập tức, hoặc bảo họ đến phòng cấp cứu/cơ sở y tế gần nhất.

Nếu người gọi nghĩ là họ đang trong tình trạng khẩn cấp, hoặc người gọi cho biết là họ cần nói chuyện với bác sĩ, hãy giúp họ liên lạc với bác sĩ bằng một trong những cách sau đây:

- Hãy để người gọi chờ trong vài giây, sau đó nối đường dây điện thoại cho người gọi được nói chuyện với bác sĩ trực
- Xin số điện thoại của người gọi và cho họ biết là bác sĩ sẽ gọi lại cho họ trong vòng 30 phút (cùng lúc, nhắn tin cho bác sĩ trực ngay lập tức)
- Cho người gọi số điện thoại nhắn tin của bác sĩ trực và cho họ biết là bác sĩ sẽ gọi lại cho họ trong vòng 30 phút, hoặc hướng dẫn người gọi đi đến trung tâm chăm sóc khẩn cấp gần nhất
- Nếu người gọi cho biết là họ cần thông dịch viên, hãy liên lạc ngay với văn phòng dịch vụ thông dịch

Thí dụ:
Kính chào quý vị, quý vị đã gọi <văn phòng dịch vụ trả lời điện thoại/văn phòng cứu xét mức độ nguy cấp để chữa trị> của Bác sĩ <Họ của bác sĩ>. Nếu đây là tình trạng cấp cứu y tế, vui lòng gác máy và gọi 911 ngay lập tức, hoặc đến phòng cấp cứu gần nhất. Nếu quý vị muốn nói chuyện với bác sĩ trực, vui lòng chờ máy và tôi sẽ nối đường dây điện thoại đến bác sĩ cho quý vị.

Kính chào quý vị, quý vị đã gọi <văn phòng dịch vụ trả lời điện thoại/văn phòng cứu xét mức độ nguy cấp để chữa trị> của Bác sĩ <Họ của bác sĩ>. Nếu đây là tình trạng cấp cứu y tế, vui lòng gác máy và gọi 911 ngay lập tức, hoặc đến phòng cấp cứu gần nhất. Nếu quý vị muốn nói chuyện với bác sĩ trực, Bác sĩ <Họ của bác sĩ> sẽ giúp đỡ quý vị. Vui lòng <nhắn tin/gọi> bác sĩ tại số <số điện thoại>. Quý vị sẽ được bác sĩ gọi lại trong vòng 30 phút.

II. ĐIỆN THOẠI GỌI VÀO ĐƯỢC TRẢ LỜI BẰNG MÁY NHẮN TIN:

Kính chào quý vị, quý vị đã gọi <ghi vào đây tên bác sĩ/nhóm y khoa>. Nếu đây là tình trạng cấp cứu y tế, vui lòng gác máy và gọi 911 ngay lập tức, hoặc đến phòng cấp cứu gần nhất. Nếu quý vị muốn nói chuyện với bác sĩ trực, (chọn một trong những trường hợp phù hợp):

- *Vui lòng chờ máy và quý vị sẽ được nối đường dây điện thoại đến Bác sĩ <Họ của bác sĩ>*
- *Quý vị có thể trực tiếp gọi cho bác sĩ trực tại số <số điện thoại>.*
- *Xin bấm số <số> để được chuyển sang trung tâm chăm sóc khẩn cấp của chúng tôi. Trung tâm chăm sóc khẩn cấp của chúng tôi nằm tại <địa chỉ trung tâm chăm sóc khẩn cấp> (Dùng ngôn ngữ thích hợp khi cho địa chỉ của địa điểm.)*
- *Xin bấm số <số> để nhắn tin cho bác sĩ trực. Quý vị sẽ được gọi lại trong vòng 30 phút*

Thí dụ:
Kính chào quý vị, quý vị đã gọi văn phòng của < tên bác sĩ/nhóm y khoa) để tìm gặp Bác sĩ <Họ của bác sĩ>. Nếu đây là tình trạng cấp cứu y tế, vui lòng gác máy và gọi 911 ngay lập tức, hoặc đến phòng cấp

cứu gần nhất. Nếu quý vị muốn nói chuyện với bác sĩ trực, vui lòng nhắn tin nơi đây, cho biết tên họ của quý vị, số điện thoại và lý do quý vị gọi hôm nay, và quý vị sẽ được gọi lại trong vòng 30 phút.

Kính chào quý vị, quý vị đã gọi <tên bác sĩ/nhóm y khoa>. Nếu đây là tình trạng cấp cứu y tế, vui lòng gác máy và gọi 911 ngay lập tức, hoặc đến phòng cấp cứu gần nhất. Nếu quý vị muốn nói chuyện với bác sĩ trực, quý vị có thể trực tiếp gọi cho bác sĩ tại số <số điện thoại> hoặc bấm số <số> để nhắn tin. Quý vị sẽ được gọi lại trong vòng 30 phút.

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

_____	_____
Authorized Representative	Date
_____	_____
Type or Print Name	Name of Provider
_____	_____
Title	Address

DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action:	2. Status of Federal Action:	3. Report Type:
☐ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	☐ a. bid/offer/application b. initial award c. post-award	☐ a. initial filing b. material change **For Material Change Only:** year _____ quarter _____ date of last report _____

4. Name and Address of Reporting Entity:	5. If Reporting Entity in No. 4 is a Subawardee, Enter Name and Address of Prime:
☐ **Prime** ☐ **Subawardee** Tier _____, *if known*: **Congressional District**, *if known*:	 **Congressional District**, *if known*:
6. Federal Department/Agency:	**7. Federal Program Name/Description:** CFDA Number, *if applicable*: _____
8. Federal Action Number, *if known*:	**9. Award Amount,** *if known*: $
10. a. Name and Address of Lobbying Registrant (*if individual, last name, first name, MI*):	**b. Individuals Performing Services** (*including address if different from No. 10a*) (*last name, first name, MI*):
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	Signature: _____ Print Name: _____ Title: _____ Telephone No.: _____ Date: _____

Federal Use Only:	Authorized for Local Reproduction Standard Form LLL (Rev. 7-97)

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a followup report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, State and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks "Subawardee," then enter the full name, address, city, State and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizationallevel below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency). Include prefixes, e.g., "RFP-DE-90-001."

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, State and zip code of the lobbying registrant under the Lobbying Disclosure Act of 1995 engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10 (a). Enter Last Name, First Name, and Middle Initial (MI).

11. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

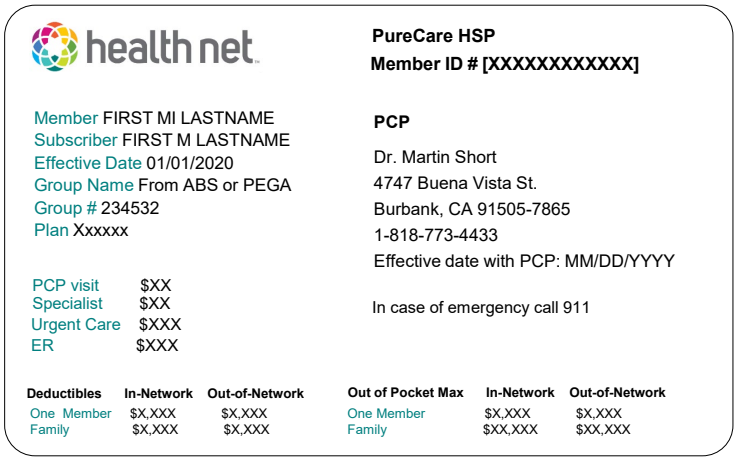
ICD-10-CM Codes for Abortion-Related Services

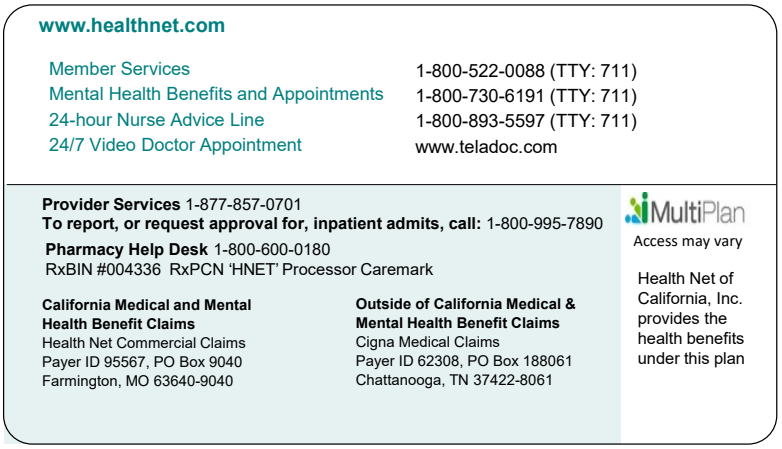
This list contains principal diagnosis codes for abortion and abortion-related services. If a code from this list is used as the principal diagnosis code, the services related to abortion will be processed by our claims processing systems at zero cost share to the member in accordance with Senate Bill 245 (the Abortion Accessibility Act). **Note: This list may not be all-inclusive and is subject to change.**

ICD-10 Codes	Descriptions
O00.00	Abdominal pregnancy without intrauterine pregnancy.
O00.01	Abdominal pregnancy with intrauterine pregnancy.
O00.101	Right tubal pregnancy without intrauterine pregnancy.
O00.102	Left tubal pregnancy without intrauterine pregnancy.
O00.109	Unspecified tubal pregnancy without intrauterine pregnancy.
O00.111	Right tubal pregnancy with intrauterine pregnancy.
O00.112	Left tubal pregnancy with intrauterine pregnancy.
O00.119	Unspecified tubal pregnancy with intrauterine pregnancy.
O00.201	Right ovarian pregnancy without intrauterine pregnancy.
O00.202	Left ovarian pregnancy without intrauterine pregnancy.
O00.209	Unspecified ovarian pregnancy without intrauterine pregnancy.
O00.211	Right ovarian pregnancy with intrauterine pregnancy.
O00.212	Left ovarian pregnancy with intrauterine pregnancy.
O00.219	Unspecified ovarian pregnancy with intrauterine pregnancy.
O00.80	Other ectopic pregnancy without intrauterine pregnancy.
O00.81	Other ectopic pregnancy with intrauterine pregnancy.
O00.90	Unspecified ectopic pregnancy without intrauterine pregnancy.
O00.91	Unspecified ectopic pregnancy with intrauterine pregnancy.
O01.1	Incomplete and partial hydatidiform mole.
O01.9	Hydatidiform mole, unspecified.
O02.1	Missed abortion.
O03.0	Genital tract and pelvic infection following incomplete spontaneous abortion.
O03.1	Delayed or excessive hemorrhage following incomplete spontaneous abortion.
O03.2	Embolism following incomplete spontaneous abortion.
O03.30	Unspecified complication following incomplete spontaneous abortion.
O03.32	Renal failure following incomplete spontaneous abortion.
O03.33	Metabolic disorder following incomplete spontaneous abortion.

ICD-10 Codes	Descriptions
O03.34	Damage to pelvic organs following incomplete spontaneous abortion.
O03.35	Other venous complications following incomplete spontaneous abortion.
O03.36	Cardiac arrest following incomplete spontaneous abortion.
O03.37	Sepsis following incomplete spontaneous abortion.
O03.38	Urinary tract infection following incomplete spontaneous abortion.
O03.39	Incomplete spontaneous abortion with other complications.
O03.4	Incomplete spontaneous abortion without complication.
O03.5	Genital tract and pelvic infection following complete or unspecified spontaneous abortion.
O03.6	Delayed or excessive hemorrhage following complete or unspecified spontaneous abortion.
O03.7	Embolism following complete or unspecified spontaneous abortion.
O03.80	Unspecified complication following complete or unspecified spontaneous abortion.
O03.81	Shock following complete or unspecified spontaneous abortion.
O03.82	Renal failure following complete or unspecified spontaneous abortion.
O03.83	Metabolic disorder following complete or unspecified spontaneous abortion.
O03.84	Damage to pelvic organs following complete or unspecified spontaneous abortion.
O03.85	Other venous complications following complete or unspecified spontaneous abortion.
O03.86	Cardiac arrest following complete or unspecified spontaneous abortion.
O03.87	Sepsis following complete or unspecified spontaneous abortion.
O03.88	Urinary tract infection following complete or unspecified spontaneous abortion.
O03.89	Complete or unspecified spontaneous abortion with other complications.
O03.9	Complete or unspecified spontaneous abortion without complication.
O04.5	Genital tract and pelvic infection following (induced) termination of pregnancy.
O04.6	Delayed or excessive hemorrhage following (induced) termination of pregnancy.
O04.7	Embolism following (induced) termination of pregnancy.
O04.80	(Induced) termination of pregnancy with unspecified complications.
O04.81	Shock following (induced) termination of pregnancy.
O04.82	Renal failure following (induced) termination of pregnancy.
O04.83	Metabolic disorder following (induced) termination of pregnancy.
O04.84	Damage to pelvic organs following (induced) termination of pregnancy.
O04.85	Other venous complications following (induced) termination of pregnancy.
O04.86	Cardiac arrest following (induced) termination of pregnancy.
O04.87	Sepsis following (induced) termination of pregnancy.
O04.88	Urinary tract infection following (induced) termination of pregnancy.

ICD-10 Codes	Descriptions
O04.89	(Induced) termination of pregnancy with other complications.
O07.0	Genital tract and pelvic infection following failed attempted termination of pregnancy.
O07.1	Delayed or excessive hemorrhage following failed attempted termination of pregnancy.
O07.2	Embolism following failed attempted termination of pregnancy.
O07.30	Failed attempted termination of pregnancy with unspecified complications.
O07.31	Shock following failed attempted termination of pregnancy.
O07.32	Renal failure following failed attempted termination of pregnancy.
O07.33	Metabolic disorder following failed attempted termination of pregnancy.
O07.34	Damage to pelvic organs following failed attempted termination of pregnancy.
O07.35	Other venous complications following failed attempted termination of pregnancy.
O07.36	Cardiac arrest following failed attempted termination of pregnancy.
O07.37	Sepsis following failed attempted termination of pregnancy.
O07.38	Urinary tract infection following failed attempted termination of pregnancy.
O07.39	Failed attempted termination of pregnancy with other complications.
O07.4	Failed attempted termination of pregnancy without complication.
O08.2	Embolism following ectopic and molar pregnancy.
O08.3	Shock following ectopic and molar pregnancy.
O08.4	Renal failure following ectopic and molar pregnancy.
O08.82	Sepsis following ectopic and molar pregnancy.
O08.83	Urinary tract infection following an ectopic and molar pregnancy.
O08.89	Other complications following an ectopic and molar pregnancy.
O20.0	Threatened abortion.
O20.8	Other hemorrhage in early pregnancy.
O20.9	Hemorrhage in early pregnancy, unspecified.
Q89.7	Multiple congenital malformations, not elsewhere classified.
Z33.2	Encounter for elective termination of pregnancy.
Z64.0	Problems related to unwanted pregnancy.





Your Health Net ID Card

Attached is a new Health Net ID Card. If there is an error on this card, or you have any questions about your coverage, please call Health Net's Member Services and provide them with your Group and Subscriber ID number. You will find the Member Services phone number on the back of this card and your Group and Subscriber ID number on the face of this card.

Carry this ID Card with you at all times, and present it to your health care provider when getting the care you need.

See your plan documents for a description of your benefits.

Your Primary Care Physician

Having a doctor who knows you is important. That's why you have a primary care physician (PCP) as part of your HSP plan. You can see your PCP first, or you can go to any provider in the PureCare HSP network. You don't need a referral.Want to change your PCP? You can:

- Use ProviderSearch at www.healthnet.com/myaon to find a doctor in the PureCare HSP network.
- Call 1-888-926-1692 (TTY: 711), Monday through Friday, 8:00 a.m. to 6:00 p.m. We will be happy to help you.
- You, the member, are responsible for obtaining certification for certain services. Call 1-800-977-7282. Your Evidence of Coverage has a list of services that require pre-certification.

Teladoc 24/7 Video Doctor Visits

Your new telehealth service provider is Teladoc. Teladoc gives you 24/7 access to U.S. board-certified doctors. You can access them with ease – either through the web, your phone or through the Teladoc app. Get the care you need in minutes from the comfort of home or at work. Or, get care even while traveling!

You may receive services on an in-person basis or via telehealth, if available, from your primary care provider, a treating specialist or from another contracting individual health professional, contracting clinic, or contracting health facility consistent with the service and existing timeliness and geographic access standards required under California law. Any cost share for services received through Teladoc will accrue toward your out-of-pocket maximum and deductible (if your plan has a deductible).By scheduling through Teladoc, you consent to receive services via telehealth through Teladoc. See your health plan coverage document for coverage information and for the definition of telehealth services. You have a right to access your medical records for services received through Teladoc. Unless you choose otherwise, any services provided through Teladoc shall be shared with your primary care provider.

Examples of IFP member eligibility status displayed on the secure provider portal

The image below shows examples of how member status displays when verifying eligibility for Individual and Family Plan (IFP) members on the secure provider portal. Status displays as “eligible” (thumbs up icon), “ineligible,” “delinquent,” or “suspended”:

Provider Communications

HEALTH INDUSTRY COLLABORATION EFFORT

HICE

Simplifying Healthcare Administration

Better Communication, Better Care:

PROVIDER TOOLS TO CARE FOR DIVERSE POPULATIONS

INTRODUCTION FOR HEALTHCARE PROFESSIONALS:

Why was this Cultural and Linguistic Provider Tool Kit created?

This set of materials was produced by a nation-wide team of healthcare professionals who, like you, are dedicated to providing high quality, effective, and compassionate care to their patients. In our awareness of differences in individual belief and behavior, changes in demographics and new legal mandates, we are constantly presented with new challenges in our attempts to deliver adequate and cultural sensitive health care to a diverse patient population. The material in this tool kit will provide you with resources and information to effectively communicate and understand our diverse patient populations. The tool kit also provides many useful instruments and aids to help with specific operational needs that can arise in your office or facility.

The tool kit contents are organized into four sections; each containing helpful background information and tools that can be reproduced and used as needed. Below you will find a list of the section topics and a small sample of their contents:

- **Interaction with a diverse patient base:** encounter tips for providers and their clinical staff, a mnemonic to assist with patient interviews, help in identifying literacy problems, and an interview guide for hiring clinical staff who have an awareness of diversity issues.
- **Communication across language barriers:** tips for locating and working with interpreters, common signs and common sentences in many languages, language identification flashcards, and employee language prescreening tool.
- **Understanding patients from various cultural backgrounds:** tips for talking about sex with a wide range of people, delivering care to lesbian, gay, bisexual or transgender, pain management across cultures, and information about different cultural backgrounds.
- **References and resources:** key legal requirements including 45 CFR 92 – Non Discrimination Rule, a summary of the "Culturally and Linguistically Appropriate Service (CLAS) Standards," which serve as a guide on how to meet legal requirements, Race/Ethnicity/Language categories, a bibliography of print resources, and a list of internet resources.

We consider this tool kit a work in progress. Patient needs and the tools we use to work with those changing needs will continue to evolve. We understand that some portions of this tool kit will be more useful than others for individual practices or service settings, after all, practices vary as much as the places where they are located. We encourage you to use what is helpful, disregard what is not, and, if possible communicate your reaction to the contents to the ICE Cultural and Linguistics Workgroup at: CL_Team@iceforhealth.org.

On behalf of the ICE Cultural and Linguistic Workgroup,

Diana Carr, MA
Health Net of California, Inc.
Medical Anthropologist

Peggy Payne, MA
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TABLE OF CONTENTS

SECTION A: RESOURCES TO ASSIST COMMUNICATION WITH A DIVERSE PATIENT POPULATION BASE

A GUIDE TO INFORMATION IN SECTION A

RESOURCES TO COMMUNICATE WITH A DIVERSE PATIENT BASE

The communication strategies suggested in this section are intended to minimize patient-provider, and patient-office staff miscommunications, and foster an environment that is non-threatening and comfortable to the patient.

We recognize that every patient encounter is unique. The goal is to eliminate cultural barriers that inhibit effective communication, diagnosis, treatment and care. The suggestions presented are intended to guide providers and build sensitivity to cultural differences and styles. By enhancing your cultural sensitivity and ability to tailor the delivery of care to your patients' needs you will:

- Enhance communication
- Decrease repeat visits
- Decrease unnecessary lab tests
- Increase compliance
- Avoid Civil Rights Act violations

The following materials are available in this section:

Working with Diverse Patients: Tips for Successful Patient Encounters	A tip sheet designed to help providers enhance their patient communication skills.
Partnering with Diverse Patients: Tips for Office Staff to Enhance Communication	A tip sheet designed to help office staff enhance their patient communication skills.
Non-verbal Communication and Patient Care	An overview of the impact of nonverbal communication on patient-provider relations and communication.
"Diverse": A Mnemonic for Patient Encounters Tips for Identifying Health Literacy Issues	A mnemonic to help you individualize care based on cultural/diversity aspects.
Tips for Identifying and Addressing Health Literacy Issues	A tip sheet to help understand and work with patients with Health literacy.
Interview Guide for Hiring Office/Clinic Staff with Diversity Awareness	A list of interview questions to help determine if a job candidate is likely to work well with individuals of diverse backgrounds.
Americans with Disabilities Act (ADA) Sign Language and Alternative Formats Requirements	Tip sheets to help providers better communicate with patients with vision, hearing, or speech disabilities.
Americans with Disabilities Act (ADA) Requirements for Effective Communication How to Implement Language Services	A tip sheet to help providers communicate effectively with their patients.
Supporting Patients with 211 and 711 Community Services	A tip sheet to help providers utilize community services for patients with special needs.

WORKING WITH DIVERSE PATIENTS: TIPS FOR SUCCESSFUL PATIENT ENCOUNTERS

To enhance patient/provider communication and to avoid being unintentionally insulting or patronizing, be aware of the following:

Styles of Speech: *People vary greatly in length of time between comment and response, the speed of their speech, and their willingness to interrupt.*

- Tolerate gaps between questions and answers, impatience can be seen as a sign of disrespect.
- Listen to the volume and speed of the patient's speech as well as the content. Modify your own speech to more closely match that of the patient to make them more comfortable.
- Rapid exchanges, and even interruptions, are a part of some conversational styles. Don't be offended if no offense is intended when a patient interrupts you.
- Stay aware of your own pattern of interruptions, especially if the patient is older than you are.

Eye Contact: *The way people interpret various types of eye contact is tied to cultural background and life experience.*

- Most Euro-Americans expect to look people directly in the eyes and interpret failure to do so as a sign of dishonesty or disrespect.
- For many other cultures direct gazing is considered rude or disrespectful. Never force a patient to make eye contact with you.
- If a patient seems uncomfortable with direct gazes, try sitting next to them instead of across from them.

Body Language: *Sociologists say that 80% of communication is non-verbal. The meaning of body language varies greatly by culture, class, gender, and age.*

- Follow the patient's lead on physical distance and touching. If the patient moves closer to you or touches you, you may do the same. However, stay sensitive to those who do not feel comfortable, and ask permission to touch them.
- Gestures can mean very different things to different people. Be very conservative in your own use of gestures and body language. Ask patients about unknown gestures or reactions.
- Do not interpret a patient's feelings or level of pain just from facial expressions. The way that pain or fear is expressed is closely tied to a person's cultural and personal background.

Gently Guide Patient Conversation: *English predisposes us to a direct communication style; however other languages and cultures differ.*

- Initial greetings can set the tone for the visit. Many older people from traditional societies expect to be addressed more formally, no matter how long they have known their physician. If the patient's preference is not clear, ask how they would like to be addressed.
- Patients from other language or cultural backgrounds may be less likely to ask questions and more likely to answer questions through narrative than with direct responses. Facilitate patient-centered communication by asking open-ended questions whenever possible.
- Avoid questions that can be answered with "yes" or "no." Research indicates that when patients, regardless of cultural background, are asked, "Do you understand," many will answer, "yes" even when they really do not understand. This tends to be more common in teens and older patients.
- Steer the patient back to the topic by asking a question that clearly demonstrates that you are listening.

PARTNERING WITH DIVERSE PATIENTS: TIPS FOR OFFICE STAFF TO ENHANCE COMMUNICATION

1. Build rapport with the patient.

- Address patients by their last name. If the patient's preference is not clear, ask, "How would you like to be addressed?"
- Focus your attention on patients when addressing them.
- Learn basic words in your patient's primary language, like "hello" or "thank you".
- Recognize that patients from diverse backgrounds may have different communication needs.
- Explain the different roles of people who work in the office.

2. Make sure patients know what you do.

- Take a few moments to prepare a handout that explains office hours, how to contact the office when it is closed, and how the PCP arranges for care (i.e. PCP is the first point of contact and refers to specialists).
- Have instructions available in the common language(s) spoken by your patient base.

3. Keep patients' expectations realistic.

- Inform patients of delays or extended waiting times. If the wait is longer than 15 minutes, encourage the patient to make a list of questions for the doctor, review health materials or view waiting room videos.

4. Work to build patients' trust in you.

- Inform patients of office procedures such as when they can expect a call with lab results, how follow-up appointments are scheduled, and routine wait times.

5. Determine if the patient needs an interpreter for the visit.

- Document the patient's preferred language in the patient chart.
- Have an interpreter access plan. An interpreter with a medical background is preferred to family or friends of the patient.
- Assess your bilingual staff for interpreter abilities. (see Employee Language Skills Self-Assessment Tool).
- Possible resources for interpreter services are available from health plans, the state health department, and the Internet. See contracted health plans for applicable payment processes.

6. Give patients the information they need.

- Have topic-specific health education materials in languages that reflect your patient base. (Contact your contracting health plans/contracted medical groups for resources.)
- Offer handouts such as immunization guidelines for adults and children, screening guidelines, and culturally relevant dietary guidelines for diabetes or weight loss.

7. Make sure patients know what to do.

- Review any follow-up procedures with the patient before he or she leaves your office.
- Verify call back numbers, the locations for follow-up services such as labs, X-ray or screening tests, and whether or not a follow-up appointment is necessary.
- Develop pre-printed simple handouts of frequently used instructions, and translate the handouts into the common language(s) spoken by your patient base. (Contact your contracting health plans/contracted medical groups for resources.)

NON- VERBAL COMMUNICATION AND PATIENT CARE

Non-verbal communication is a subtle form of communication that takes place in the **initial three seconds** after meeting someone for the first time and can continue through the entire interaction. Research indicates that non-verbal communication accounts for approximately **70%** of a communication episode. Non-verbal communication can impact the success of communication more acutely than the spoken word. Our culturally informed unconscious framework evaluates gestures, appearance, body language, the face, and how space is used. Yet, we are rarely aware of how persons from other cultures perceive our nonverbal communication or the subtle cues we have used to assess the person.

The following are case studies that provide examples of non-verbal miscommunication that can sabotage a patient-provider encounter. Broad cultural generalizations are used for illustrative purposes. They should not be mistaken for stereotypes. A stereotype and a generalization may appear similar, but they function very differently. A **stereotype** is an ending point; no attempt is made to learn whether the individual in question fits the statement. A **generalization** is a beginning point; it indicates common trends, but further information is needed to ascertain whether the statement is appropriate to a particular individual.

Generalizations can serve as a guide to be accompanied by individualized in-person assessment. As a rule, ask the patient, rather than assume you know the patient's needs and wants. If asked, patients will usually share their personal beliefs, practices and preferences related to prevention, diagnosis and treatment.

Eye Contact

Ellen was trying to teach her Navaho patient, Jim Nez, how to live with his newly diagnosed diabetes. She soon became extremely frustrated because she felt she was not getting through to him. He asked very few questions and never met her eyes. She reasoned from this that he was uninterested and therefore not listening to her.[1]

It is rude to meet and hold eye contact with an elder or someone in a position of authority such as health professionals in most Latino, Asian, American Indian and many Arab countries. It may be also considered a form of social aggression if a male insists on meeting and holding eye contact with a female.

Touch and Use of Space

A physician with a large medical group requested assistance encouraging young female patients to make and keep their first well woman appointment. The physician stated that this group had a high no-show rate and appointments did not go as smoothly as the physician would like.

Talk the patient through each exam so that the need for the physical contact is

1, 2 Galanti, G. (1997). *Caring for Patients from Different Cultures*. University of Pennsylvania Press.
Hall, E.T. (1985). *Hidden Differences: Studies in International Communication.* Hamburg: Gruner & Jahr.
Hall, E.T. (1990). *Understanding Cultural Differences.* Yarmouth, ME: Intercultural Press.

understood, prior to the initiation of the examination. Ease into the patients' personal space. If there are any concerns, ask before entering the three-foot zone. This will help ease the patient's level of discomfort and avoid any misinterpretation of physical contact. Additionally, physical contact between a male and female is strictly regulated in many cultures. An older female companion may be necessary during the visit.

Gestures

An Anglo patient named James Todd called out to Elena, a Filipino nurse: "Nurse, nurse." Elena came to Mr. Todd's door and politely asked, "May I help you?" Mr. Todd beckoned her to come closer by motioning with his right index finger. Elena remained where she was and responded in an angry voice, "What do you want?" Mr. Todd was confused. Why had Elena's manner suddenly changed?[1]

Gestures may have dramatically different meanings across cultures. It is best to think of gestures as a local dialect that is familiar only to insiders of the culture. Conservative use of hand or body gestures is recommended to avoid misunderstanding. In the case above, Elena took offense to Mr. Todd's innocent hand gesture. In the Philippines (and in Korea) the "come here" hand gesture is used to call animals.

Body Posture and Presentation

Carrie was surprised to see that Mr. Ramirez was dressed very elegantly for his doctor's visit. She was confused by his appearance because she knew that he was receiving services on a sliding fee scale. She thought the front office either made a mistake documenting his ability to pay for service, or that he falsely presented his income.

Many cultures prioritize respect for the family and demonstrate family respect in their manner of dress and presentation in public. Regardless of the economic resources that are available or the physical condition of the individual, going out in public involves creating an image that reflects positively on the family – the clothes are pressed, the hair is combed, and shoes are clean. A person's physical presentation is not an indicator of their economic situation.

Use of Voice

Dr. Moore had three patients waiting and was feeling rushed. He began asking health related questions of his Vietnamese patient Tanya. She looked tense, staring at the ground without volunteering much information. No matter how clearly he asked the question he couldn't get Tanya to take an active part in the visit.

The **use** of voice is perhaps one of the most difficult forms of non-verbal communication to change, as we rarely hear how we sound to others. If you speak too fast, you may be seen as not being interested in the patient. If you speak too loud, or too soft for the space involved, you may be perceived as domineering or lacking confidence. Expectations for the use of voice vary greatly between and within cultures, for male and female, and the young and old. *The best suggestion is to search for non-verbal cues to determine how your voice is affecting your patient.*

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[1] Galanti, G. (1997). *Caring for Patients from Different Cultures*. University of Pennsylvania Press.
Hall, E.T. (1985). *Hidden Differences: Studies in International Communication.* Hamburg: Gruner & Jahr.
Hall, E.T. (1990). *Understanding Cultural Differences.* Yarmouth, ME: Intercultural Press.

"DIVERSE" A MNEMONIC FOR PATIENT ENCOUNTERS

A mnemonic will assist you in developing a personalized care plan based on cultural/diversity aspects. Place in the patient's chart or use the mnemonic when gathering the patient's history on a SOAP progress note.

	Assessment	Sample Questions	Assessment Information/ Recommendations
D	**Demographics-** *Explore regional background, level of –acculturation, age and sex as they influence health care behaviors.*	Where were you born? Where was "home" before coming to the U.S.? How long have you lived in the U.S.? What is the patient's age and sex?	
I	**Ideas-** *ask the patient to explain his/her ideas or concepts of health and illness.*	What do you think keeps you healthy? What do you think makes you sick? What do you think is the cause of your illness? Why do you think the problem started?	
V	**Views of health care treatments-** *ask about treatment preference, use of home remedies, and treatment avoidance practices.*	Are there any health care procedures that might not be acceptable? Do you use any traditional or home health remedies to improve your health? What have you used before? Have you used alternative healers? Which? What kind of treatment do you think will work?	
E	**Expectations**- *ask about what your patient expects from his/her doctor?*	What do you hope to achieve from today's visit? What do you hope to achieve from treatment? Do you find it easier to talk with a male/female? Someone younger/older?	
R	**Religion**- *asks about your patient's religious and spiritual traditions.*	Will religious or spiritual observances affect your ability to follow treatment? How? Do you avoid any particular foods? During the year, do you change your diet in celebration of religious and other holidays?	
S	**Speech-** *identifies your patient's language needs including health literacy levels. Avoid using a family member as an interpreter.*	What language do you prefer to speak? Do you need an interpreter? What language do you prefer to read? Are you satisfied with how well you read? Would you prefer printed or spoken instructions?	
E	**Environment –** *identify patient's home environment and the cultural/diversity aspects that are part of the environment. Home environment includes the patient's daily schedule, support system and level of independence.*	Do you live alone? How many other people live in your house? Do you have transportation? Who gives you emotional support? Who helps you when you are ill or need help? Do you have the ability to shop/cook for yourself? What times of day do you usually eat? What is your largest meal of the day?	

TIPS FOR IDENTIFYING AND ADDRESSING HEALTH LITERACY ISSUES

LOW HEALTH LITERACY CAN PREVENT PATIENTS FROM UNDERSTANDING THEIR HEALTH CARE SERVICES.

Health Literacy is defined by the National Health Education Standards[1] as "*the capacity of an individual to obtain, interpret, and understand basic health information and services and the competence to use such information and services in ways which are health-enhancing.*"

This includes the ability to understand written instructions on prescription drug bottles, appointment slips, medical education brochures, doctor's directions and consent forms, and the ability to negotiate complex health care systems. Health literacy is not the same as the ability to read and is not necessarily related to year of education. A person who functions adequately at home or work may have marginal or inadequate literacy in health care environment.

Possible Signs of Low Health Literacy

Your patients may frequently say:

- I forgot my glasses.
- My eyes are tired.
- I'll take this home for my family to read.
- What does this say? I don't understand this.

Your patients' behaviors may include:

- Not getting their prescriptions filled, or not taking their medications as prescribed.
- Consistently arriving late to appointments.
- Returning forms without completing them.
- Requiring several calls between appointments to clarify instructions.

Barriers to Health Literacy

- The ability to read and comprehend health information is impacted by a range of factors including age, socioeconomic background, education and culture.
- A patient's culture and life experience may have an effect on their health literacy.
- An accent, or a lack of accent, can be misread as an indicator of a person's ability to read English.
- Different family dynamics can play a role in how a patient receives and processes information.
- In some cultures it is inappropriate for people to discuss certain body parts or functions leaving some with a very poor vocabulary for discussing health issues.
- In adults, reading skills in a second language may take 6-12 years to develop.

TIPS FOR DEALING with LOW HEALTH LITERACY[1]

✓ Use simple words and avoid jargon. ✓ Never use acronyms. ✓ Avoid technical language (if possible). ✓ Repeat important information – a patient's logic may be different from yours. ✓ Ask patients to repeat back to you important information. ✓ Ask open-ended questions. ✓ Use medically trained interpreters familiar with cultural nuances.	✓ Give information in small chunks. ✓ Articulate words. ✓ "Read" written instructions out load. ✓ Speak slowly (don't shout). ✓ Use body language to support what you are saying. ✓ Draw pictures, use posters, models or physical demonstrations. ✓ Use video and audio media as an alternative to written communications.

ADDITIONAL RESOURCES

Use **Ask Me 3®**[2]. Ask Me 3® is a program designed by health literacy experts intended to help patients become more active in their health care. It supports improved communication between patients, families and their health care providers.

Patients who understand their health have better health outcomes. Encourage your patients to ask these three specific questions:

1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?

Asking these questions is proven to help patients better understand their health conditions and what they need to do to stay healthy.

For more information or resources on Ask Me 3® and to view a video on how to use the questions, please visit http://www.npsf.org/?page=askme3. Ask Me 3 is a registered trademark licensed to the National Patient Safety Foundation (NPSF).

American Medical Association (AMA)

The AMA offer multiple publications, tools and resources to improve patient outcomes. For more information, visit: http://www.ama-assn.org/ama/pub/about-ama/ama-foundation.page.

[1] Joint Committee on National Education Standards, 1995
[2] National Patient Safety Foundation, Ask Me 3®. http://www.npsf.org/?page=askme3

INTERVIEW GUIDE FOR HIRING OFFICE/CLINIC STAFF WITH DIVERSITY AWARENESS

The following set of questions is meant to help you determine whether a job candidate will be sensitive to the cultural and linguistic needs of your patient population. By integrating some or all of these questions into your interview process, you will be more likely to hire staff that will help you create an office/clinic atmosphere of openness, affirmation, and trust between patients and staff. *Remember* that bias and discrimination can be obvious and flagrant or small and subtle. Hiring practices should reflect this understanding.

INTERVIEW QUESTIONS

Q. *What experience do you have in working with people of diverse backgrounds, cultures and ethnicities? The experiences can be in or out of a health care environment.*

The interviewee should demonstrate understanding and willingness to serve diverse communities. Any experience, whether professional or volunteer, is valuable.

Q: *Please share any particular challenges or successes you have experienced in working with people from diverse backgrounds.*

You will want to get a sense that the interviewee has an appreciation for working with people from diverse backgrounds and understands the accompanying complexities and needs in an office setting.

Q. *In the health care field we come across patients of different ages, language preference, sexual orientation, religions, cultures, genders, and immigration status, etc. all with different needs. What skills from your past customer service or community/healthcare work do you think are relevant to this job?*

This question should allow a better understanding of the interviewees approach to customer service across the spectrum of diversity, their previous experience, and if their skills are transferable to the position in question. Look for examples that demonstrate an understanding of varying needs. Answers should demonstrate listening and clear communication skills.

Q. *What would you do to make all patients feel respected? For example, some Medicaid or Medicare recipients may be concerned about receiving substandard care because they lack private insurance.*

The answer should demonstrate an understanding of the behaviors that facilitate respect and the type of prejudices and bias that can result in substandard service and care.

AMERICANS WITH DISABILITIES ACT (ADA) REQUIREMENTS

The following information is excerpts from the U.S. Department of Justice, Civil Rights Division, Disability Rights Section. For complete information, please visit: www.ada.gov/effective-comm.htm.

The Department of Justice published revised final regulations implementing the Americans with Disabilities Act (ADA) for title II (State and local government services) and title III (public accommodations and commercial facilities) on September 15, 2010, in the Federal Register. These requirements, or rules, clarify and refine issues that have arisen over the past 20 years and contain new, and updated, requirements, including the 2010 Standards for Accessible Design (2010 Standards).

EFFECTIVE COMMUNICATION

Overview

People who have vision, hearing, or speech disabilities ("communication disabilities") use different ways to communicate. For example, people who are blind may give and receive information audibly rather than in writing and people who are deaf may give and receive information through writing or sign language rather than through speech.

The ADA requires that title II entities (State and local governments) and title III entities (businesses and nonprofit organizations that serve the public) communicate effectively with people who have communication disabilities. The goal is to ensure that communication with people with these disabilities is equally effective as communication with people without disabilities. This publication is designed to help title II and title III entities ("covered entities") understand how the rules for effective communication, including rules that went into effect on March 15, 2011, apply to them.

- The purpose of the effective communication rules is to ensure that the person with a vision, hearing, or speech disability can communicate with, receive information from, and convey information to, the covered entity.
- Covered entities must provide auxiliary aids and services when needed to communicate effectively with people who have communication disabilities.
- The key to communicating effectively is to consider the nature, length, complexity, and context of the communication and the person's normal method(s) of communication.
- The rules apply to communicating with the person who is receiving the covered entity's goods or services as well as with that person's parent, spouse, or companion in appropriate circumstances.

AUXILIARY AIDS AND SERVICES

The ADA uses the term "auxiliary aids and services" ("aids and services") to refer to the ways to communicate with people who have communication disabilities.

- For people who are blind, have vision loss, or are deaf-blind, this includes providing a qualified reader; information in large print, Braille, or electronically for use with a computer screen-reading program; or an audio recording of printed information. A "qualified" reader means someone who is able to read effectively, accurately, and impartially, using any necessary specialized vocabulary.

- For people who are deaf, have hearing loss, or are deaf-blind, this includes providing a qualified note taker; a qualified sign language interpreter, oral interpreter, cued-speech interpreter, or tactile interpreter; real-time captioning; written materials; or a printed script of a stock speech (such as given on a museum or historic house tour). A "qualified" interpreter means someone who is able to interpret effectively, accurately, and impartially, both receptively (i.e., understanding what the person with the disability is saying) and expressively (i.e., having the skill needed to convey information back to that person) using any necessary specialized vocabulary.
- For people who have speech disabilities, this may include providing a qualified speech-to-speech transliterator (a person trained to recognize unclear speech and repeat it clearly) , especially if the person will be speaking at length, such as giving testimony in court, or just taking more time to communicate with someone who uses a communication board. In some situations, keeping paper and pencil on hand so the person can write out words that staff cannot understand or simply allowing more time to communicate with someone who uses a communication board or device may provide effective communication. Staff should always listen attentively and not be afraid or embarrassed to ask the person to repeat a word or phrase they do not understand.

In addition, aids and services include a wide variety of technologies including:
1) Assistive listening systems and devices;
2) Open captioning, closed captioning, real-time captioning, and closed caption decoders and devices;
3) Telephone handset amplifiers, hearing-aid compatible telephones; text telephones (TTYs), videophones, captioned telephones, and other voice, text, and video-based telecommunications products;
4) Videotext displays;
5) Screen reader software, magnification software, and optical readers;
6) Video description and secondary auditory programming (SAP) devices that pick up video-described audio feeds for television programs;
7) Accessibility features in electronic documents and other electronic and information technology that is accessible (either independently or through assistive technology such as screen readers).

EFFECTIVE COMMUNICATION PROVISIONS

Covered entities must provide aids and services when needed to communicate effectively with people who have communication disabilities. The key to deciding what aid or service is needed to communicate **effectively** is to consider the nature, length, complexity, and context of the communication as well as the person's normal method(s) of communication.

Some easy solutions work in relatively simple and straightforward situations. For example:

- In a lunchroom or restaurant, reading the menu to a person who is blind allows that person to decide what dish to order.
- In a retail setting, pointing to product information or writing notes back and forth to answer simple questions about a product may allow a person who is deaf to decide whether to purchase the product.
- Other solutions may be needed where the information being communicated is more extensive or complex.

For example:
In a law firm, providing an accessible electronic copy of a legal document that is being drafted for a client who is blind allows the client to read the draft at home using a computer screen-reading program.

In a doctor's office, an interpreter generally will be needed for taking the medical history of a patient who uses sign language or for discussing a serious diagnosis and its treatment options.

A person's method(s) of communication are also key.
For example,

- Sign language interpreters are effective only for people who use sign language.
- Other methods of communication, such as those described above, are needed for people who may have lost their hearing later in life and does not use sign language.
- Similarly, Braille is effective only for people who read Braille.
- Other methods are needed for people with vision disabilities who do not read Braille, such as providing accessible electronic text documents, forms, etc. that can be accessed by the person's screen reader program.

Covered entities are also required to accept telephone calls placed through Telecommunication Relay Services (TRS) and Video Relay Services (VRS), and staff that answers the telephone must treat relay calls just like other calls. The communications assistant will explain how the system works if necessary.

Remember, the purpose of the effective communication rules is to ensure that the person with a communication disability can receive information from, and convey information to, the covered entity.

COMPANIONS

In many situations, covered entities communicate with someone other than the person who is receiving their goods or services. For example:

- School staff usually talk to a parent about a child's progress;
- Hospital staff often talks to a patient's spouse, other relative, or friend about the patient's condition or prognosis.

The rules refer to such people as "companions" and require covered entities to provide effective communication for companions who have communication disabilities.

The term "companion" includes any family member, friend, or associate of a person seeking or receiving an entity's goods or services who is an appropriate person with whom the entity should communicate.

USE OF ACCOMPANYING ADULTS OR CHILDREN AS INTERPRETERS

Historically, many covered entities have expected a person who uses sign language to bring a family member or friend to interpret for him or her. These people often lacked the impartiality and specialized vocabulary needed to interpret effectively and accurately. It was particularly problematic to use people's children as interpreters.

The ADA places responsibility for providing effective communication, including the use of interpreters, directly on covered entities. They cannot require a person to bring someone to interpret for him or her. A covered entity can rely on a companion to interpret in only two situations.

(1) In an emergency involving an imminent threat to the safety or welfare of an individual or the public, an adult or minor child accompanying a person who uses sign language may be relied upon to interpret or facilitate communication only when a qualified interpreter is not available.

(2) In situations **not** involving an imminent threat, an adult accompanying someone who uses sign language may be relied upon to interpret or facilitate communication when a) the individual requests this, b) the accompanying adult agrees, and c) reliance on the accompanying adult is appropriate under the circumstances. This exception does **not** apply to minor children.

Even under exception (2), covered entities may **not** rely on an accompanying adult to interpret when there is reason to doubt the person's impartiality or effectiveness. For example:

- It would be inappropriate to rely on a companion to interpret who feels conflicted about communicating bad news to the person or has a personal stake in the outcome of a situation.
- When responding to a call alleging spousal abuse, police should never rely on one spouse to interpret for the other spouse.

WHO DECIDES WHICH AID OR SERVICE IS NEEDED?

When choosing an aid or service, title II entities are required to give primary consideration to the choice of aid or service requested by the person who has a communication disability. The state or local government must honor the person's choice, unless it can demonstrate that another equally effective means of communication is available, or that the use of the means chosen would result in a fundamental alteration or in an undue burden (see limitations below).

If the choice expressed by the person with a disability would result in an undue burden or a fundamental alteration, the public entity still has an obligation to provide an alternative aid or service that provides effective communication if one is available.

Title III entities are **encouraged** to consult with the person with a disability to discuss what aid or service is appropriate. The goal is to provide an aid or service that will be effective, given the nature of what is being communicated and the person's method of communicating.

Covered entities may require reasonable advance notice from people requesting aids or services, based on the length of time needed to acquire the aid or service, but may not impose excessive advance notice requirements. "Walk-in" requests for aids and services must also be honored to the extent possible.

For more information about the ADA, please visit the website or call the toll-free number. www.ADA.gov
ADA Information Line 800-514-0301 (Voice) and 800-514-0383 (TTY)

ADA REQUIREMENTS FOR EFFECTIVE COMMUNICATION

The purpose of the effective communication rules is to ensure that the person with a vision, hearing or speech disability can communicate with, receive information from, and convey information to, the covered entity (physician office, clinic, hospital, nursing home, etc.)
Covered entities must provide auxiliary aids and services when needed to communicate effectively with people who have communication disabilities. The person with the disability can choose the type of aid/service.

Your patient may need assistance because …	**These are some options we can provide for you…..**
Am blind or have vision impairments that keep me from reading	- Large print materials - Physician can complete form for talking books through National Library Service for the Blind and Physically Handicapped https://www.loc.gov/nls/pdf/application.pdf - Physician can complete form for Vision enabled telephone-- http://www.californiaphones.org/application -Check with health plans to see what they have available (audio recordings of printed materials, etc.)
Am hard of hearing and have trouble hearing and understanding directions, or answering the doorbell	- Amplifier/ Pocket Talker - Written materials - Qualified sign language interpreter - Qualified note taker - Telecommunications Relay Service (TRS) 7-1-1 - Have physician dictate into voice-recognition software and patient can type answers back
Have difficulty speaking clearly and making myself understood	- Allow for extra time and attentive listening - Qualified note taker - Telecommunications Relay Services (TRS) 7-1-1 - Communication board or paper and pencil - Have physician dictate into voice-recognition software and patient can type answers back

* All requirements also apply to individual's companion or caregiver when communication with that person is appropriate. An individual's companion or caregiver should not be relied on to act as the qualified interpreter.

Resources

- The Gerontological Society of America
  http://aging.arizona.edu/sites/aging/files/activity_1_reading_1.pdf
- American Speech Language Hearing Association
  http://www.asha.org/public/speech/development/Communicating-Better-With-Older- People/
- Administration for Community Living DHHS
  http://www.aoa.acl.gov/AoA_Programs/Tools_Resources/Older_Adults.aspx
- The Look Closer, See Me Generational Diversity and Sensitivity training program
  http://nursing.uc.edu/content/dam/nursing/docs/CFAWD/LookCloserSeeMe/Module%204_GDST_Reference%20Guide.pdf
- U.S Department of Justice- ADA requirements for Effective Communication
  https://www.ada.gov/effective-comm.htm

Language Services:
The KEY to Patient Engagement

Where do I start?
Check out the Q&A below to learn more...

Why does my office need a language service plan?

Clear communication is the absolute heart of medical practice. Seven out of ten surveyed physicians indicated that language barriers represent a top priority for the health care field[1]. Unaddressed barriers can:

- Compromise quality of care
- Result in poor outcomes
- Have legal consequences
- Increase litigation risk

Where do I start?

Get Ready:
- Gather your team
- Make a commitment
- Identify needs

Get Set: *identify resources*

Go: *pull it all together, implement, evaluate, plan for the future*

What language service needs should I begin to identify?

Keep it simple and write down:
- *What you know about your patient demographics*
- *What you already do to provide language services*
- *Where you can grow and strengthen your language services*

Where can I find resources?

- Providing Language Services
- Incorporating Interpreter Services
- Self-assessment checklist
- Language Access Assessment and Planning Tool

Get Ready, Get Set, Go!

Get ready!
- Identify a designee or small team and commit to improve your capacity to serve individuals with limited English proficiency (LEP)
- Identify the most common languages of LEP patients you serve
- Create a checklist of what is already in place related to: interpreters, qualified bilingual staff and translated materials
- Document what needs to be enhanced

Get set!
- Review resources and identify those most useful for your office

Go!
- Create plan, implement, evaluate and plan for the future:
- Staff training on language service plan and cultural competency

[1] Wirthlin Worldwide 2002 RWJF Survey

SUPPORTING PATIENTS WITH 211 AND 711 COMMUNITY SERVICES

211 and 711 are free and easy to use services that can be used as resources to support patients with special needs. Each of these services operates in all States and is offered at no cost to the caller 24 hours a day/7 days a week.

211

211 is a free and confidential service that provides a single point of contact for people that are looking for a wide range of health and human services programs. With one call, individuals can speak with a local highly trained service professional to assist them in finding local social services agencies. and guide them through the maze of groups that specialize in housing assistance, food programs, counseling, hospice, substance abuse and other aid.

For more information, look for your local 211.org.

711

711 is a no cost relay service that uses an operator, phone system and a special teletypewriter (TDD or TTY) to help people with hearing or speech impairments have conversations over the phone. The 711 relay service can be used to place a call to a TTY line or receive a call from a TTY line. Both voice and Telecommunications Relay Service (TRS) users can initiate a call from any telephone, anywhere in the United States, without having to remember and dial a seven or ten-digit access number.

Simply dial 711 to be automatically connected to a TRS operator. Once connected the t TRS operator will relay your spoken message in writing and will read responses back to you.

In some areas, 711 offers speech impairment assistance. Special trained speech recognition operators available to help facilitate communication with individuals that may have speech impairments.

For more information, visit http://ddtp.cpuc.ca.gov/homepage.aspx

Teletype Device

Relay Operator

Cell or Landline Phone

SECTION B: RESOURCES TO COMMUNICATE ACROSS LANGUAGE BARRIERS

A GUIDE TO INFORMATION IN SECTION B

RESOURCES TO COMMUNICATE ACROSS LANGUAGE BARRIERS

This section offers resources to help health care providers identify the linguistic needs of their Limited English Proficient (LEP) patients and strategies to meet their communication needs.

Research indicates that LEP patients face linguistic barriers when accessing health care services. These barriers have negative impacts on patient satisfaction and knowledge of diagnosis and treatment. Patients with linguistic barriers are less likely to seek treatment and preventive services. This leads to poor health outcomes and longer hospital stays.

This section contains useful tips and ready-to-use tools to help remove the linguistic barriers and improve the linguistic competence of health care providers. The tools are intended to assist health care providers in delivering appropriate and effective linguistic services, which leads to:

- Increased patient health knowledge and compliance with treatment
- Decreased problems with patient-provider encounters and increased patient satisfaction
- Increased **appropriate** utilization of health care services by patients
- Potential reduction in liability from medical errors

The following materials area available in this section:

Tips for Working with LEP Members	Suggestions to help communicate with LEP patients.
Useful Tips for Communicating Across Language Barriers	Suggestions to help identify and document language needs.
Tips for Working with Interpreters	Suggestions to maximize the effectiveness of an interpreter.
Tips for Locating Interpreter Services	Information to know when locating interpreter services.
Common Sentences in Foreign Languages (Spanish & Vietnamese)	Simple phrases that can be used to communicate with LEP patients while waiting for an interpreter.
Common Signs in Foreign Languages (Spanish & Vietnamese)	Simple signs that can be enlarged and posted in your facility.
Language Identification Flashcard	Tool to identify patient languages.
Employee Language Pre-Screening Survey	Pre-screening tool to identify employees that may be eligible for formal language proficiency testing
Request for Proposal (RFP) Questions	Sample screening questions to interview translation vendors

TIPS FOR WORKING WITH LIMITED ENGLISH PROFICIENT MEMBERS

California law requires that health plans and insurers offer free interpreter services to both LEP members and health care providers and also ensure that the interpreters are professionally trained and are versed in medical terminology and health care benefits.

Who is a LEP member?

Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English, may be considered limited English proficient (LEP).

How to identify a LEP member over the phone

- Member is quiet or does not respond to questions
- Member simply says yes or no, or gives inappropriate or inconsistent
- answers to your questions
- Member may have trouble communicating in English or you may have a
- very difficult time understanding what they are trying to communicate
- Member self identifies as LEP by requesting language assistance

Tips for working with LEP members and how to offer interpreter services

- Member speaks no English and you are unable to discern the language
- Connect with contracted telephonic interpretation vendor to identify language needed.
- Member speaks some English:
- Speak slowly and clearly. Do not speak loudly or shout. Use simple words and short sentences.
- How to offer interpreter services:

"*I think I am having trouble with explaining this to you, and I really want to make sure you understand. Would you mind if we connected with an interpreter to help us? Which language do you speak?*"

OR

"*May I put you on hold? I am going to connect us with an interpreter.*" (If you are having a difficult time communicating with the member)

Best practice to capture language preference

For LEP members it is a best practice to capture the members preferred language and record it in the plan's member data system.

"*In order for me (or Health Plan) to be able to communicate most effectively with you, may I ask what your preferred spoken and written language is?*"

*This universal symbol for interpretive services at the top right of this document is from Hablamos Juntos, a Robert Wood Johnson funded project found at:

http://www.hablamosjuntos.org/signage/symbols/default.using_symbols.asp#bpw

TIPS FOR COMMUNICATING: ACROSS LANGUAGE BARRIERS

Limited English Proficient (LEP) patients are faced with language barriers that undermine their ability to understand information given by healthcare providers as well as instructions on prescriptions and medication bottles, appointment slips, medical education brochures, doctor's directions, and consent forms. They experience more difficulty (than other patients) processing information necessary to care for themselves and others.

Tips to Identify a Patient's Preferred Language

- Ask the patient for their preferred spoken and written language.
- Display a poster of common languages spoken by patients; ask them to point to their language of preference.

Post information relative to the availability of interpreter services.

Make available and encourage patients to carry "I speak…." or "Language ID" cards.

(Note: Many phone interpreter companies provide language posters and cards at no charge.)

Tips to Document Patient Language Needs

For all Limited English Proficient (LEP) patients, document preferred language in paper and/or electronic medical records.

- Post color stickers on the patient's chart to flag when an interpreter is needed.

  (e.g. Orange =Spanish, Yellow=Vietnamese, Green=Russian).

Tips to Assessing which Type of Interpreter to Use

- Telephone interpreter services are easily accessed and available for short conversations or unusual language requests.
- Face-to-face interpreters provide the best communication for sensitive, legal or long communications.
- Trained bilingual staff provides consistent patient interactions for a large number of patients.
- For reliable patient communication, avoid using minors and family members.

Tips to Overcome Language Barriers

Use Simple Words	• Avoid jargon and acronyms • Provide educational material in the languages your patients read • Limit/avoid technical language
Speak Slowly	• Do not shout, articulate words completely • Use pictures, demonstrations, video or audiotapes to increase understanding • Give information in small chunks and verify comprehension before going on.
Repeat Information	• Always confirm patient's understanding of the information - patient's logic may be different from yours

TIPS FOR WORKING WITH INTERPRETERS

TELEPHONIC INTERPRETERS

- Tell the interpreter the purpose of your call. Describe the type of information you are planning to convey. *
- Enunciate your words and try to avoid contractions, which can be easily misunderstood as the opposite of your meaning, e.g., "can't - cannot." *
- Speak in short sentences, expressing one idea at a time.*
- Speak slower than your normal speed of talking, pausing after each phrase.*
- Avoid the use of double negatives, e.g., "If you don't appear in person, you won't get your benefits"*
- Instead, "You must come in person in order to get your benefits."
- Speak in the first person. Avoid the "he said/she said." *
- Avoid using colloquialisms and acronyms, e.g., "MFIP." If you must do so, please explain their meaning.*
- Provide brief explanations of technical terms, or terms of art, e.g., "Spend-down" means the client must use up some of his/her monies or assets in order to be eligible for services." *
- Pause occasionally to ask the interpreter if he or she understands the information that you are providing, or if you need to slow down or speed up in your speech patterns. If the interpreter is confused, so is the client. *
- Ask the interpreter if, in his or her opinion, the client seems to have grasped the information that you are conveying. You may have to repeat or clarify certain information by saying it in a different way.*
- **ABOVE ALL, BE PATIENT** with the interpreter, the client and yourself! Thank the interpreter for performing a difficult and valuable service. *
- The interpreter will wait for you to initiate the closing of the call and will be the last to disconnect from the call.

When working with an interpreter over a speakerphone or with dual head/handsets, many of the principles of on-site interpreting apply. The only additional thing to remember is that the interpreter is "blind" to the visual cues in the room. The following will help the interpreter do a better job. **

When the interpreter comes onto the line let the interpreter know the following: **

- Who you are
- Who else is in the room
- What sort of office practice this is
- What sort of appointment this is

For example, "Hello interpreter, this is Dr. Jameson, I have Mrs. Dominguez and her adult daughter here for Mrs. Dominguez' annual exam." **

- Give the interpreter the opportunity to introduce himself or herself quickly to the patient. **
- If you point to a chart, a drawing, a body part or a piece of equipment, describe what you are pointing to as you do it.**

ON-SITE INTERPRETERS

- Hold a brief meeting with the interpreter beforehand to clarify any items or issues that require special attention, such as translation of complex treatment scenarios, technical terms, acronyms, seating arrangements, lighting or other needs.
- For **face-to-face** interpreting, position the interpreter off to the side and immediately behind the patient so that direct communication and eye contact between the provider and patient is maintained.
- For **American Sign Language (ASL)** interpreting, it is usually best to position the interpreter next to you as the speaker, the hearing person or the person presenting the information, opposite the deaf or hard of hearing person. This makes it easy for the deaf or hard of hearing person to see you and the interpreter in their line of sight.
- **Be aware** of possible gender conflicts that may arise between interpreters and patients. In some cultures, males should not be requested to interpret for females.
- **Be attentive** to cultural biases in the form of preferences or inclinations that may hinder clear communication. For example, in some cultures, especially Asian cultures, "yes" may not always mean "yes." Instead, "yes" might be a polite way of acknowledging a statement or question, a way of politely reserving one's judgment, or simply a polite way of declining to give a definite answer at that juncture.
- **Greet the patient first**, not the interpreter. **
- During the medical interview, speak directly to the patient, not to the interpreter: "Tell me why you came in today" instead of "Ask her why she came in today." **
- A professional interpreter will use the first person in interpreting, reflecting exactly what the patient said: e.g. "My stomach hurts" instead of "She says her stomach hurts." This allows you to hear the patient's "voice" most accurately and deal with the patient directly. **
- Speak at an even pace in relatively short segments; pause often to allow the interpreter to interpret. You do not need to speak especially slowly; this actually makes a competent interpreter's job more difficult. **
- Don't say anything that you don't want interpreted; it is the interpreter's job to interpret everything. **
- If you must address the interpreter about an issue of communication or culture, let the patient know first what you are going to be discussing with the interpreter. **

- Speak in: Standard English (avoid slang) **
    - Layman's terms (avoid medical terminology and jargon)
    - Straightforward sentence structure
    - Complete sentences and ideas
- Ask one question at a time. **
- Ask the interpreter to point out potential cultural misunderstandings that may arise.
  Respect an interpreter's judgment that a particular question is culturally inappropriate and either rephrase the question or ask the interpreter's help in eliciting the information in a more appropriate way. **
- Do not hold the interpreter responsible for what the patient says or doesn't say. The interpreter is the medium, not the source, of the message. **
- Avoid interrupting the interpretation. Many concepts you express have no linguistic or conceptual equivalent in other languages. The interpreter may have to paint word pictures of many terms you use.
- This may take longer than your original speech. **
- Don't make assumptions about the patient's education level. An inability to speak English does not necessarily indicate a lack of education. **
- Acknowledge the interpreter as a professional in communication. Respect his or her role. **

** "Addressing Language Access Issues in Your Practice - A Toolkit for Physicians and Their Staff Members," California Endowment website.
* "Limited English Proficiency Plan," Minnesota Department of Human Services: Helpful hints for using telephone interpreters (page 6).

TIPS FOR LOCATING INTERPRETER SERVICES

Steps I need to take to locate interpreter services:

1) Identify the languages spoken by your patients, and
2) Identify the language services available to meet these needs

For example:

Language spoken by my patients	Resources to help me communicate with patients
Spanish	Certified bilingual staff
Armenian	Telephone interpreter or in person interpreter

Identify the language capability of your staff (See Employee Language Skills Self-Assessment)
• Keep a list of available certified bilingual staff that can assist with LEP patients on-site.
• Ensure the competence of individuals providing language assistance by formally testing with a qualified bilingual proficiency testing vendor. Certified interpreters are HIPAA compliant.
• Do Not: Rely on staff other than certified bilingual/multilingual staff to communicate directly with individuals with limited English proficiency
• Do Not: Rely on a minor child to interpret or facilitate communication, except in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available. ***IF you use a minor, document the reason a minor was used.***

<u>Identify services available</u> do not require an individual with limited English proficiency to provide his/her own interpreter
• **Ask all health plans you work with if and when they provide interpreter services, including American Sign Language interpreters, as a covered benefit for their members.**
• **Identify community based qualified interpreter resources**
• **Create and provide to your staff policies and procedures to access interpreter services.**
• **Keep an updated list of specific telephone numbers and health plan contacts for language services.**
• **If you are coordinating interpreter services directly, ask the agency providing the interpreter how they determine interpreter quality.**
• **711 relay services are available to assist in basic communication with deaf or hard of hearing patients. In some areas services to communicate with speech impaired individuals may also be available.**

For further information, you may contact the National Council on Interpretation in Health Care, the Society of American Interpreters, the Translators & Interpreters Guild, the American Translators Association, or any local Health Care Interpreters association in your area.

LANGUAGE IDENTIFICATION FLASHCARDS

The sheets on the following page can be used as a tool to assist the office staff or physician in identifying the language that your patient is speaking. Pass the sheets to the patient and point to the English statement. Motion to have the patient read the other languages and to point to the language that the patient prefers. (Conservative gestures can communicate this.) Record the patient's language preference in their medical record.

The **Language Identification Flashcard** was developed by the U.S. Census Department and can be used to identify most languages that are spoken in the United States.

Printer friendly version of the Language Assistance Flashcard is on next page.

Industry Collaboration Effort

Interpreting Services Available

English Translation: Point to your language. An interpreter will be called. The interpreter is provided at no cost to you.

Arabic العربية
أشر إلى لغتك. وسيتم الاتصال بمترجم فوري. كما سيتم إحضار المترجم الفوري مجانًا.

Armenian Հայերեն
Նշեք, թե որ լեզվով եք խոսում: Թարգմանիչ կկանչենք: Թարգմանչի ծառայությունները տրամադրվում են անվճար:

Bengali বাংলা
আপনার ভাষার দিকে নির্দেশ করুন। একজন দ্বোভাষীকে ডাকা হবে। দ্বোভাষী আপনি নিখরচায় পাবেন।

Cambodian (Khmer) ខ្មែរ (កម្ពុជា)
សូមចង្អុលភាសាអ្នក។ យើងនឹងហៅអ្នកបកប្រែភាសាមកជូន។ អ្នកបកប្រែភាសានឹងជួយអ្នកដោយមិនគិតថ្លៃ។

Chinese (Cantonese) 廣東話
請指認您的語言，以便為您提供免費的口譯服務。

Chinese (Mandarin) 普通话
请指认您的语言，以便为您提供免费的口译服务。

Farsi (Persian) فارسي
زبان مورد نظر خود را مشخص کنید. یک مترجم برای شما درخواست خواهد شد. مترجم بصورت رایگان در اختیار شما قرار می گیرد.

Greek Ελληνικά
Δείξτε τη γλώσσα σας και θα καλέσουμε ένα διερμηνέα. Ο διερμηνέας σας παρέχεται δωρεάν.

Hindi हिंदी
अपनी भाषा को इंगित करें। जिसके अनुसार आपके लिए दुभाषिया बुलाया जाएगा। आपके लिए दुभाषिया की निशुल्क व्यवस्था की जाती है।

Hmong Hmoob
Taw rau koj hom lus. Yuav hu rau ib tug neeg txhais lus. Yuav muaj neeg txhais lus yam uas koj tsis tau them dab tsi.

Japanese 日本語
あなたの話す言語を指してください。
無料で通訳サービスを提供します。

Korean 한국어
귀하께서 사용하는 언어를 지정하시면 해당 언어 통역 서비스를 무료로 제공해 드립니다.

Laotian ພາສາລາວ
ຊີ້ບອກພາສາທີ່ເຈົ້າເວົ້າໄດ້. ພວກເຮົາຈະຕິດຕໍ່ນາຍພາສາໃຫ້. ທ່ານບໍ່ຕ້ອງເສຍເງິນຄ່າແປໃຫ້ແກ່ນາຍແປພາສາ.

Portuguese Português
Indique o seu idioma. Um intérprete será chamado. A interpretação é fornecida sem qualquer custo para você.

Punjabi ਪੰਜਾਬੀ
ਆਪਣੀ ਭਾਸ਼ਾ ਵੱਲ ਇਸ਼ਾਰਾ ਕਰੋ। ਜਿਸ ਮੁਤਾਬਕ ਇਕ ਦੁਭਾਸ਼ੀਆ ਬੁਲਾਇਆ ਜਾਵੇਗਾ। ਤੁਹਾਡੇ ਲਈ ਦੁਭਾਸ਼ੀਆ ਦੀ ਮੁਫਤ ਇੰਤਜ਼ਾਮ ਕੀਤਾ ਜਾਂਦਾ ਹੈ।

Russian Русский
Укажите язык, на котором вы говорите. Вам вызовут переводчика. Услуги переводчика предоставляются бесплатно.

Samoan Fa`asamoa
Fa`asino lau gagana. Ole a vala`au se fa`amatala`upu. Ua saunia se fa`amatala`upu e aunoa ma se tau e te totogiina.

Somali Af-Soomaali
Farta ku fiiqluqadaada… Waxa laguugu yeeri doonaa turjubaan. Turjubaanka wax lacagi kaaga bixi mayso.

Spanish Español
Señale su idioma y llamaremos a un intérprete. El servicio es gratuito.

Tagalog Tagalog
Ituro po ang inyong wika. Isang tagasalin ang ipagkakaloob nang libre sa inyo.

Thai ไทย
ช่วยชี้ที่ภาษาที่ท่านพูด แล้วเราจะจัดหาล่ามให้ท่าน การใช้ล่ามไม่ต้องเสียค่าใช้จ่าย

Tongan Tongan Lea Faka-Tonga
Tuhu`i mai ho`o lea fakafonua. `E ui ha fakatonulea. `Oki ta`etotongi kia `a e fakatonulea.

Urdu اردو
اپنی زبان پر اشارہ کریں- ایک ترجمان کو بلاجائے گا- ترجمان کا انتظام آپ پر بغیر کسی خرچ کے کیا جائے گا-

Vietnamese Tiếng Việt
Hãy chỉ vào ngôn ngữ của quý vị. Một thông dịch viên sẽ được gọi đến, quý vị sẽ không phải trả tiền cho thông dịch viên.

Provided courtesy of Industry Collaboration Effort and LanguageLine Solutions.

COMMON SIGNS IN MULTIPLE LANGUAGES

You may use this tool to mark special areas in your office to help your Limited English Proficient (LEP) patients. It is suggested that you laminate each sign and post it.

English		Welcome
Español	*Spanish*	Bienvenido/a
Tiếng Việt	*Vietnamese*	Hân hạnh tiếp đón quý vị
中文	*Chinese*	歡迎

English		Registration
Español	*Spanish*	Oficina de Registro
Tiếng Việt	*Vietnamese*	Quầy tiếp khách
中文	*Chinese*	登記處

English		Cashier
Español	*Spanish*	Cajera
Tiếng Việt	*Vietnamese*	Quầy trả tiền
中文	*Chinese*	收銀部

English		Enter
Español	*Spanish*	Entrada
Tiếng Việt	*Vietnamese*	Lối vào
中文	*Chinese*	入口

English		Exit
Español	*Spanish*	Salida
Tiếng Việt	*Vietnamese*	Lối ra
中文	*Chinese*	出口

English		Restroom
Español	*Spanish*	Baños
Tieáng Vieâït	*Vietnamese*	Phòng vệ sinh
中文	*Chinese*	洗手間

Point to a sentence	**Señale una frase**	**Xin chỉ vào câu**	**指向句子**

Instructions	*Instrucciones*	*Chỉ Dẫn*	*指示*
We can use these cards to help us understand each other. Point to the sentence you want to communicate. If needed, later we will call an interpreter.	*Podemos utilizar estas tarjetas para entendernos. Señale la frase que desea comunicar. Si necesita, después llamaremos a un intérprete.*	*Chúng ta có thể dùng những thẻ này để giúp chúng ta hiểu nhau. Xin chỉ vào câu đúng nghĩa quý vị muốn nói. Chúng tôi sẽ nhờ một thông dịch viên đến giúp nếu chúng ta cần nói nhiều hơn.*	*這卡可以幫助大家更明白對方。 請指向您想溝通的句子， 如有需要，稍後我們可以為您安排傳譯員。*

COMMON SENTENCES IN MULTIPLE LANGUAGES (ENGLISH-SPANISH-VIETNAMESE-CHINESE)

English	Spanish / Español	Vietnamese / Tiếng Việt	Cl
Point to a sentence	Señale una frase	Xin chỉ vào câu	
Courtesy statements	***Frases de cortesía***	***Từ ngữ lịch sự***	
Please wait.	Por favor espere (un momento).	Xin vui lòng chờ.	請等等
Thank you.	Gracias.	Cám ơn.	多謝
One moment, please.	Un momento, por favor.	Xin đợi một chút.	請等一會
Point to a sentence	Señale una frase	Xin chỉ vào câu	
Patient may say….	***El paciente puede decir…***	***Bệnh nhân có thể nói...***	病
My name is…	Mi nombre es ...	Tôi tên là...	我的名字是
I need an interpreter.	Necesito un intérprete.	Chúng tôi cần thông dịch viên.	我需要一位
I came to see the doctor, because…	Vine a ver al doctor porque ...	Tôi muốn gặp bác sĩ vì...	我來見醫生
I don't understand.	No entiendo.	Tôi không hiểu.	我不明白

Patient may say…	*El paciente puede decir…*	*Bệnh nhân có thể nói...*	*病人可能會說...*
Please hurry. It is urgent.	Por favor apúrese. Es urgente.	Vui lòng nhanh lên. Tôi có chuyện khẩn cấp.	請盡快，這是非常緊急。
Where is the bathroom?	Dónde queda el baño?	Phòng vệ sinh ở đâu?	洗手間在那裏？
How much do I owe you?	Cuánto le debo?	Tôi cần phải trả bao nhiêu tiền?	我欠您多少錢？
Is it possible to have an interpreter?	Es posible tener un intérprete?	Có thể nhờ một thông dịch viên đến giúp chúng ta không?	可否找一位傳譯員？

Point to a sentence **Señale una frase** **Xin chỉ vào câu** **指向句子**

Staff may ask or say…	*El personal del médico le puede decir…*	*Nhân viên có thể hỏi hoặc nói..*	*職員可能會問或說。。。*
How may I help you?	¿En qué puedo ayudarle?	Tôi có thể giúp được gì?	我怎樣可以幫您呢？
I don't understand. Please wait.	No entiendo. Por favor espere.	Tôi không hiểu. Xin đợi một chút.	我不明白，請等等。
What language do you prefer?	¿Qué idioma prefiere?	Quí vị thích dùng ngôn ngữ nào?	您喜歡用什麼語言呢： • Cantonese 廣東話 • Mandarin 國語
We will call an interpreter.	Vamos a llamar a un intérprete.	Chúng tôi sẽ gọi thông dịch viên	我們會找一位傳譯員。
An interpreter is coming.	Ya viene un intérprete.	Sẽ có một thông dịch viên đến giúp chúng ta.	傳譯員就快到。

COMMON SENTENCES IN MULTIPLE LANGUAGES (ENGLISH-SPANISH-VIETNAMESE-CHINESE)

English	Spanish / Español	Vietnamese / Tiếng Việt	
Point to a sentence	Señale una frase	Xin chỉ vào câu	

Staff may ask or say…	*El personal del médico le puede decir…*	*Nhân viên có thể hỏi hoặc nói..*	*職員*
What is your name?	¿Cuál es su nombre?	Qúy vị tên gì?	您叫什麼
Who is the patient?	¿Quién es el paciente?	Ai là bệnh nhân?	誰是病人
Please write the patient's:	Por favor escriba, acerca del paciente:	Xin viết lý lịch của bệnh nhân:	請寫出病
Name	Nombre	Tên	姓名
Address	Dirección	Địa Chỉ	地址
Telephone number	Número de teléfono	Số Điện Thoại	電話號碼
Identification number	Número de identificación	Số ID	醫療卡號
Birth date:	Fecha de nacimiento:	Ngày Sinh:	出生日期
Month/Day/Year	Mes/Día/Año	Tháng/Ngày/Năm	
Now, fill out these forms, please	***Ahora, por favor conteste estas formas.***	*Bây giờ xin điền những đơn này.*	*現*

Point to a sentence	**Señale una frase**	**Lonje dwèt ou sou yon fraz**

Instructions	*Instrucciones*	*Esplikasyon*
We can use these cards to help us understand each other. Point to the sentence you want to communicate. If needed, later we will call an interpreter.	*Podemos utilizar estas tarjetas para entendernos. Señale la frase que desea comunicar. Si necesita, después llamaremos a un intérprete.*	*Nou kapab sèvi ak kat sa yo pou ede nou youn konprann lòt. Lonje dwèt ou sou sa ou vle di a. Si nou bezwen yon entèprèt, n ap voye chache youn apre.*

COMMON SENTENCES IN MULTIPLE LANGUAGES\(ENGLISH-SPANISH-FRENCH CREOLE)

English	Spanish / Español	Creole/ Kr
Point to a sentence	**Señale una frase**	**Lonje dwèt ou s**
Courtesy statements	***Frases de cortesía***	***Pawòl pou Ko***
Please wait.	Por favor espere (un momento).	Tanpri, tann (yon moman)
Thank you.	Gracias.	Mèsi.
One moment, please.	Un momento, por favor.	Tann yon moman, tanpri.
Patient may say….	***El paciente puede decir…***	*Pasyan an ka*
My name is…..	Mi nombre es	Non mwen se…
I need an interpreter.	Necesito un intérprete.	Mwen bezwen yon entèprèt
I came to see the doctor, because ….	Vine a ver al doctor porque	Mwen vin wè dokè a, paske…
I don't understand.	No entiendo.	Mwen pa konprann.
Please hurry. It is urgent.	Por favor apúrese. Es urgente.	Tanpri fè vit. Sa ijan.
Where is the bathroom?	Dónde queda el baño?	Kote twalèt la yo?
How much do I owe you?	Cuánto le debo?	Konbyen pou mwen peye?
Is it possible to have an interpreter?	Es posible tener un intérprete?	ske mwen ka gen yon entèprèt?

Staff may ask or say….	*El personal del médico le puede decir…*	**Anplwaye medikal la kapab di oubyen mande...**
Please hold. I will be right back	Por favor espere un momento. Ya regreso.	Tanpri, tann yon moman. M ap tounen touswit.
How may I help you?	¿En qué puedo ayudarle?	Kisa mwen ka ѐ pou ou?
I don't understand. Please wait.	No entiendo. Por favor espere.	Mwen pa konprann. Tanpri, tann yon moman.
What language do you prefer?	¿Qué idioma prefiere?	Ki lang ou pito?
We will call an interpreter.	Vamos a llamar a un intérprete.	Nou pral rele yon enѐprѐt.
An interpreter is coming.	Ya viene un intérprete.	Gen yon enѐprѐt ki nan wout.
What is your name?	¿Cuál es su nombre?	Kouman ou rele?
Who is the patient?	¿Quién es el paciente?	Ki moun ki pasyan an?

COMMON SENTENCES IN MULTIPLE LANGUAGES\(ENGLISH-SPANISH-FRENCH CREOLE)

English	Spanish / Español	Creole/ Krey
Point to a sentence	Señale una frase	Lonje dwèt ou sou
Staff may ask or say….	*El personal del médico le puede decir…*	**Anplwaye medikal la kapab**
Please write **the patient's**:	Por favor escriba, acerca **del paciente**:	Tanpri, ekri enfimasyon sa yo **po**
Name	Nombre	Non
Address	Dirección	Adrs
Telephone number	Número de teléfono	Nimewo telefin
Identification number	Número de identificación	Nimewo didantite
Birth date:	Fecha de nacimiento:	Dat nesans:
Month / Day / Year	Mes / Día / Año	Mwa / Jou
Now, fill out these forms, please	*Ahora, por favor conteste estas formas.*	*Kounye a, ekri enfimasyon yo ma*

EMPLOYEE LANGUAGE PRE-SCREENING TOOL

Dear Physician:

The attached prescreening tool is provided as a resource to assist you in identifying employees that may be eligible for formal language proficiency testing. Those who self-assess at 3 or above are candidates that are more likely to pass a professional language assessment.

This screening tool is not meant to serve as an assessment for qualified medical interpreters or meet the CA Language Assistance Program law or any other regulatory requirements.

Thank you

Printer friendly version of the EMPLOYEE LANGUAGE PRE SCREENING TOOL KIT provided on next page.

EMPLOYEE LANGUAGE PRE SCREENING TOOK KEY

Key	Spoken Language
(1)	Satisfies elementary needs and minimum courtesy requirements. Able to understand and respond to 2-3 word entry-level questions. May require slow speech and repetition.
(2)	Meets basic conversational needs. Able to understand and respond to simple questions. Can handle casual conversation about work, school, and family. Has difficulty with vocabulary and grammar.
(3)	Able to speak the language with sufficient accuracy and vocabulary to have effective formal and informal conversations on most familiar topics related to health care.
(4)	Able to use the language fluently and accurately on all levels related to health care work needs. Can understand and participate in any conversation within the range of his/her experience with a high degree of fluency and precision of vocabulary. Unaffected by rate of speech.
(5)	Speaks proficiently equivalent to that of an educated native speaker. Has complete fluency in the language, including health care topics, such that speech in all levels is fully accepted by educated native speakers in all its features, including breadth of vocabulary and idioms, colloquialisms, and pertinent cultural preferences. Usually has received formal education in target language.
Key	**Reading**
(1)	No functional ability to read. Able to understand and read only a few key words.
(2)	Limited to simple vocabulary and sentence structure.
(3)	Understands conventional topics, non-technical terms and heath care terms.
(4)	Understands materials that contain idioms and specialized health care terminology; understands a broad range of literature.
(5)	Understands sophisticated materials, including those related to academic, medical and technical vocabulary.
Key	**Writing**
(1)	No functional ability to write the language and is only able to write single elementary words.
(2)	Able to write simple sentences. Requires major editing.
(3)	Writes on conventional and simple health care topics with few errors in spelling and structure. Requires minor editing.
(4)	Writes on academic, technical, and most health care and medical topics with few errors in structure and spelling.
(5)	Writes proficiently equivalent to that of an educated native speaker/writer. Writes with idiomatic ease of expression and feeling for the style of language. Proficient in medical, healthcare, academic and technical vocabulary.
Interpretation vs. Translation	**Interpretation:** Involves spoken communication between two parties, such as between a patient and a pharmacist, or between a family member and doctor. **Translation:** Involves very different skills from interpretation. A translator takes a written document in one language and changes it into a document in another language, preserving the tone and meaning of the original. *Source: University of Washington Medical Center*

EMPLOYEE LANGUAGE PRESCREENING TOOL
(FOR CLINICAL AND NON-CLINICAL EMPLOYEES)

This prescreening tool is intended for clinical and non-clinical employees who are bilingual and are being considered for formal language proficiency testing.

Employee's Name: _____ **Department/Job Title:** _____

_____

Work Days: **Mon / Tues/ Wed/ Thurs/ Fri/ Sat/ Sun** **Work Hours (Please Specify):** _____

_____

Directions: (1) List any/all language(s) or dialects you know.
(2) Indicate how fluently you speak, read and/or write each language

Language	**Dialect, region, or country**	**Fluency: see attached key (Circle)**			**I would like to use my language skills to speak with patients (Circle)**	**I would like to use my reading language skills to communicate with patients (Circle)**	**I would like to use my language skills to write patient communications (Circle)**
		Speaking	Reading	Writing			
1.		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	Yes No	Yes No	Yes No
2.		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	Yes No	Yes No	Yes No
3.		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	Yes No	Yes No	Yes No
4.		1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	Yes No	Yes No	Yes No

TO BE SIGNED BY THE PERSON COMPLETING THIS FORM

I, _____, attest that the information provided above is accurate.

Date: _____

SCREENING QUESTIONS FOR INTERVIEWING TRANSLATION VENDORS

Request for Proposal (RFP) Questionnaire Screening questions for interviewing Translation Vendors
General Business Requirements Questions
1. What geographic areas do you currently serve?
2. Please indicate your areas of expertise (i.e. Medical/Health, Education, Law, etc.).
3. Is your company aware and automatically follow special certifications for states you provide services in/for?
4. Please list all languages currently available. List only languages that have at least one active translator currently and regularly available. Also list whether the translators available are native speakers and if so, where they are from.
5. Please list the 3-5 most common languages your organization translates.
6. Describe your process for translating documents based on regional dialects for one language. For example, how do you facilitate translating a document into Spanish for Southern California and New York?
7. Describe how your translation staff is knowledgeable in the sensitivities, norms, and regional dialects of various cultural groups?
8. Please list all national states and global countries you provide Services in.
9. What differentiates your company from your competition as it relates to the services outlined in this RFP?
10. Are you able to customize your services at the client level? Please provide an example of how you may customize other programs in place.
11. Is your company able to assign dedicated resource team to support services?
12. What percent of your current business is providing services within the health care industry?
13. Please define the language proficiency of medical terminology and use of health care industry language for employees providing services.
14. Do you use validated test instruments to assess your medical or health care terminology translators?
15. Do you support the most recent version of InDesign?
16. What is your process for ensuring software capabilities are up-to-date while still maintaining support for older file formats?
17. Can you produce translations on any day of the year?
18. What are your company's top three measures of a successful relationship between your company's organization and your clients? State how your company would measure and report each.
19. Please demonstrate how your company was flexible with an unusual client request.
20. What is your process to work with document owners to fine tune translations to match their specific target audience?

Request for Proposal (RFP) Questionnaire Screening questions for interviewing Translation Vendors
21. Do you maintain a translation glossary for each of your clients? (Glossary- a set of terms and their preferred translation)
22. Are you open to the total translation memory being provided to us (health plan) upon request?
23. Can you provide Spanish translations and translations into traditional Chinese characters within 24 hours?
Administration Questions
1. What are your standard hours of operation?
2. Do you have a privacy and confidentiality policy? If yes, please describe.
3. What are your policies regarding direct contact between a translator and the client?
4. What is the average amount of time to complete a translated document from receipt to delivery?
5. How much advance notice is needed to request translation services?
Customer Service Questions
1. Please describe your Customer Service model for these services.
2. Please describe the grievance and complaint escalation process and resolution of service issues?
3. What is the experience level of project management team with localization and cultural adaptation?
4. What is the coverage of services for different time zones?
5. Do you provide full or partial services on holidays and weekends?
6. Describe new hire onboarding and ongoing training and specialized health care industry training provided to staff and/or contracted individuals.
7. Please explain your capabilities to ensure cultural adaptation.
Service Level Questions
1. Please list and describe your standard Service Levels. You may attach them separately.
2. Do you offer service guarantees? If yes, please provide.
Translation Services Questions
1. How long has your company been providing Translation Services as part of its offering?
2. Process - Please provide an overview of your full Translation Services process from initial engagement from customer to completion.
3. Please translate the provided document labeled "XXXX"
Quality Assurance Practices/Proficiencies Questions
1. Please describe the process for screening potential interpreters and translators.
2. What are the educational credentials of your translators? Do your credentialed translators do all the translation work or do they merely supervise the work of others?
3. Are your translator's employees of the company or are they contracted employees? What percentage belongs to each group (% employees and % contracted)?

Request for Proposal (RFP) Questionnaire Screening questions for interviewing Translation Vendors
4. Please indicate which of the following skills are evaluated in an initial screening or translators: ___Basic Language Skills ___Industry Specific Terminology ___Cultural Awareness ___Ethics ___Written Translation Skills ___Others (Please explain)
5. What training program is provided to translators once they have been hired? Please include details of any in-house or outsourced training including number of hours, topics covered, etc.
6. Is continuing education required? If yes, how many hours per year?
7. What percentage of your translators are certified by: ___Internal Process ___State Process ___Federal Court ___Private External Organization (please list)
8. Describe your internal quality control or monitoring process.
9. What system do you have in place to resolve complaints?
10. Please describe your accuracy standards. What guarantees do you provide? Would you be willing to put 20 percent of your fees at risk contingent upon meeting agreed-upon guaranteed standards? Would you consider a Service Level Agreement (SLA)? If so, what standards do you customarily include in an SLA?
11. Do you provide an attestation or Certificate of Authenticity or equivalent document? If so, please provide a sample.
12. Please list all certifications and all other QM certifications your company holds/maintains.
13. Please describe your Quality Assurance program.
14. How often does your company review and revise the quality program?
15. How does your company ensure quality of services, including linguists and document translations, and actions for substandard performance?
16. Do you have a process to guarantee consistency between translations from multiple linguists? Please define this process and describe the process to ensure localization, terminology consistency, accuracy and appropriate literacy.
17. Describe your quality control processes. What do you have in place to assure that structure and format are precisely the same as the English original
18. How long has your company been providing Proficiency and Certification Services as part of its offering?
19. Please provide an overview of your Proficiency and Certification Service program.
20. Does your program include examination of general language usage in formal and professional context? Please Define.
21. Does your program include examination of fluency in the assessment language?
22. Describe industry experience and Supplier ability to use terminology and phrases in the assessment language that is specific to the healthcare industry
23. What type of reporting/scoring system does your program use to determine examinees proficiency level in the assessment language. The proficiency level describes the examinee's performance in several areas of oral language proficiency. If applicable, please include sample scorecard.

Request for Proposal (RFP) Questionnaire Screening questions for interviewing Translation Vendors
Experience Questions
1. How long have you been in business?
2. Please provide at least three references.
3. Please list current health care organization clients for whom you have provided written translation services. Please list the types of documents that have been translated for health care clients.
4. Can your organization guarantee that translators working on <<client's name>> documents will have had experience translating health care documents?
5. How do you address the uniqueness of some terminology that occurs in health care, particularly complementary health care?
6. Please describe your experience in translating health web sites and images. If applicable, please provide the names of client for which you have provided this service.
7. Do you currently or have you furnished translation services to any federal, state or local agency? If yes, list the organization and type of service provided.
8. Describe your range of graphic design/desktop publishing services that you provide, including both print and Web. Please indicate the number of staffed designers you have and the design software (PC/Mac Quark, InDesign, PageMaker, Illustrator, Freehand, Photoshop, Dream weaver, etc.) your staff uses to create brochures, flyers, and other marketing/education materials. Please provide a breakdown of the additional costs and average turnaround times associated with your graphic design services, including making changes or edits.
9. Describe whether or not your services include the review of culturally sensitive images and text. For example, do your services include the review of images within a graphic document in order to determine whether they are culturally sensitive and appropriate?
Reporting Questions
1. Do you offer a standard reporting package? If yes, please attach.
2. Do you provide reports confirming language proficiency of employees or contractors that provide services?
Fee Questions
1. Please describe your pricing practices and fee schedule.
2. Do you provide estimates for work to be performed? If so, please provide a quote to translate the attached documents into Spanish?
3. What kind of volume discounts do you offer?
4. Do you offer services on a single use basis?
5. What information is provided on billing statements? Please include a sample.

Request for Proposal (RFP) Questionnaire Screening questions for interviewing Translation Vendors
6. What is your pricing/billing policy for making edits or changes to documents translated? For a document that is 40 pages in length, what would the cost be to translate into 6 languages by in-country translators: ___Simplified Chinese for China ___Japanese ___Canadian French ___Russian ___Brazilian Portuguese ___Argentine Spanish
7. What is your pricing/billing policy for making edits or changes to documents translated? For a document that is 40 pages in length, what would the cost be to translate into 6 languages by in-country translators: ___Simplified Chinese for China ___Japanese ___Canadian French ___Russian ___Brazilian Portuguese ___Argentine Spanish
8. What guarantees are available if the work produced does not meet our expectations?
9. What is your flexibility and cost implication of translating a document into different dialects of one language? Are multiple dialects the same cost as multiple languages?
10. Are your prices the same for all languages; common and rarely spoken?
11. <<Client's name>> generally remits payment within 45 days of invoice date. Please indicate if this is not acceptable? What are your standard payment terms?
12. Please list and describe any fees associated with your program(s) and please list all rates associated with different languages, countries, processes, e.g. project management, engineering, translation or telephonic per minute rates, etc.
13. Do you provide pricing for leveraged (previously translated) words?
14. Are all translations priced per word or is there a minimum charge per document? For example if the content to be translated is 50 words, is the pricing per word or based on a minimum word count?
15. Do you charge for attestations, desk top publishing, rush jobs or providing documents in many different programs such as providing the same document in Word, PDF and In-Design or Quark?
Technology Questions
1. Do you use a submission portal? If so, is all communication via the submission portal?
2. What technology is used to manage translation memory?

SECTION C: RESOURCES TO INCREASE AWARENESS OF CULTURAL BACKGROUNDS AND ITS IMPACT ON HEALTH CARE DELIVERY

A GUIDE TO INFORMATION IN SECTION C

Resources to Increase Awareness of Cultural Background and its Impact on Health Care Delivery

Everyone approaches illness as a result of their own experiences, including education, social conditions, economic factors, cultural background, and spiritual traditions, among others. In our increasingly diverse society, patients may experience illness in ways that are different from their health professional's experience. Sensitivity to a patient's view of the world enhances the ability to seek and reach mutually desirable outcomes. If these differences are ignored, unintended outcomes could result, such as misunderstanding instructions and poor compliance.

The following tools are intended to help you review and consider important factors that may have an impact on health care. Always remember that even within a specific tradition, local and personal variations in belief and behavior exist. Unconscious stereotyping and untested generalizations can lead to disparities in access to service and quality of care. The bottom line is: if you don't know your patient well, ask respectful questions. Most people will appreciate your openness and respond in kind.

The following materials are available in this section:

What is Health Disparities/Health Equity?	A detained description of Health Disparities
Let's Talk About Sex	A guide to help you understand and discuss gender roles, modesty, and privacy preferences that vary widely among different people when taking sexual health history information.
Delivering Care to Lesbian, Gay, bisexual or Transgender (LGBT)	A guide to the Lesbian, Gay, Bisexual or Transgender communities.
Cultural Background – Information on Special Topics	Points of reference to become familiar with diverse cultural backgrounds.
Effectively Communicating with the Elderly	A tip sheet on how to better communicate with elderly patients.
Pain Management Across Cultures	A guide to help you understand the ways people may use to describe pain and approach to treatment options.

HEALTH EQUITY, HEALTH EQUALITY AND HEALTH DISPARITIES

What does health equity mean?

Health Equity is attainment of the highest level of health for all people.

Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.

Source: http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_05_Section1.pdf

What are health disparities and why do they matter to all of us?

A health disparity is a particular type of health difference that is closely linked with social or economic disadvantage.

Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health and/or a clean environment based on:

- Racial or ethnic group
- Religion
- Socioeconomic status
- Gender
- Age
- Mental health
- Cognitive, sensory, or physical disability
- Sexual orientation
- Geographic location
- Other characteristics historically linked to discrimination or exclusion

Source: http://minorityhealth.hhs.gov/npa

Health disparities matter to all of us. Here are just 2 examples of what can happen when there are disparities…

Example 1: *A man who speaks only Spanish is not keeping his blood sugar under control because he does not understand how to take his medication. As a result, he suffers permanent vision loss in one eye.*

Example 2: *A gay man is treated differently after telling office staff that he is married to a man, and feels so uncomfortable that he does not tell the doctor his serious health concerns. As a result, he does not get the tests that he needs, his cancer goes untreated, and by the time he is diagnosed his tumor is stage 4.*

The Difference between Health Equality and Health Equity

Why treating everyone the same, without acknowledgement of diversity and the need for differentiation, may be clinically counterproductive

Equality denotes that everyone is at the same level. **Equity** refers to the qualities of justness, fairness, impartiality and evenhandedness, while equality is about equal sharing and exact division. Source: http://www.differencebetween.net/language/difference-between-equity-and-equality

Health equity is different from health equality. The term refers specifically to the **absence of disparities in controllable areas** of health. It may not be possible to achieve complete health equality, as some factors are beyond human control. Source: World Health Organization, http://www.who.int.healthsystems/topics/equity

An example of **health inequality** is when one population dies younger than another because of genetic differences that cannot be controlled. An example of **health inequity** is when one population dies younger than another because of poor access to medications, which is something that could be controlled. Source: Kawachi I., Subramanian S., Almeida-Filho N. "A glossary for health inequalities. *J Epidemiol Community Health* 2002; 56:647-652.

Health Equity and Culturally and Linguistically Appropriate Services (CLAS)

How are they connected?

Health inequities in our nation are well documented. The provision of culturally and linguistically appropriate services (CLAS) is one strategy to help eliminate health inequities.

By tailoring services to an individual's culture and language preference, you can help bring about **positive health outcomes** for diverse populations.

The provision of health care services that **are respectful of and responsive to the health beliefs, practices and needs of diverse patients** can help close the gap in health care outcomes.

The pursuit of health equity must remain at the forefront of our efforts. We must always remember that dignity and quality of care are rights of all and not the privileges of a few.

For more background and information on CLAS, visit https://www.thinkculturalhealth.hhs.gov

Plans for Achieving Health Equity and What You Can Do

With growing concerns about health inequities and the need for health care systems to reach increasingly diverse patient populations, cultural competence has become more and more a matter of national concern.

As a health care provider, you can take the first step to improve the quality of health care services given to diverse populations.

By learning to be more **aware of your own cultural beliefs** and more responsive to those of your patients, you and your office staff can think in ways you might not have before. That can lead to self-awareness and, over time, changed beliefs and attitudes that will translate into **better health care**.

Knowing your patients and making sure that you **collect and protect specific data**, for example their preferred spoken and written languages, can have a major impact on their care.

The website https://www.thinkculturalhealth.hhs.gov , sponsored by the Office of Minority Health, offers the latest resources and tools to promote cultural and linguistic competency in health care.

You may access free and accredited continuing education programs as well as tools to help you and your organization provide respectful, understandable and effective services.

Source: Think Cultural Health (TCH), https://www.thinkculturalhealth.hhs.gov **Think Cultural Health** *is the flagship initiative of the OMH Center for Linguistic and Cultural Competence in Health Care. The goal of* **Think Cultural Health** *is to Advance Health Equity at Every Point of Contact through the development and promotion of culturally and linguistically appropriate services*

Who else is addressing Health Disparities?

Many groups are working to address health disparities, including community health workers, patient advocates, hospitals, and health plans as well as government organizations.

The Affordable Care Act (ACA) required the establishment of Offices of Minority Health within six agencies of the Department of Health and Human Services (HHS):

- Agency for Healthcare Research and Quality (AHRQ)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- Food and Drug Administration (FDA)
- Health Resources and Services Administration (HRSA)
- Substance Abuse and Mental Health Services Administration (SAMHSA)

These offices join the HHS Office of Minority Health and NIH National Institute on Minority Health and Health Disparities to lead and coordinate activities that improve the health of racial and ethnic minority populations and eliminate health disparities. Source: Offices of Minority http://minorityhealth.hhs.gov

Links to key resources for providers who want to end health disparities

- National Partnership for Action to End Health Disparities, http://minorityhealth.hhs.gov/npa
- Offices of Minority Health at HHS, http://minorityhealth.hhs.gov
- Think Cultural Health, https://www.thinkculturalhealth.hhs.gov

LET'S TALK ABOUT SEX

Consider the following strategies when navigating the cultural issues surrounding the collection of sexual health histories.

Areas of Cultural Variation	Points To Consider	Suggestions
Gender Roles	• Gender roles vary and change as the person ages (i.e. women may have much more freedom to openly discuss sexual issues as they age). • A patient may not be permitted to visit providers of the opposite sex unaccompanied (i.e. a woman's husband or mother-in-law will accompany her to an appointment with a male provider). • Some cultures prohibit the use of sexual terms in front of someone of the opposite sex or an older person. • Several family members may accompany an older patient to a medical appointment as a sign of respect and family support.	• Before entering the exam room, tell the patient and their companion exactly what the examination will include and what needs to be discussed. Offer the option of calling the companion(s) back into the exam room immediately following the physical exam. • As you invite the companion or guardian to leave the exam room, have a health professional of the same gender as the patient standing by and re-assure the companion or guardian that the person will be in the room at all times. • Use same sex non-family members as interpreters.
Sexual Health and Patient Cultural Background	• If a sexual history is requested during a non-related illness appointment, patients may conclude that the two issues – for example, blood pressure and sexual health are related. • In many health belief systems there are connections between sexual performance and physical health that are different from the Western tradition. • Example: Chinese males may discuss sexual performance problems in terms of a "weak liver. • Be aware that young adults may not be collecting sexual history information is part of preventive care and is not based on an assumption that sexual behaviors are taking place. • Printed materials on topics of sexual health may be considered inappropriate reading materials.	• Explain to the patient why you are requesting sexually related information at that time. • For young adults, clarify the need for collecting sexual history information and consider explaining how you will protect the confidentiality of their information. • Offer sexual health education verbally. Whenever possible, provide sexual health education by a health care professional who is the same t. gender as the patient

Areas of Cultural Variation	Points To Consider	Suggestions
Confidentiality Preferences	• Patients may not tell you about their preferences and customs surrounding the discussion of sexual issues. You must watch their body language for signals or discomfort, or ask directly how they would like to proceed. • A patient may be required to bring family members to their appointment as companions or guardians. Printed materials on topics of sexual health may be considered inappropriate reading materials. • Be attentive to a patient's body language or comments that may indicate that they are uncomfortable discussing sexual health with a companion or guardian in the room.	• It may help to apologize for the need to ask sexual or personal questions. Apologize and explain the necessity. • Try to offer the patient a culturally acceptable way to have a confidential conversation. For example: "To provide complete care, I prefer one-on-one discussions with my patients. However, if you prefer, you may speak with a female/male nurse to complete the initial information." • Inform the patient and the accompanying companion(s) of any applicable legal requirements regarding the collection and protection of personal health information.

LESBIAN, GAY, BISEXUAL OR TRANSGENDER (LGBT)

Communities are made up of many diverse cultures, sexual orientations, and gender identities. Individuals who identify as lesbian, gay, bisexual or transgender (LGBT)[1] may have unmet health and health care needs resulting in health disparities. In fact, the LGBT community is subject to a disproportionate number of health disparities and is at higher risk for poor health outcomes.

According to Healthy People 2020[2], LGBT health disparities include:

Psychosocial Considerations

- Youth are 2 to 3 times more likely to attempt suicide and are more likely to be homeless.
- LGBT populations have the highest rates of tobacco, alcohol, and other drug use.
- Elderly LGBT individuals face additional barriers to health because of isolation and a lack of social services and culturally competent providers.

Clinical Considerations

- Lesbians are less likely to get preventive services for cancer; along with bisexual females are more likely to be overweight or obese.
- Gay men are at higher risk of HIV and other STDs, especially among communities of color.
- Transgender individuals have a high prevalence of HIV/STDs, victimization, mental health issues, and suicide and are less likely to have health insurance than straight or LGB individuals.

Visit glma.org for more information about:

- Creating a welcoming environment,
- General guidelines (including referral resources),
- Confidentiality, and
- Sensitivity training.

Visit glaad.org for additional resources on how to fairly and accurately report on transgender people

[1] The term LGBT is used as an umbrella term to describe a person's sexual orientation or gender identity/expression including (but not limited to) lesbian, gay, bisexual, transgender, queer, questioning, intersex, and asexual. Transgender is an umbrella term for a person who's gender identity or expression does not match their sex assigned at birth.

[2] https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health

Do not use any gender or sexual orientation terms to identify your patient without verifying how they specifically self-identify.

Resources to Increase Awareness of Cultural Backgrounds and its Impact on Health Care Delivery

- **GLMA cultural competence webinar series**
- **Providing Enhanced Resources Cultural Competency Training**
- **LGBT Health Resources**
- **Equal Employment Opportunity Commission** for your local EEOC field office
- **Creating an LGBT Friendly Practice**
- **LGBT Training Curricula for Behavioral Health and Primary Care Practitioners**
- **Preventing Discrimination**
- **Bullying Policies & Laws**

CULTURAL BACKGROUND INFORMATION ON SPECIAL TOPICS

Use of Alternative or Herbal Medications

- People who have lived in poverty, or come from places where medical treatment is difficult to get, will often come to the doctor only after trying many traditional or home treatments. Usually patients are very willing to share what has been used if asked in an accepting, nonjudgmental way. This information is important for the accuracy of the clinical assessment.

- Many of these treatments are effective for treating the symptoms of illnesses. However, some patients may not be aware of the difference between treating symptoms and treating the disease.
- Some treatments and "medicines" that are considered "folk" medicine or "herbal" medications in the United States are part of standard medical care in other countries. Asking about the use of medicines that are "hard to find" or that are purchased "at special stores" may get you a more accurate understanding of what people are using than asking about **"alternative," "traditional," "folk," or "herbal" medicine.**

Pregnancy and Breastfeeding

- Preferred and acceptable ages for a first pregnancy vary from culture to culture. Latinos are more accepting of teen pregnancy; in fact it is quite common in many of the countries of origin. Russians tend to prefer to have children when they are older. It is important to understand the cultural context of any particular pregnancy. Determine the level of social support for the pregnant women, which may not be a function of age.

- Acceptance of pregnancy outside of marriage also varies from culture to culture and from family to family. In many Asian cultures there is often a profound stigma associated with pregnancy outside of marriage. However, it is important to avoid making assumptions about how welcome any pregnancy may be.
- Some Vietnamese and Latino women believe that colostrum is not good for a baby. An explanation from the doctor about why the milk changes can be the best tool to counter any negative traditional beliefs.
- The belief that breastfeeding works as a form of birth control is very strongly held by many new immigrants. It is important to explain to them that breastfeeding does not work as well for birth control if the mother gets plenty of good food, as they are more able to do here than in other parts of the world.

Weight

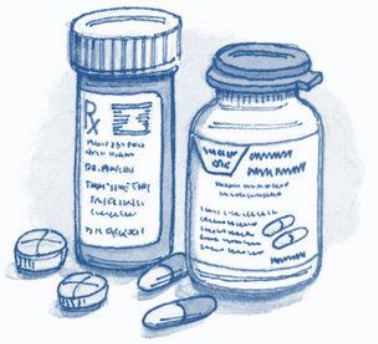
- In many poor countries, and among people who come from them, "chubby" children are viewed as healthy children because historically they have been better able to survive childhood diseases. Remind parents that sanitary conditions and medical treatment here protect children better than extra weight.
- In many of the countries that immigrants come from, weight is seen as a sign of wealth and prosperity. It has the same cultural value as extreme thinness has in our culture – treat it as a cultural as well as a medical issue for better success.

Infant Health

- It is very important to avoid making too many positive comments about a baby's general health.
    - Among traditional Hmong, saying a baby is "pretty" or "cute" may be seen as a threat because of fears that spirits will be attracted to the child and take it away
    - Some traditional Latinos will avoid praise to avoid attracting the "evil eye"
    - Some Vietnamese consider profuse praise as mockery
- It is often better to focus on the quality of the mother's care – "the baby looks like you take care of him well."
- Talking about a new baby is an excellent time to introduce the idea that preventive medicine should be a regular part of the new child's experience. Well-baby visits may be an entirely new concept to some new mothers from other countries. Protective immunizations are often the most accepted form of preventive medicine. It may be helpful to explain well-baby visits and check-ups as a kind of extension of the immunization process.

Substance Abuse

- When asking question regarding issues of substance (or physical) abuse, concerns about family honor and privacy may come into play. For example, in Vietnamese and Chinese cultures family loyalty, hierarchy, and filial piety are of the utmost importance and may therefore have a direct effect on how a patient responds to questioning, especially if family members are in the same room. Separating family members, even if there is some resistance to the idea, may be the only way to accurately assess some of these problems.



- Gender roles are often expressed in the use or avoidance of many substances, especially alcohol and cigarettes. When discussing and treating these issues the social component of the abuse needs to be considered in the context of the patient's culture.
- Alcohol is considered part of the meal in many societies, and should be discussed together with eating and other dietary issues.

Physical Abuse

- Ideas about acceptable forms of discipline vary from culture to culture. In particular, various forms of corporal punishment are accepted in many places. Emphasis must be placed on what is acceptable ***here***, and what may cause physical harm.

- Women may have been raised with different standards of personal control and autonomy than we expect in the United States. They may be accepting physical abuse *not* because of feelings of low self-esteem, but because it is socially accepted among their peers, or because they have nobody they can go to with their concerns. It is important to treat these cases as social rather than psychological problems.

- Immigrants learn quickly that abuse is reported and will lead to intervention by police and social workers. Even victims may not trust doctors, social workers, or police. It may take time and repeated visits to win the trust of patients. Remind patients that they do not have to answer questions (silence may tell you more than misleading answers). Using depersonalized conversational methods will increase success in reaching reluctant patients.

- Families may have members with conflicting values and rules for acceptable behavior that may result in conflicting reports about suspected physical abuse. This does not necessarily mean that anyone is being deceptive, just seeing things differently. This may cause special difficulties for teens who may have adopted new cultural values common to Western society, but must live in families that have different standards and behaviors.

- Behavioral indicators of abuse are different in different cultures. Many people are not very emotionally and physically expressive of physical and mental pain. Learn about the cultural norms of your patient populations to avoid overlooking or misinterpreting unknown signs of trauma.

- Do not confuse physical evidence of traditional treatments with physical abuse. Acceptable traditional treatments, such as coin rubbing or cupping, may leave marks on the skin, which look like physical abuse. Always consider this possibility if you know the family uses traditional home remedies.

Communicating with the Elderly

- Always address older patients using formal terms of address unless you are directly told that you may use personal names. Also remind staff that they should do the same.
- Stay aware of how the physical setting may be affecting the patient. Background noise, glaring or reflecting light, and small print forms are examples of things that may interfere with communication. The patients may not say anything, or even be aware that something physical is interfering with their understanding.
- Stay aware that many people believe that giving a patient a terminal prognosis is unlucky or will bring death sooner and families may not want the patient to know exactly what is expected to happen. If the family has strong beliefs along these lines the patient probably shares them. Follow ethical and legal requirements, but stay cognizant of the patient's cultural perspective. Offer the opportunity to learn the truth, at whatever level of detail desired by the patient.
- It is important to explain the specific needs for having an advance directive before talking about the treatment choices and instructions. This will help alleviate concerns that an advance directive is for the benefit of the medical staff rather than the patient.
- Elderly, low-literacy patients may be very skilled at disguising their lack of reading skills and may feel stigmatized by their inability to read. If you suspect this is the case you should not draw attention to this issue but seek out other methods of communication.

EFFECTIVELY COMMUNICATING WITH THE ELDERLY

Older Adult Communication from Your Patients Perspective	
I Wish You Knew…	**I Wish You Would Do…**
I want to be respected and addressed formally. I appreciate empathy.	Introduce yourself and greet me with Mr., Mrs. or Ms. Avoid using overly friendly terms, patronizing speech such as "honey, dear" and baby talk. Be empathetic and try to see through my lens.
I want to be spoken to directly, even if my caregiver is with me. I want to participate in the conversation and in making decisions.	Don't assume I cannot understand or make decisions. Include me in the conversation. Speak to me directly and check for understanding.
I can't hear well with lots of background noise and it is hard to see with glaring or reflecting light.	When possible, try to find a quiet place when speaking to hard of hearing patients. If there is unavoidable noise, speak clearly, slower and with shorter phrases as needed. Adjust glare or reflecting light as much as possible
I may have language barrier and cultural beliefs that may affect adherence to the treatment plan.	Offer language assistance to help us better understand each other. Ask about cultural beliefs that may impact my adherence to the treatment plan. (See Kleinman's Questions)
Medical jargon and acronyms confuse me.	Use layperson language, not acronyms or popular slang terms.
I respect my doctor and am not always comfortable asking questions. I don't like to be rushed.	Encourage questions. Avoid interrupting or rushing me. Don't make me feel like you do not have time to hear me out. Give me time to ask questions and express myself. After you ask a question, allow time for responses. Do not jump quickly from one topic to another without an obvious transition.
Nodding my head doesn't always mean I understand,	Focus on what is most important for me to know. Watch for cues to guide communication and information sharing. Ask questions to see if I truly comprehend. Check for understanding using Teach-Back.
I need instructions to take home with me. I may be very skilled at disguising my lack of reading skills and may be embarrassed to tell you.	Explain what will happen next. Watch for cues that indicate vision or literacy issues to inform you about the best way to communicate with me. Don't draw too much attention to my reading skills. Seek appropriate methods to effectively communicate with me, including large font and demonstration.
Some topics such as advance directives or a terminal prognosis are very sensitive for me.	Explain the specific need of having an advance directive before talking about treatment choices to help me alleviate my concern that this advance directive is for the benefit of the medical staff and not me. Related to a terminal prognosis, follow ethical and legal requirements, but be aware of my cultural perspective. Offer me the opportunity to learn the truth, at whatever level of detail that I desire. My culture may be one that believes that giving a terminal prognosis is unlucky or will bring death sooner and my family and I may not want you to tell me directly.

Resources

- The Gerontological Society of America

  http://aging.arizona.edu/sites/aging/files/activity_1_reading_1.pdf

- American Speech Language Hearing Association

  http://www.asha.org/public/speech/development/Communicating-Better-With-Older-People/

- Administration for Community Living DHHS

  http://www.aoa.acl.gov/AoA_Programs/Tools_Resources/Older_Adults.aspx

- The **LOOK CLOSER, SEE ME** Generational Diversity and Sensitivity training program

  http://nursing.uc.edu/content/dam/nursing/docs/CFAWD/LookCloserSeeMe/Module%204_GDST_Reference%20Guide.pdf

PAIN MANAGEMENT ACROSS CULTURES

Your ability to provide adequate pain management to some patients can be improved with a better understanding of the differences in the way people deal with pain. Here is some important information about the cultural variations you may encounter when you treat patients for pain management.

These tips are generalizations only. It is important to remember that each patient should be treated as an individual.

Areas of Cultural Variation	Points to Consider	Suggestions
Reaction to pain and expression of pain	• Cultures vary in what is considered acceptable expression of pain. As a result, expression of pain will vary from stoic to extremely expressive for the same level of pain. • Some men may not verbalize or express pain because they believe their masculinity will be questioned.	• Do not mistake lack of verbal or facial expression for lack of pain. Under-treatment of pain is a problem in populations where stoicism is a cultural norm. • Because the expression of pain varies, ***ask*** the patient what level, or how much, pain relief they think they need. • Do not be judgmental about the way someone is expressing their pain, even if it seems excessive or inappropriate to you. The way a person in pain behaves is socially learned.
Spiritual and religious beliefs about using pain medication	• Members of several faiths will not take pain relief medications on religious fast days, such as Yom Kippur or daylight hours of Ramadan. For these patients, religious observance may be more important than pain relief. • Other religious traditions forbid the use of narcotics. • Spiritual or religious traditions may affect a patient's preference for the form of medication delivery, oral, IV, or IM.	• Consultation with the family and Spiritual Counselor will help you assess what is appropriate and acceptable. Variation from standard treatment regimens may be necessary to accommodate religious practices. • Accommodating religious preferences, when possible, will improve the effectiveness of the pain relief treatment. • Offer a choice of medication delivery. If the choice is less than optimal, ask why the patient has that preference and negotiate treatment for best results.
Beliefs About Drug Addiction	• Recent research has shown that people from different genetic backgrounds react to pain medication differently. Family history and community tradition may contain evidence about specific medication effects in the population. • Past negative experience with pain medication shapes current community beliefs, even if the	• Be aware of potential differences in the way medication acts in different populations. A patient's belief that they are more easily addicted may have a basis in fact. • Explain how the determination of type and amount of medication is made. Explain changes from past practices.

		what the patient may be using. There may be some reluctance to tell you about alternative therapies until they feel it is "safe" to talk about them. • Accommodate or integrate your treatments with alternative treatments when possible.
Methods Needed to Assess pain	• Most patients are able to describe their pain using a progressive scale, but others are not comfortable using a numerical scale, and the scale of facial expressions (smile to grimace) may be more useful.	• Ask the patient specifically how they can best describe their pain. • Use multiple methods of assessing pain-scales and analogies, if you feel the assessment of pain is producing ambiguous or incorrect results. • Once the severity of the pain can be assessed, explain in detail the expected result of the use of the pain medication in terms of whatever descriptive tools the patient has used. Check comprehension with teach-back techniques. • Instead of using scales, which might not be known to the patient, asking for comparative analogies, such as "like a burn from a stove," "cutting with a knife," or "stepping on a stone," may produce a more accurate description.

* **Note: Avoid** using family members as interpreters. **Minors** are **prohibited** from being used as interpreters. Find an interpreter with a health care background. **Document** in the patient's medical chart the request for or refusal of an interpreter.

SECTION D: REFERENCE RESOURCES FOR CULTURALLY AND LINGUISTIC SERVICES

A GUIDE TO INFORMATION IN SECTION D

Reference Resources for Culturally and Linguistic Services

Cultural and linguistic services have been mandated for federally funded program recipients in response to the growing evidence of health care disparities and as partial compliance with Title VI of the Civil Rights Act of 1964. The major requirements for the provision of cultural and linguistic services for patients in federally funded programs are included in this section.

Eliminate Health Disparities

Culturally and linguistically appropriate services are increasingly recognized as a key strategy to eliminating disparities in health and health care (e.g., Betancourt, 2004; 2006; Brach & Fraser, 2000; HRET, 2011). Among several other factors, lack of cultural competence and sensitivity among health and health care professionals has been associated with the perpetuation of health disparities (e.g., Geiger, 2001; Johnson, Saha, Arbelaez, Beach, & Cooper, 2004). This is often the result of miscommunication and incongruence between the patient or consumer's cultural and linguistic needs and the services the health or health care professional is providing (Zambrana, Molnar, Munoz, & Lopez, 2004). The provision of culturally and linguistically appropriate services can help providers address these issues by providing knowledge and skills to manage the provider-level, individual-level, and system-level factors referenced in the Institute of Medicine's seminal report Unequal Treatment that intersect to perpetuate health disparities (IOM, 2003).[1]

Health Equity & Culturally and Linguistically Appropriate Services are Connected

Culturally and linguistically appropriate services (CLAS) are one strategy to help eliminate health inequities. By tailoring services to an individual's culture and language preference, providers can help bring about positive health outcomes for diverse populations. The provision of health care services that are respectful of and responsive to the health beliefs, practices and needs of diverse patients can help close the gap in health care outcomes.1

This section includes:

- Current cultural and linguistic requirements for federally funded programs.
- Guidelines for cultural and linguistic services.
- Purpose of the enhanced National CLAS Standards.
- Web based resources for more information related diversity and the delivery of cultural and linguistic services.

[1] https://www.thinkculturalhealth.hhs.gov/

The following materials are available in this section:

45 CFR 92, Non Discrimination Rule	Language Assistance Services requirements as part of the Affordable Care Act modifications (2016).
Title VI of the Civil Rights Act of 1964	The Civil Rights Act of 1964 text.
Standards to Provide "CLAS" Culturally and Linguistically Appropriate Services	A summary of the fifteen "CLAS" standards.
Executive Order 13166, August 2000	The text of the Executive Order signed in August 2000 that mandated language services for Limited English Proficient (LEP) members enrolled in federally funded programs.
Race/Ethnicity/Language (REL) Categories	Importance of collecting REL and appropriate use.
Bibliography of Major Sources Used in the Production of the Tool Kit	A listing of resources that informed the work of the ICE Cultural and Linguistic Workgroup.
Cultural Competence Web Resources	A listing of internet resources related to diversity and the delivery of cultural and linguistic services.
Acknowledgement of Contributors from the ICE Cultural and Linguistic Workgroup	A listing of the contributors from the ICE Cultural and Linguistic Workgroup.

45 CFR 92, NON DISCRIMINATION RULE

§ 92.201 Meaningful access for individuals with limited English proficiency. (a) General requirement. A covered entity shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities. (b) Evaluation of compliance. In evaluating whether a covered entity has met its obligation under paragraph (a) of this section, the Director shall: (1) Evaluate, and give substantial weight to, the nature and importance of the health program or activity and the particular communication at issue, to the individual with limited English proficiency; and (2) Take into account other relevant factors, including whether a covered entity has developed and implemented an effective written language access plan, that is appropriate to its particular circumstances, to be prepared to meet its obligations in § 92.201(a). (c) Language assistance services requirements.

Language assistance services required under paragraph (a) of this section must be provided free of charge, be accurate and timely, and protect the privacy and independence of the individual with limited English proficiency. (d) Specific requirements for interpreter and translation services. Subject to paragraph (a) of this section: (1) A covered entity shall offer a qualified interpreter to an individual with limited English proficiency when oral interpretation is a reasonable step to provide meaningful access for that individual with limited English proficiency; and (2) A covered entity shall use a qualified translator when translating written content in paper or electronic form. (e) Restricted use of certain persons to interpret or facilitate communication.

A covered entity shall not: (1) Require an individual with limited English proficiency to provide his or her own interpreter; (2) Rely on an adult accompanying an individual with limited English proficiency to interpret or facilitate communication, except: (i) In an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available; or (ii) Where the individual with limited English proficiency specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances; (3) Rely on a minor child to interpret or facilitate communication, except in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available; or (4) Rely on staff other than qualified bilingual/multilingual staff to communicate directly with individuals with limited English proficiency. (f) Video remote interpreting services.

A covered entity that provides a qualified interpreter for an individual with limited English proficiency through video remote interpreting services in the covered entity's health programs and activities shall provide: (1) Real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication; (2) A sharply delineated image that is large enough to display the interpreter's face and the participating individual's face regardless of the individual's body position; (3) A clear, audible transmission of voices; and (4) Adequate training to users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the video remote interpreting. (g) Acceptance of language assistance services is not required. Nothing in this section shall be construed to require an individual with limited English proficiency to accept language assistance service.

TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

"No person in the United States shall, on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance."

Under Title IV, any agency, program, or activity that receives funding from the federal government may not discriminate on the basis of race, color or national origin. This is the oldest and most basic of the many federal and state laws requiring "meaningful access" to healthcare, and "equal care" for all patients. Other federal and state legislation protecting the right to "equal care" outline how this principle will be operationalized.

State and Federal courts have been interpreting Title VI, and the legislation that it generated, ever since 1964. The nature and degree of enforcement of the equal access laws has varied from place to place and from time to time. Recently, however, both the Office of Civil Rights and the Office of Minority Health have become more active in interpreting and enforcing Title VI.

Additionally, in August 2000, the U.S. Department of Health and Human Services Office of Civil Rights issued "Policy Guidance on the Prohibition against National Origin Discrimination As it Affects Persons with Limited English Proficiency." This policy established 'national origin' as applying to limited English-speaking recipients of federally funded programs.

NATIONAL STANDARDS TO PROVIDE "CLAS" CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES

The purpose of the enhanced National CLAS Standards is to provide a blueprint for health and health care organizations to implement CLAS that will advance health equity, improve quality, and help eliminate health care disparities. All 15 Standards are necessary to advance health equity, improve quality, and help eliminate health care disparities.

Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

4. Educate and train governance, leadership, and workforce in culturally and linguistically **appropriate policies and practices on an ongoing basis.**

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

EXECUTIVE ORDER 13166, AUGUST 2000

Improving Access to Services for Persons with Limited English Proficiency (Verbatim)

By the authority vested in me as President by the Constitution and the laws of the United States of America, and to improve access to federally conducted and federally assisted programs and activities for persons who, as a result of national origin, are limited in their English proficiency (LEP), it is hereby ordered as follows:

Section 1. Goals.

The Federal Government provides and funds an array of services that can be made accessible to otherwise eligible persons who are not proficient in the English language. The Federal Government is committed to improving the accessibility of these services to eligible LEP persons, a goal that reinforces its equally important commitment to promoting programs and activities designed to help individuals learn English. To this end, each Federal agency shall examine the services it provides and develop and implement a system by which LEP persons can meaningfully access those services consistent with, and without unduly burdening, the fundamental mission of the agency. Each Federal agency shall also work to ensure that recipients of Federal financial assistance (recipients) provide meaningful access to their LEP applicants and beneficiaries. To assist the agencies with this endeavor, the Department of Justice has today issued a general guidance document (LEP Guidance), which sets forth the compliance standards that recipients must follow to ensure that the programs and activities they normally provide in English are accessible to LEP persons and thus do not discriminate on the basis of national origin in violation of title VI of the Civil Rights Act of 1964, as amended, and its implementing regulations. As described in the LEP Guidance, recipients must take reasonable steps to ensure meaningful access to their programs and activities by LEP persons.

Sec. 2. Federally Conducted Programs and Activities.

Each Federal agency shall prepare a plan to improve access to its federally conducted programs and activities by eligible LEP persons. Each plan shall be consistent with the standards set forth in the LEP Guidance, and shall include the steps the agency will take to ensure that eligible LEP persons can meaningfully access the agency's programs and activities. Agencies shall develop and begin to implement these plans within 120 days of the date of this order, and shall send copies of their plans to the Department of Justice, which shall serve as the central repository of the agencies' plans.

Sec. 3. Federally Assisted Programs and Activities.

Each agency providing Federal financial assistance shall draft title VI guidance specifically tailored to its recipients that is consistent with the LEP Guidance issued by the Department of Justice. This agency-specific guidance shall detail how the general standards established in the LEP Guidance will be applied to the agency's recipients. The agency-specific guidance shall take into account the types of services provided by the recipients, the individuals served by the recipients, and other factors set out in the LEP Guidance. Agencies that already have developed title VI guidance that the Department of Justice determines is consistent with the LEP Guidance shall examine their existing guidance, as well as their programs and activities, to determine if additional guidance is necessary to comply with this order.

The Department of Justice shall consult with the agencies in creating their guidance and, within 120 days of the date of this order, each agency shall submit its specific guidance to the Department of Justice for review and approval. Following approval by the Department of Justice, each agency shall publish its guidance document in the Federal Register for public comment.

Sec. 4. Consultations.

In carrying out this order, agencies shall ensure that stakeholders, such as LEP persons and their representative organizations, recipients, and other appropriate individuals or entities, have an adequate opportunity to provide input. Agencies will evaluate the particular needs of the LEP persons they and their recipients serve and the burdens of compliance on the agency and its recipients. This input from stakeholders will assist the agencies in developing an approach to ensuring meaningful access by LEP persons that is practical and effective, fiscally responsible, responsive to the particular circumstances of each agency, and can be readily implemented.

Sec. 5. Judicial Review.

This order is intended only to improve the internal management of the executive branch and does not create any right or benefit, substantive or procedural, enforceable at law or equity by a party against the United States, its agencies, its officers or employees, or any person.

WILLIAM J. CLINTON

THE WHITE HOUSE

Office of the Press Secretary

(Aboard Air Force One)

For Immediate Release August 11, 2000

Reference: http://www.usdoj.gov/crt/cor/Pubs/eolep.htm

RACE/ETHNICITY/LANGUAGE (REL) CATEGORIES IMPORTANCE OF COLLECTING REL AND APPROPRIATE USE

Collecting REL information helps providers to administer better care for patients. Access to accurate data is essential for successfully identifying inequalities in health that could be attributed to race, ethnicity or language barriers and to improve the quality of care and treatment outcomes.
The health plans collect this data and can make this data available to providers upon request. Provider must collect member spoken language preference and document this on the member's record. Below is the listing of the basic race and ethnicity categories used by health plans.

Office of Management and Budget (OMB) Ethnicity Categories:

- Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
- Non-Hispanic or Latino: Patient is not of Hispanic or Latino ethnicity.
- Declined: A person who is unwilling to provide an answer to the question of Hispanic or Latino ethnicity.
- Unavailable: Select this category if the patient is unable to physically respond, there is no available family member or caregiver to respond for the patient, or if for any reason, the demographic portion of the medical record cannot be completed. Hospital systems may call this field "Unknown", "Unable to Complete," or "Other

Office of Management and Budget (OMB) Race Categories:

- American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
- Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- Black or African American: A person having origins in any of the black racial groups of Africa.
- Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands
- White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
- Some Other Race: A person who does not self-identify with any of the OMB race categories. *OMB-Mod
- Declined: A person who is unwilling to choose/provide a race category or cannot identify him/herself with one of the listed races.
- *Unavailable: Select this category if the patient is unable to physically respond, there is no available family member or caregiver to respond for the patient, or if for any reason, the demographic portion of the medical record cannot be completed. Hospital systems complete," or "Other. "may call this field "Unknown," "Unable to*

  Source: www.whitehouse.gov/omb/fedreg_race-ethnicity
  Reference: http://www.usdoj.gov/crt/cor/Pubs/eolep.htm

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www.whitehouse.gov/omb/fedreg_race-ethnicity

www.who.int.healthsystems/topics/equity

CULTURAL COMPETENCE WEB RESOURCES

U.S. Department of Health and Human Services - Think Cultural Health	https://www.thinkculturalhealth.hhs.gov
Diversity RX	http://diversityrx.org/resources
Institute for Healthcare Improvement	http://www.ihi.org/Pages/default.aspx
U.S. Department of Health and Human Services - Office of Minority Health	http://www.minorityhealth.hhs.gov/
Cross Cultural Health Care Program	http://xculture.org
National Institute of Health	https://www.nih.gov
U.S. Department of Health and Human Services – Health Resources and Services Administration	http://www.hrsa.gov/culturalcompetence/index.html
Provider's Guide to Quality & Culture	http://www.msh.org/resources/providers-guide-to-quality-culture
U.S. Department of Justice – Civil Rights Division	https://www.justice.gov/crt
National Center for Cultural Competence – Georgetown University	http://www.nccccurricula.info/awareness/C7.html
Industry Collaboration Effort (ICE)	http://iceforhealth.org/aboutice.asp

Remember – Web pages can expire often. If the web address does not work, use Google and search under the organization's name.

GLOSSARY OF TERMS

Auxiliary Aid

services or devices that enable persons with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in, and enjoy the benefits of, programs or activities conducted by the agency.

American Sign Language Auxiliary Aid

services or devices that enable persons with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in, and enjoy the benefits of, programs or activities conducted by the agency.

American Sign Language (ASL)

a nonverbal method of communicating by deaf or speech-impaired people in which the hands and fingers are used to indicate words and concepts.

Barrier

an obstacle, impediment, obstruction, boundary, or separation.

Braille

a system of reading and printing that enables the blind to read by using the sense of touch. Raised dots arranged in patterns represent numerals and letters of the alphabet and can be identified by the fingers.

Body Language

the revelation of attitude or mood through physical gestures, posture, or proximity; nonverbal communication.

Communication

the sending of data, messaged, or other forms of information from one entity to another.

Communication, Impaired Verbal

the state in which a person experiences a decreased, delayed, or absent ability to receive, process, transmit, and use a system of symbols or anything that conveys meaning.

Communication, Nonverbal

in interpersonal relationships, the use of communication techniques that do not involve words.

Cultural Competence

sensitivity to the cultural, philosophical, religious, and social preferences of people of varying ethnicities or nationalities. Professional skill in the use of such sensitivities facilitates the giving of optimal patient care.

Culture

shared human artifacts, attitudes, beliefs, customs, entertainment, ideas, language, laws, learning, and moral conduct.

Demographics

of or related to the study of changes that occur in the large groups of people over a period of time.

Disability

any physical, mental, or functional impairment that limits a major activity. It may be partial or complete.

Discrimination

the process of distinguishing or differentiating. **2.** Unequal and unfair treatment or denial of rights or privileges without reasonable cause.

Diverse

of a different kind, form, character, etc.; unlike. **2.** including representatives from more than one social, cultural, or economic group, especially members of ethnic or religious minority groups.

Engagement

in the behavioral sciences, a term often used to denote active involvement in everyday activities that have personal meaning.

Gender Identity

ones self-concept with respect to being male or female: a person's sense of his or her true sexual identity.

Health Disparities

is often interpreted to mean racial or ethnic disparities, many dimensions of disparity exist in the United States, particularly in health. If a health outcome is seen to a greater or lesser extent between populations, there is disparity. Race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location all contribute to an individual's ability to achieve good health.

Health Equity

an avoidable and unfair difference in health status between segments of the population.

Health Literacy

the ability to understand the causes, prevention, and treatment of disease. **2.** the degree of communication that enhances people's related information.

Interpretation
: In psychotherapy, the analysis of the meaning of what the patient says or does. It is explained to the patient to help provide insight.

Interpreter
: one who translates orally for parties conversing in different languages.

Language
: the spoken or written words or symbols used by a population for communication.

Limited English Proficient (LEP)
: is a term used in the United States that refers to a person who is not fluent in the English language, often because it is not their native language.

Mnemonic
: Anything intended to aid memory.

Race
: the descendants of a genetically cohesive ancestral group. **2.** A political or social designation for a group of people thought to share a common ancestry or common ethnicity.

Resource
: an asset valuable commodity or service.

Service
: help or assistance.

Speech
: the oral expression of one's thoughts. **2.** the utterance of articulate words or sounds.

Speech transliterator
: a person trained to recognize unclear speech and repeat it clearly

Teletypewriter
: a telegraphic apparatus by which signals are sent by striking the letters and symbols of the keyboard of an instrument resembling a typewriter and are received by a similar instrument that automatically prints them in type corresponding to the keys struck.

Transgender
: an umbrella term for people whose gender identity and/or gender expression differs from what is typically associated with the sex they were assigned at birth.

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Guidance to Comply with New Interpreter Quality Standards
Requirements on the use of Bilingual/Multilingual Staff as Interpreters

Summary of Requirements and Documentation		
Requirement	**Potential Evidence**	**Provider Office to Note Documentation of Qualification**
Office has a documented policy to offer interpreter support to LEP patients	☐ Local office written policy; or ☐ Local office policy that defers and adheres to the policy distributed by medical group Note: Policy includes documentation of patient language needs in medical record	Written policy available for viewing by an auditor Policy title:
Adheres to generally accepted interpreter ethics principles, including client confidentiality	Signed attestation of understanding of interpreter ethics and patient confidentiality. Must include a review of National Code of Ethics for Interpreters in Health Care published at: http://www.ncihc.org/assets/documents/publications/NCIHC%20National%20Standards%20of%20Practice.pdf	Signed attestations are available. ☐ Yes ☐ No
Has *demonstrated* proficiency in speaking and understanding both spoken English and at least one other spoken language	☐ Formal assessment of proficiency; or ☐ Annual job performance evaluations that document proficiency in speaking and communicating in English and one other language	☐ Yes, assessment results are available for viewing; or ☐ Yes, documentation from an annual job performance evaluation for proficiency in speaking and communicating in English and one other language is available
Is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary terminology and phraseology	☐ Formal assessment of proficiency; or Annual performance evaluations document ☐ Ability to interpret effectively, ☐ Ability to interpret accurately, ☐ Ability to interpret impartially, ☐ Ability to interpret receptively and expressly, ☐ Ability to interpret to and from English and another language using any **necessary specialized vocabulary terminology and phraseology** Note: see NCIHC Interpreter Code of Ethics for description of above.	☐ Yes, assessment results are available for viewing; or ☐ Yes, documentation from an annual job performance evaluation for proficiency in speaking and communicating in English and one other language is available
For more information on Interpreter Quality Standards, please see the Industry Collaboration Effort (ICE) Better Communication, Better Care: Provider Tools to Care for Diverse Populations, Section D. **http://www.iceforhealth.org/library/documents/Better_Communication,_Better_Care_-_Provider_Tools_to_Care_for_Diverse_Populations.pdf**		

Language Proficiency Assessment Resources

The bilingual assessment vendors included on this list are suggestions that providers might consider if they choose to use a bilingual assessment vendor to help ensure that they are using qualified bilingual staff to provide patient care, as these organizations have self-attested that they meet the required criteria. However, that should not be considered an endorsement for any language service vendor by ICE. The ICE C&L Team has not in the past and does not now endorse any language service vendors.

Language Proficiency Assessment Resources						
		Description & Types of Services				
Organization	**Website / Contact Information**	**# of Offered Languages**	**Custom to Medical Specialty**	**Assessments**	**Certification &/or Experience**	**Cost**
Berkeley Language Institute (BLI) Supports the client's efforts to adhere to Federal, Department of Health & Human Services Standards for CLAS, and State laws and regulations (DMC and Joint Commission).	http://www.berkeleylanguageinstitute.com/index.html 1-510-655-9469 Marci Valdivieso marci@berkeleylanguageinstitute.com	**8 languages offered**: Arabic, Chinese (Mandarin, Cantonese, and Taishanese/ Toisan), French, Korean, Russian, Spanish, Tagalog, Vietnamese	Yes	• Professional language assessments for interpreters, translators, & bilingual speakers • Language Proficiency Oral Assessment – ideal for current & pre-employment bilingual employees • Language Proficiency Written Assessment • Medical Staff Oral Assessment • Healthcare Interpreter Assessments	Evaluators are experienced linguists that have: • At least five years interpreter & translator experience • Have shown an aptitude to be language evaluators. • They are generally certified by/with the National Board or CCHI if the language pair is an option, or • They are otherwise assessed and trained prior to being given evaluation assignments	Cost will vary depending on language pair and type of assessment $115 - $190/ person
Culture Advantage Designed by a culturally-diverse team of healthcare professionals & certified medical interpreters.	https://cultureadvantage.org/ 1-316-217-0198 Marlene Obermeyer, MA, RN director@cultureadvantage.org	**10 languages offered**: Arabic, Chinese Mandarin, Japanese, Farsi, Korean, Portuguese, Russian, Spanish, Tagalog, Vietnamese	Yes All medical specialties offered in the professional program	• Bilingual Staff Medical Interpreting Skills Assessment (MISA) • Specialty-specific Medical Interpreting Skills Assessment	• Evaluators are healthcare professionals who speak the language pair & have received a Professional Clinical Interpreter Certificate; Evaluators may partner with a CMI/CHI who speaks the language pair	Cost will vary $200 /MISA $250 - $950 for Online Courses
ISI Language Solutions ITAP helps healthcare facilities meet the linguistic and cultural requirements of Title VI of the Civil Rights Act, HIPAA, Medicare, Medicaid, Healthcare Reform, JCAHO and state regulations.	https://isilanguagesolutions.com/industries/healthcare/ 1-818-753-9181 John Lopez john@isitrans.com Christina Xu Christina@isitrans.com	**22 languages offered**: Arabic, Armenian, Bengali, Chinese (Cantonese & Mandarin), Farsi, French, Georgian, Gujarati, Hebrew, Hindi, Hmong, Japanese, Khmer, Korean, Portuguese, Russian, Spanish, Tagalog, Thai, Vietnamese	No	• Interpreter Training Assessment Program (ITAP) – 4 modules implemented individually or as a whole ○ Language Proficiency Assessment ○ Building Cultural Competency Workshop ○ Medical Terminology Workshop ○ Medical Interpreting Ethics and Protocol Workshop	Professional Linguists • Certification or Accreditation from American Translators Association (ATA) or equivalent organization • Degree in Translation or foreign equivalent • Subject-Matter expertise in the field of Life Sciences • Extensive experience in translation and linguistics	Must contact for costs Cost example: • Flat rate/ test - $80

To report any updates to this document, i.e., an organization that should no longer be included, or an organization that meets the criteria and should be included on this document, please contact: Ivy Diaz at ivy.diaz@healthnet.com or Valencia Walker at: ValenciaDenise.Walker@Cigna.com.

Language Proficiency Assessment Resources

		Description & Types of Services				
Organization	**Website / Contact Information**	**# of Offered Languages**	**Custom to Medical Specialty**	**Assessments**	**Certification &/or Experience**	**Cost**
Language Line Academy (LLA) Our professional testing and training ensures the qualifications and skills of bilingual and interpreter staff for effective communication and documented proof for compliance with laws and regulations.	https://www.langualeline.com/ 1-844-552-8378 Ana Catalina Arguedas Fernández lla@languageline.com	**1 language offered**: Spanish	Yes Pediatrics Mental Health OB/Gyn Ophthalmology Gastroenterology Oncology Cardiology Pharmacy	• Healthcare Bilingual Fluency assessment for clinicians and medical staff • Certificate of Competency in Medical Interpreting – test takes 45 minutes to one hour • Interpreter Readiness Assessment • Interpreter Skills Test	LLA testers have a variety of qualifications, including: • M.A., Translation & Interpretation • Years of medical interpreting experience • External interpreter certification credentials	Cost will vary $145 - $160/ test Volume discounts available
Language Testing International (LTI) In partnership with the American Council on the Teaching of Foreign Languages (ACTFL), we proudly offer our corporate clients valid and reliable reading, writing, speaking, and listening tests.	https://www.languagetesting.com/ 1-800-486-8444 Marketing/ Scheduling Team Diane ext. 123 Dina ext. 127 info@languagetesting.com	**100+ languages offered**, most popular: Arabic, French, German, Italian, Korean, Mandarin, Pashto, Persian Farsi, Portuguese, Russian, Spanish View complete list of languages online	Offers general testing/ proficiency assessments Does not specifically assess proficiency for healthcare interpretation or translation services	• Oral Proficiency Interview 15 – 30 minute telephonic interview • Oral Proficiency Interview – Computer 20 – 40 minute on-demand, internet or phone-delivered proficiency test • Writing Proficiency Test via the web 20 – 80 minutes • Listening Proficiency Test 50 – 125 minutes • Reading Proficiency Test 50 – 125 minutes	LTI strictly uses • Certified ACTFL testers and raters Ensuring quality and validity of tests	Contact for costs Package options available for some languages Cost examples: • $100 - $200/ person for phone survey • $159 for web based proctoring
MasterWord For professionals working in healthcare organizations, we aid in ensuring compliance with The Joint Commission, CLAS, as well as Section 1557 of the ACA standards with our impactful cultural competency training.	https://www.masterword.com/ 1-866-716-4999 masterword@masterword.com	**250+ languages offered** for interpreting and translation **Contact for languages offered for proficiency assessments**	Not specified Offers On Demand training & Webinars for Healthcare, includes: • Maternal Fetal Medicine • Cardiology • Mental Health • Oncology • Emergency	• Language Proficiency Assessment: 60 minutes Contact for languages • Health Care Interpreter Assessment (HCIA®): 32 min. / 45 min. –oral / written Currently the full assessment is available in Spanish, Arabic, Vietnamese, Chinese Mandarin, and Burmese. Other languages are also assessed by professional evaluators using a modified version of this assessment.	Assessments based on formats of CCHI & NBCMI national certification exams	On Demand Assessments: $105 - $155

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Ivy Diaz at ivy.diaz@healthnet.com or Valencia Walker at: ValenciaDenise.Walker@Cigna.com.

COMMUNICATIONS TOOL KIT

This document will help you in the design of written materials to be both inclusive, sensitive, and compliant with the National Culturally and Linguistically Appropriate Service (CLAS) Standards and Section 1557 of the Affordable Care Act (ACA).

We do not want to be exclusionary, insensitive, or contribute to people feeling they are not welcome. Using gender neutral and culturally sensitive wording when creating any documents-whether for staff, members, providers, or the community is best practice, aligns with regulations and it fosters inclusivity. We need to be aware of the language we use. Utilize the below list when writing or reviewing documents. The list includes either offensive or non-inclusive phrases or words that have been found in materials, written as indicated. When reviewing documents, perform a search for the words as written below in the various ways (utilize the "find" function – select "Control F") and replace them with sensitive terms as applicable:

Exclusionary	***Inclusive***
his, her, his or her, his/her	their, the members
he, she, he or she, he/she	they, the members
him, her, him or her, him/her	them
himself, herself, himself or herself	themselves
woman, man, men or women	the member or the individual, members or individuals
gender specific screenings – well-woman etc.	take out the gender term and leave as "preventative screening" or "annual well-check". In general we need to use medical terms – do not "gender" services. Documents often reference "women should have a mammogram…" and instead should say "members should have a mammogram" etc.
pregnant women, pregnant woman	pregnant individuals, child-bearers, child-bearer
mother, father , mom, dad	parent as applicable
maternity	excluding any formal contract/program language requirement or information-change to "pregnancy", "childbirth", "pregnancy and childbirth" "prenatal", "postnatal" etc. as applicable
Gender-Male, Female - Sex and Gender/Gender Identity are different. Stay away from using them synonymously because it can be exclusionary; sex should reference medical terminology and gender/gender identity should reference the social construct of gender/gender identity…gender identities.	When need to know sex – include sex terms: male, female, or intersex When need to know gender – include gender/gender identity terms: woman, man, transgender, boy, girl, nonbinary, gender fluid, two-spirit, etc.- many more terms available. Consider asking "sex assigned at birth" and "gender identity" to be more inclusive.
both sexes	for sex there is male, female, intersex if inferring gender/gender identity there are many terms (based on context change to "individuals" or just say "sex" of member or "gender identity of member")

Offensive/Insensitive	***Sensitive***
hearing impaired	deaf or hard of hearing
visual impairment	blind or low vision
LEP members	members with limited English proficiency
gender reassignment surgery, sex change	gender affirming surgery, transition
sexual preference	sexual orientation
hermaphrodite, hermaphroditism	"intersex" if applicable or if actually referencing gender affirming procedures, use "gender affirming treatment"
transgenders, a transgender, transgendered	Transgender should be used as an adjective, not a noun. For example, "Tony is a transgender man". Adding "ed" is insensitive-being transgender is a part of someone's identity, nothing happened to make someone transgender as the "ed" may suggest.

For additional questions on creating culturally sensitive materials:
email Ivy Diaz at ivy.diaz@healthnet.com or Peggy Payne, ICE Co-Chair at peggy.payne@cigna.com

24-888/BKT1617350EH02w (9/24)

INPATIENT CALIFORNIA HEALTHNET COMMERCIAL PRIOR AUTHORIZATION

Complete and **Fax** to: 1-844-694-9165

HMO

POS

PPO

Standard requests - Determination within 5 business days of receiving all necessary information.

Urgent requests - I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 72 hours to avoid complications and unnecessary suffering or severe pain.

X

URGENT REQUESTS MUST BE SIGNED BY THE PHYSICIAN TO RECEIVE PRIORITY

***Indicates Required Field**

MEMBER INFORMATION

Last Name, First

*Date of Birth

*Member ID

(MMDDYYYY)

REQUESTING PROVIDER INFORMATION

Requesting Provider Contact Name

*Requesting NPI

*Requesting TIN

Phone

Requesting Provider *Address*

*Fax

City, State, Zip

SERVICING PROVIDER / FACILITY INFORMATION

Same as Requesting Provider

Servicing Provider Contact Name

*Servicing NPI

*Servicing TIN

Phone

Servicing Provider/Facility Name Address

Fax

City, State, Zip

AUTHORIZATION REQUEST

***Primary** Procedure Code

(CPT/HCPCS) (Modifier)

Additional Procedure Code

(CPT/HCPCS) (Modifier)

***Start Date** OR Admission Date

(MMDDYYYY)

*Diagnosis Code

(ICD-10)

Additional Procedure Code

(CPT/HCPCS) (Modifier)

Additional Procedure Code

(CPT/HCPCS) (Modifier)

Discharge Date (if applicable) otherwise Length of Stay will be based on Medical Necessity

(MMDDYYYY)

Additional Diagnosis Code

(ICD-10)

*INPATIENT SERVICE TYPE

(Enter the Service type number in the boxes)

Delivery
779 C-Section Delivery
720 Vaginal Delivery

Inpatient Rehab
427 Rehab

Transplant
992 Transplant

Miscellaneous
121 Long Term Acute Care
970 Medical
414 Premature/False Labor
402 Skilled Nursing Facility
411 Surgical
490 Boarder Baby
300 Neonate

Miscellaneous
121 Hospice Inpatient
492 Sub Acute

Behavioral Health
528 BH Chemical Substance Abuse
529 BH Psychiatric Admission

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Rev. 02242021
XD-PAF-1653

No-Cost Interpreter Services Available 24/7 for Your Patients

Your patients can access no-cost interpreter services.

Phone interpreters are available in over 150 languages for immediate needs.

Request in-person or video interpreters a minimum of five business days before the appointment during regular business hours. Allow 10 business days for in-person sign language interpreter requests.

When asking for an interpreter, tell us:

- The member's Health Net identification (ID) number
- The appointment date, time and place
- Language needed

Please allow for a phone interpreter if that is the only interpreter available for the language, date and time of the appointment.

Ask for no-cost interpreter services to help you effectively communicate with your patients.

Line of business	Phone number	Hours of availability
Individual & Family Plans (Ambetter PPO)	844-463-8188	Monday through Friday, 8 a.m. to 5 p.m., Pacific time (see below for after hours)
Individual & Family Plans (Ambetter HMO)	888-926-2164	
Employer Group HMO, POS and PPO	800-641-7761	
After-hours language assistance line	800-546-4570	Monday through Friday, 5 p.m. to 8 a.m., Pacific time; weekends and holidays
Medi-Cal	800-675-6110	Monday through Friday, 8 a.m. to 6 p.m., Pacific time. For after hours select member option
Behavioral Health	800-647-7526	Monday through Friday, 8 a.m. to 5 p.m., Pacific time (not available for after hours)

For office use only. Do NOT post in a patient area.

Phone numbers listed here are for provider use only. Members may contact the number listed on the back of their ID card for member services.

24-1158 (11/24)

wellcare By health net

Akorbi
PEOPLE ■ TECHNOLOGY ■ LANGUAGE

Access interpretation services 24/7 at no cost. This chart includes languages commonly spoken in your community; additional languages are available.

English
Do you speak [language]? We will provide an interpreter at no personal cost to you.

Amharic (አማርኛ)
አማሪኛ ይናገራሉ? እርሶ በግልዎ ምንም ወጪ ሳያወጡ አስተርጓሚ እናቀርባለን።

Arabic (اللغة العربية)
هل تتحدث اللغة العربية؟ سوف نوفر لك مترجماً فورياً من دون أي تكلفة عليك.

Armenian (հայերէն)
Դուք հայերեն եք խոսում: Մենք Ձեզ անվճար թարգմանիչ կտրամադրենք:

Bengali (বাংলা)
আপনি কি বাংলায় কথা বলেন? আমরা আপনাকে একজন দোভাষী দেবো যার জন্য আপনার ব্যক্তিগতভাবে অর্থ ব্যয় করতে হবে না।

Burmese (မြန်မာ)
သင် မြန်မာစကား ပြောပါသလား။ သင့်အတွက် ကုန်ကျစရိတ် မရှိစေဘဲ စကားပြန်တစ်ဦး ကျွန်ုပ်တို့ ပေးပါမည်။

Cambodian (ភាសាខ្មែរ)
តើអ្នកនិយាយភាសាខ្មែរដែរទេ? យើងខ្ញុំនឹងផ្តល់ជូនអ្នកបកប្រែភាសាដោយឥតគិតថ្លៃផ្ទាល់ខ្លួនដល់អ្នក។

Cantonese (粵語)
您講粵語嗎？我們將免費為您提供翻譯 。

Farsi (فارسی)
فارسی صحبت می‌کنید؟ یک مترجم شفاهی رایگان در اختیار شما قرار خواهیم داد.

French (Français)
Vous parlez français ? Nous vous fournirons gratuitement un interprète.

Greek (Ελληνικά)
Μιλάτε ελληνικά; Θα σας παρέχουμε ένα διερμηνέα χωρίς καμία οικονομική επιβάρυνση για εσάς.

Hindi (हिन्दी)
क्या आप हिंदी बोलते हैं? हम आपके लिए बिना किसी लागत के एक दुभाषिया उपलब्ध कराएंगे।

Hmong (Hmoob)
Koj puas yog ib tus neeg uas hais tau lus Hmoob? Peb yuav nrhiav kom muaj ib tug kws txhais lus rau koj uas yeej tsis muaj nqi dab tsi rau koj them li.

Japanese (日本語)
日本語を話せますか？ 通訳が必要な場合、
こちらで無料で手配させていただきます。

Korean (한국어)
한국어를 사용하십니까? 무료로 통역 서비스를 제공해 드리겠습니다.

Lao (ພາສາລາວ)
ທ່ານເວົ້າພາສາບໍ? ພວກເຮົາຈະຈັດກຽມນາຍແປພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ.

Mandarin (中文)
您講中文嗎? 我們將免費為您提供翻譯。

Mixteco
¿Ka'an ndávi ni? Ná ke'eí un ña'a noo meni ta koo ya'avian.

Navajo (Diné bizaad)
Diné k'ehjíísh yánílti'? Ata' halne'ígíí náhóló t'áájíík'eh.

Portuguese (Português)
Você fala português? Nós lhe forneceremos um intérprete, sem qualquer custo adicional.

Punjabi (ਪੰਜਾਬੀ)
ਕੀ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ? ਅਸੀਂ ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਨਿੱਜੀ ਲਾਗਤ ਦੇ ਇੱਕ ਦੁਭਾਸ਼ੀਆ ਉਪਲਬਧ ਕਰਾਂਗੇ।

Russian (Русский)
Вы говорите по-русски? Мы предоставим вам переводчика бесплатно.

Spanish (Español)
¿Habla español? Le proporcionaremos un intérprete sin costo alguno para usted.

Tagalog
Nakapagsasalita ka ba ng Tagalog? Magbibigay kami ng interpreter nang wala kang babayaran.

Thai (ภาษาไทย)
คุณพูดภาษาไทยใช่หรือไม่
เราจะจัดหาล่ามให้คุณโดยไม่มีค่าใช้จ่ายส่วนตัว

Vietnamese (Tiếng Việt)
Quý vị có nói tiếng Việt không? Chúng tôi sẽ cung cấp một thông dịch viên miễn phí cho quý vị.

American Sign Language (ASL)

Please call Provider Services using the number on the member's ID card or contact 800-929-9224.

For office use only. Do NOT post in a patient area.

ADULT HEALTH MAINTENANCE CHECKLIST

Name: _____ D.O.B. _____

Age: _____ Sex: Male Female MR# _____

Immunizations current: Yes No
(See Immunization list below)

TB Risk: Yes No
(Every Periodic Physical Examination)

Advanced Directive discussed: Yes No

Date Discussed: _____

Examination & Tests	Age Range	Frequency	DATE DONE	DATE DONE	DATE DONE
INITIAL HEALTH ASSESSMENT	18 yrs. and older	Within 120 days of effective date with Plan or effective date with the PCP. May be requested from Previous PCP if done within last year.			
IHEBA/"Staying Healthy"	18 yrs and Older	Within 120 days of effective date with Plan or effective date with the PCP. Reviewed at every Periodic Health Evaluation and re-administered every 3-5 years.	Record on Staying Healthy Form.		
Check-Up Visit	18 yrs. and older	Every 1-3 years			
	Age > 65	Annually			
Cholesterol	Male, 35 yrs. and older	Every 5 years			
	Female, 45 yrs. and older	Every 5 years			
Diabetes Mellitus Screening	As risk factors indicate	PRN			
Urinalysis	65 yrs. and older	PRN			
Breast Exam	Age > 40 yrs.	Annually			
Mammography	50-74 yrs.	Every 2 years			
Pelvic Exam	19-39 yrs.	Every 1-3 yrs.			
	40 and older	Annually			
Pap Smear	Onset of sexual activity or 21-65 yrs.	Every 1 to 3 yrs. At 65 discontinue routine screening if previous screenings negative. Discontinue at age 70 unless clinically indicated.			
Chlamydia	< age 25, all sexually active non-pregnant women > age 25, as risk factors indicate				
Bone Density	65 yrs. and older	At least once			
Vitamin D Deficiency	65 yrs. and older	At clinician's discretion			
TSH Screening	40 yrs. and older	Every 5 years			
Fecal Occult Blood	50-75 yrs., then at clinician's discretion	Annually			
Sigmoidoscopy	50 and older	3-5 yrs.			
	High Risk	PRN			
Colonoscopy	50 and older	Every 10 years			
Prostate Exam	Physician discretion and as clinically indicated	PRN			
PSA	50 and older or as clinically indicated	PRN			
Adult Immunizations					
Tetanus-Diptheria-Pertussis(Tdap) Tetanus-Diphtheria (Td)	18 yrs. and older 18 yrs. and older	1 dose only Every 10 yrs.			
HPV	Females, 18-26 yrs. (HPV2 or HPV4) Males, 18-26 yrs (HPV 4)	3 doses			
Varicella	18 yrs. and older	2 doses if no evidence of immunity			
Zoster	60 yrs. and older	1 dose			
MMR	Born 1957 or after Born before 1957	1-2 doses unless immunity documented Considered immune, unless documentation of immunity required			
Influenza	18 yrs. and older	Annually			
Pneumococcal	18 yrs. and older	1-2 doses, when clinically indicated			
Hepatitis A	18 yrs. and older	2 doses			
Hepatitis B	18 yrs. and older	3 doses			
Meningococcal	18 yrs. and older	1 dose, 2nd dose if high risk			

Advanced Directive Education: Date_________
Refused______ Yes_______ Initials:_______

Advanced Directive Education: Date_________
Refused______ Yes_______ Initials:_______

Advanced Directive Education: Date_________
Refused______ Yes_______ Initials:_______

Advanced Directive Education: Date_________
Refused______ Yes_______ Initials:_______

Advanced Directive Education: Date_________
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Advanced Directive Education: Date_________
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Advanced Directive Education: Date_________
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Refused______ Yes_______ Initials:_______

Advanced Directive Education: Date_________
Refused______ Yes_______ Initials:_______

Advanced Directive Education: Date_________
Refused______ Yes_______ Initials:_______

LAST NAME: **FIRST NAME:** **MRN#**

PLACE OF SCREENING: **CIRCLE ONE:** ANSI - #____ ISO - #____

AUDIOMETER: **SCORING:** Child responds at 25 dB: Child does not respond at 25 dB: ☐

DATE OF LAST CALIBRATION: **AGE:**

1st Screen Date:_____	RIGHT Ear	1000	2000	3000	4000	LEFT Ear	1000	2000	3000	4000
2nd Screen Date:_____		1000	2000	3000	4000		1000	2000	3000	4000

Vision Test Date:_____		Right Eye	Left Eye
	Without Glasses	20/	20/
	With Glasses	20/	20/

Comments: _____

Referred To: _____

Signature & Title of Person Performing Test

DATE OF LAST CALIBRATION: **AGE:**

1st Screen Date:_____	RIGHT Ear	1000	2000	3000	4000	LEFT Ear	1000	2000	3000	4000
2nd Screen Date:_____		1000	2000	3000	4000		1000	2000	3000	4000

Vision Test Date:_____		Right Eye	Left Eye
	Without Glasses	20/	20/
	With Glasses	20/	20/

Comments: _____

Referred To: _____

Signature & Title of Person Performing Test

DATE OF LAST CALIBRATION: **AGE:**

1st Screen Date:_____	RIGHT Ear	1000	2000	3000	4000	LEFT Ear	1000	2000	3000	4000
2nd Screen Date:_____		1000	2000	3000	4000		1000	2000	3000	4000

Vision Test Date:_____		Right Eye	Left Eye
	Without Glasses	20/	20/
	With Glasses	20/	20/

Comments: _____

Referred To:

Signature & Title of Person Performing Test

HISTORIA MEDICA Y EXAMEN FISICO

MRN # _____

NOMBRE:	ESTADO CIVIL: ❑· S ❑ C ❑ V ❑ D ❑ SEP.	FECHA:
FECHA DE NACIMIENTO:	TEL (CASA):	TEL (TRABAJO):
OCUPACION/EMPLEADOR	Nº del Seg. Soc.:	Nº del SEGURO:

HISTORIA MEDICA FAMILIAR

SI ALGUN PARIENTE SANGUINEO HA TENIDO CUALQUIERA DE LAS SIGUIENTES ENFERMEDADES, PONGA UN CIRCULO ALREDEDOR DEL NUMERO E INDIQUE QUE PARIENTE.

1) ALCOHOLISMO
2) ANEMIA
3) ASMA
4) ARTRITIS
5) SANGRA FACILMENTE
6) CANCER
7) DIABETES
8) EPILEPSIA
9) GLAUCOMA
10) ASMA DEL HENO
11) ENFERMEDAD CARDIACA
12) HIPERTENSION
13) ENFERMEDAD RENAL
14) ENFERMEDAD MENTAL
15) MIGRAÑA
16) OSTEOPOROSIS
17) APOPLEJIA
18) TIROIDES
19)
20)

INTERNACIONES EN HOSPITALES

(sin incluir embarazos)

AÑO — ENFERMEDAD U OPERACION

ALERGIAS

Pasado:

Presente:

ANOTE TODOS LOS MEDICAMENTOS QUE TOMA AHORA: (incluso los que se venden sin receta médica)

1) _____ 7) _____
2) _____ 8) _____
3) _____ 9) _____
4) _____ 10) _____
5) _____ 11) _____
6) _____ 12) _____

VACUNA (Fecha de la última)	PRUEBA / EXAMEN (Fecha del último)
Tétano / Difteria	Colesterol
Influenza	Dental
Neumocócica	Vista
Hepatitis	Oído
	Rectal / Excremento
	Sigmoidoscopía
	Prueba cutánea de tuberculosis

HISTORIA MEDICA

Marque con una palomita (✓) e indique la edad en la que tuvo cualquiera de los siguientes síntomas o enfermedades. MARQUE con una equis (X) los problemas actuales.

PROBLEMAS PRINCIPALES 1) _____ 2) _____ 3) _____

❑ Oído disminuido
❑ Zumbido en el oído
❑ Infecciones de oído - *frecuentes*
❑ Mareos
❑ Falla de la vista ❑ Dolor del ojo
❑ Visión doble o borrosa
❑ Infecciones del ojo - *frecuentes*
❑ Sangrado de la nariz - *recurrentes*
❑ Problema del seno
❑ Dolores de garganta - *frecuentes*
❑ Asma del heno / Alergias
❑ Ronquera - *prolongada*
❑ Neumonía / Pleuresía
❑ Bronquitis / Tos crónica
❑ Asma / Jadeo
Falta de aliento:
❑ Haciendo esfuerzo
❑ Estando acostado
❑ Dolor del pecho
❑ Presión sanguínea alta
❑ Soplo cardíaco
❑ Pulso irregular
❑ Palpitaciones
❑ Tobillos hinchados
❑ Desmayos
❑ Dolor de pierna - *caminando*
❑ Venas varicosas / Flebitis
❑ Pérdida del apetito - *reciente*
❑ Dificultad para tragar

❑ Indigestión o acidez estomacal
❑ Ulceras pépticas
❑ Dolor abdominal - *crónico*
❑ Problema de vesícula biliar
❑ Ictericia / Hepatitis
❑ Cambio de hábitos de evacuación intestinal
❑ Diarrea ❑ Estreñimiento
❑ Diverticulosis
❑ Enfermedad de Crohn / Colitis
❑ Excrementos sanguinolentos o alquitranados
❑ Hemorroides
❑ Hernia
❑ Infecciones urinarias - frecuentes
❑ Sangre en la orina
❑ Emisión de orina ❑ Durante la noche más de dos veces
❑ Dolorosa
❑ Pérdida del control
❑ Disminución de la Fuerza/Flujo
❑ Cálculos renales
❑ Enfermedad venérea
❑ Derrame uretral
❑ Fatiga crónica
❑ Pérdida de peso - *reciente*
❑ Anemia
❑ Se magulla fácilmente

❑ Cancer
❑ Diabetes
❑ Enfermedad de tiroides
❑ Convulsiones / Ataques epilépticos
❑ Apoplejía
❑ Temblor / Manos temblantes
❑ Debilidad muscular
❑ Adormecimiento / Sensaciones de hormigueo
❑ Dolores de cabeza - *frecuentes*
❑ Artritis / Reumatismo
❑ Dolor de Espalda - *recurrente*
❑ Fracturas óseas / Lesión de articulaciones
❑ Gota
❑ Osteoporosis
❑ Dolor de pie
❑ Pies fríos y adormecidos
❑ Sarpullido
❑ Ronchas
❑ Psoriasis
❑ Eczema
❑ Sueño - *dificultad*
❑ Nerviosismo
❑ Depresión
❑ Pérdida de la memoria
❑ Mal humor - *excesivo*
❑ Fobias

❑ Enfermedad mental
❑ Varicela
❑ Poliomielitis
❑ Paperas
❑ Sarampión
❑ Rubéola
❑ Fiebre reumática
❑ Escarlatina
❑ Tuberculosis
❑ Herpes
❑ Contacto con sangre o fluidos corporales
❑ Alcohol _____ onzas por semana
❑ Fuma _____ cig. por día
Número de años_____
❑ Café / Té
Nº de tazas por día _____
❑ Directivas con adelanto

HOMBRES - Favor de completar
Fecha del último examen de próstata

❑ Normal ❑ Anormal
Fecha de la última PSA _____

MUJERES - Favor de completar
Flujo Menstrual:
❑ Reg. ❑ Irreg.
❑ Dolor / Cólico
Días de flujo _____
Duraciones del ciclo _____
Fecha del último período _____
❑ Dolor / Sangramiento durante o después del coito
Número de:
Embarazos _____
Abortos provocados _____
Abortos espontáneos _____
Nacimientos con vida _____
Método de control de la natalidad _____
Píldora de control de la natalidad (nombre) _____
❑ Calores súbitos / Menopausia
Fecha del último examen pélvico _____
Fecha de la última prueba de Papanicolaou _____
❑ Normal ❑ Anormal

Fecha del último examen de senos _____
Fecha del último mamograma ____
❑ Normal ❑ Anormal

SINOPSIS **PARA USO DE OFICINA SOLAMENTE:**

Directivas Anticipadas: ❑ Si ❑ No Educativo de Directivas Anticipadas: ❑ Cuestionario "Mantengase Saludable" Fecha:_____

Firma: Dr./Dra.

MEDICATION AND SUMMARY CHART MRN

NAME: **DATE OF BIRTH:** **HT:** **WT:**

ALLERGIES

Pharmacy Name & Telephone #

Patient's (home) Telephone #s: (work)

PROBLEM # START DATE	MEDICATION DOSAGE/FREQ.	REFILL DATES *(record any changes in dosage or frequency)*				STOP DATE OR CONTINUED

CHRONIC PROBLEM LIST

	Date Resolved
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	

Signature Page

(Please post on left-hand side of each Medical Record)

Please Write Signature as Entries are Typically Signed	Print Name in Full (First Name, Last Name, Title)

Health Net of California, Inc

Confidential - Protected Health Information

HEALTH NET MEMBER GRIEVANCE FORM

Name: _____Date: _____

Subscriber Identification Number: _____ Group Number: _____

Address:

_____

_____

_____

_____

Daytime Telephone No. _____

_____

Participating Physician Group: _____

_____

Please explain in detail the circumstances that led to your dissatisfaction with Health Net of California, Inc. (Health Net). It is essential that you list the dates, persons and facilities involved, as completely as possible. Please include the original copy of any claims or bills received which are related to your issue. (Be sure to make a copy for your records.) Use reverse side or additional paper if necessary. Mail this form and documents to: Health Net, Appeals and Grievances Department, P.O. Box 10348, Van Nuys, CA 91410-0348 or fax to (877) 831-6019.

Problem Statement: Date of Occurrence: _____Location: _____

Provider Name: _____

Describe the problem/complaint in detail:

_____

_____

_____

_____

_____

Use back of this form if additional space is needed.

Health Net's desire is to provide high quality medical care in the most satisfactory manner possible. To do this, we must be aware of any service difficulties you experience. By filling out this form, you are providing us with necessary information to continually maintain our high standards. We will respond to you in no later than 30 days. If you believe a delay in the decision making may impose an imminent and serious threat to your health, please contact our customer service department at 1-800-522-0088 to request an expedited review.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against t your health plan, you should first telephone your health plan at **1-800-522-0088** 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-HMO-2219) and a TDD line (1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

6003757 (8/2013), (9/2019)

ALERE LEVEL OF CARE CRITERIA

NICU – Revenue Code 174

1. Ventilator/Intubated
2. Extracorporeal Membrane Oxygenation (ECMO) / Nitric Oxide (NO)
3. Any nasal flow delivered at > 2 lpm. For infants < 1kg, any nasal flow delivered at > 1 lpm.
4. Chest Tube
5. Exchange transfusion, dialysis
6. IV bolus or continuous drip therapy for severe physiologic/metabolic instability
7. Apnea/bradycardia > 10 day all requiring tactile stimulation or any episodes requiring Positive Pressure Ventilation (PPV)
8. Unstable vital signs requiring therapy or conditions requiring frequent Vital Signs. (Medical Director consultation required prior to assignment).

TRANSITIONAL – Revenue Code 173

1. Isolette/Warmer for thermoregulation
2. Static ↓ oxygen requirement via nasal cannula (less than or equal to 2 lpm or hood
3. Enteral nutrition delivered by methods other than p.o.
4. Intravenous fluids/blood transfusion
5. Initial sepsis evaluation (CBC, blood culture and treatment in an asymptomatic patient on the first day of evaluation)
6. Apnea/bradycardia not meeting criteria in NICU level of care
7. Neonatal abstinence syndrome when (NAS) score are: greater than or equal to 8 on three consecutive scores or greater than or equal to 12 on two consecutive scores. (Medical Director consult required prior to assignment)

CONVALESCENT – Revenue Code 172

1. Phototherapy – intensive (double phototherapy or greater)
2. IV heplock meds
3. Neonatal Abstinence Syndrome when (NAS) scores are < 8
4. No Apnea/Bradycardia (greater than 48 hours since last episode, and otherwise meeting detained Level of Care I criteria.)
5. Diagnostic work-up/surveillance, otherwise stable using >1 consultant and/or diagnostic test.
6. Temperature instability
7. Advancing to full volume feeds
8. Stable with sub-optimal PO
9. Apnea countdown
10. Post hemorrhagic hydrocephalus

11. Growing preemie
12. Growing preemie who is stable except O_2 with feeds

DETAINED/NORMAL – Revenue Code 171

1. Diagnostic work-up/surveillance otherwise stable using 1 consultant or diagnostic test
2. Routine well baby care
3. Phototherapy (single source phototherapy)

Neonatal level of care determinations are subject to interpretation by the Alere Care Manager and Medical Director. The hospital representative has the right to discuss a determination with the Alere Care Manager and/or Medical Director and is provided the right to appeal levels of care assigned.

Nondiscrimination Notice

In addition to the State of California nondiscrimination requirements (as described in benefit coverage documents), Health Net of California, Inc. and Health Net Life Insurance Company (Health Net) comply with applicable federal civil rights laws and do not discriminate, exclude people or treat them differently on the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, sexual orientation, age, disability, or sex.

Health Net:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net's Customer Contact Center at:
Individual & Family Plan (IFP) Members On Exchange/Covered California 1-888-926-4988 (TTY: 711)
Individual & Family Plan (IFP) Members Off Exchange 1-800-839-2172 (TTY: 711)
Individual & Family Plan (IFP) Applicants 1-877-609-8711 (TTY: 711)
Group Plans through Health Net 1-800-522-0088 (TTY: 711)

If you believe that Health Net has failed to provide these services or discriminated in another way based on one of the characteristics listed above, you can file a grievance by calling Health Net's Customer Contact Center at the number above and telling them you need help filing a grievance. Health Net's Customer Contact Center is available to help you file a grievance. You can also file a grievance by mail, fax or email at:

Health Net of California, Inc./Health Net Life Insurance Company Appeals & Grievances
PO Box 10348, Van Nuys, CA 91410-0348

Fax: 1-877-831-6019
Email: Member.Discrimination.Complaints@healthnet.com (Members) or
Non-Member.Discrimination.Complaints@healthnet.com (Applicants)

For HMO, HSP, EOA, and POS plans offered through Health Net of California, Inc.: If your health problem is urgent, if you already filed a complaint with Health Net of California, Inc. and are not satisfied with the decision or it has been more than 30 days since you filed a complaint with Health Net of California, Inc., you may submit an Independent Medical Review/Complaint Form with the Department of Managed Health Care (DMHC). You may submit a complaint form by calling the DMHC Help Desk at 1-888-466-2219 (TDD: 1-877-688-9891) or online at www.dmhc.ca.gov/FileaComplaint.

For PPO and EPO plans underwritten by Health Net Life Insurance Company: You may submit a complaint by calling the California Department of Insurance at 1-800-927-4357 or online at https://www.insurance.ca.gov/01-consumers/101-help/index.cfm.

If you believe you have been discriminated against because of race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights (OCR), electronically through the OCR Complaint Portal, at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

FLY018690EP00 (6/18)

English
No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call the Customer Contact Center at the number on your ID card or call Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). For California marketplace, call IFP On Exchange 1-888-926-4988 (TTY: 711) or Small Business 1-888-926-5133 (TTY: 711). For Group Plans through Health Net, call 1-800-522-0088 (TTY: 711).

Arabic
خدمات لغوية مجانية. يمكننا أن نوفر لك مترجم فوري. ويمكننا أن نقرأ لك الوثائق بلغتك. للحصول على المساعدة اللازمة، يرجى التواصل مع مركز خدمة العملاء عبر الرقم المبين على بطاقتك أو الاتصال بالرقم الفرعي لخطة الأفراد والعائلة: 1-800-839-2172 (TTY: 711). للتواصل في كاليفورنيا، يرجى الاتصال بالرقم الفرعي لخطة الأفراد والعائلة عبر الرقم: 1-888-926-4988 (TTY: 711) أو المشروعات الصغيرة 1-888-926-5133 (TTY: 711). لخطط المجموعة عبر Health Net، يرجى الاتصال بالرقم 1-800-522-0088 (TTY: 711).

Armenian
Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են կարդալ ձեր լեզվով: Օգնության համար զանգահարեք Հաճախորդների սպասարկման կենտրոն ձեր ID քարտի վրա նշված հեռախոսահամարով կամ զանգահարեք Individual & Family Plan (IFP) Off Exchange՝ 1-800-839-2172 հեռախոսահամարով (TTY՝ 711): Կալիֆորնիայի համար զանգահարեք IFP On Exchange՝ 1-888-926-4988 հեռախոսահամարով (TTY՝ 711) կամ Փոքր բիզնեսի համար՝ 1-888-926-5133 հեռախոսահամարով (TTY՝ 711): Health Net-ի Խմբային ծրագրերի համար զանգահարեք 1-800-522-0088 հեռախոսահամարով (TTY՝ 711):

Chinese
免費語言服務。您可使用口譯員服務。您可請人將文件唸給您聽並請我們將某些文件翻譯成您的語言寄給您。如需協助，請撥打您會員卡上的電話號碼與客戶聯絡中心聯絡或者撥打健康保險交易市場外的 Individual & Family Plan (IFP) 專線：1-800-839-2172（聽障專線：711）。如為加州保險交易市場，請撥打健康保險交易市場的 IFP 專線 1-888-926-4988（聽障專線：711），小型企業則請撥打 1-888-926-5133（聽障專線：711）。如為透過 Health Net 取得的團保計畫，請撥打 1-800-522-0088（聽障專線：711）。

Hindi
बिना शुल्क भाषा सेवाएं। आप एक दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेजों को अपनी भाषा में पढ़वा सकते हैं। मदद के लिए, अपने आईडी कार्ड में दिए गए नंबर पर ग्राहक सेवा केंद्र को कॉल करें या व्यक्तिगत और फैमिली प्लान (आईएफपी) ऑफ एक्सचेंज: 1-800-839-2172 (TTY: 711) पर कॉल करें। कैलिफोर्निया बाजारों के लिए, आईएफपी ऑन एक्सचेंज 1-888-926-4988 (TTY: 711) या स्मॉल बिजनेस 1-888-926-5133 (TTY: 711) पर कॉल करें। हेल्थ नेट के माध्यम से ग्रुप प्लान के लिए 1-800-522-0088 (TTY: 711) पर कॉल करें।

Hmong
Tsis Muaj Tus Nqi Pab Txhais Lus. Koj tuaj yeem tau txais ib tus kws pab txhais lus. Koj tuaj yeem muaj ib tus neeg nyeem cov ntaub ntawv rau koj ua koj hom lus hais. Txhawm rau pab, hu xovtooj rau Neeg Qhua Lub Chaw Tiv Toj ntawm tus npawb nyob ntawm koj daim npav ID lossis hu rau Tus Neeg thiab Tsev Neeg Qhov Kev Npaj (IFP) Ntawm Kev Sib Hloov Pauv: 1-800-839-2172 (TTY: 711). Rau California qhov chaw kiab khw, hu rau IFP Ntawm Qhov Sib Hloov Pauv 1-888-926-4988 (TTY: 711) lossis Lag Luam Me 1-888-926-5133 (TTY: 711). Rau Cov Pab Pawg Chaw Npaj Kho Mob hla Health Net, hu rau 1-800-522-0088 (TTY: 711).

Japanese
無料の言語サービスを提供しております。通訳者もご利用いただけます。日本語で文書をお読みすることも可能です。ヘルプが必要な場合は、IDカードに記載されている番号で顧客連絡センターまでお問い合わせいただくか、Individual & Family Plan（IFP）（個人・家族向けプラン）Off Exchange：1-800-839-2172（TTY：711）までお電話ください。カリフォルニア州のマーケットプレイスについては、IFP On Exchange 1-888-926-4988（TTY：711）または Small Business 1-888-926-5133（TTY：711）までお電話ください。Health Netによるグループプランについては、1-800-522-0088（TTY：711）までお電話ください。

Khmer
សេវាភាសាដោយឥតគិតថ្លៃ។ លោកអ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ លោកអ្នកអាចស្តាប់គេអានឯកសារឱ្យលោកអ្នកជាភាសារបស់លោកអ្នក។ សម្រាប់ជំនួយ សូមហៅទូរស័ព្ទទៅកាន់មជ្ឈមណ្ឌលទំនាក់ទំនងអតិថិជនតាមលេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក ឬហៅទូរស័ព្ទទៅកាន់កម្មវិធី Off Exchange របស់គម្រោងជាលក្ខណៈបុគ្គល និងក្រុមគ្រួសារ (IFP) តាមរយៈលេខ៖ 1-800-839-2172 (TTY: 711)។ សម្រាប់ទីផ្សាររដ្ឋ California សូមហៅទូរស័ព្ទទៅកាន់កម្មវិធី On Exchange របស់គម្រោង IFP តាមរយៈលេខ 1-888-926-4988 (TTY: 711) ឬក្រុមហ៊ុនអាជីវកម្មខ្នាតតូចតាមរយៈលេខ 1-888-926-5133 (TTY: 711)។ សម្រាប់គម្រោងជាក្រុមតាមរយៈ Health Net សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-800-522-0088 (TTY: 711)។

Korean
무료 언어 서비스입니다. 통역 서비스를 받으실 수 있습니다. 문서 낭독 서비스를 받으실 수 있으며 일부 서비스는 귀하가 구사하는 언어로 제공됩니다. 도움이 필요하시면 ID 카드에 수록된 번호로 고객서비스 센터에 연락하시거나 개인 및 가족 플랜(IFP)의 경우 Off Exchange: 1-800-839-2172(TTY: 711)번으로 전화해 주십시오. 캘리포니아 주 마켓플레이스의 경우 IFP On Exchange 1-888-926-4988(TTY: 711), 소규모 비즈니스의 경우 1-888-926-5133(TTY: 711)번으로 전화해 주십시오. Health Net을 통한 그룹 플랜의 경우 1-800-522-0088(TTY: 711)번으로 전화해 주십시오.

Navajo
Doo bą́ąh ílínígóó saad bee háká ada'iiyeed. Ata' halne'ígíí da ła' ná hádídóot'įįł. Naaltsoos da t'áá shí shizaad k'ehjí shichį' yídooltah nínízingo t'áá ná ákódoolníił. Ákót'éego shíká a'doowoł nínízingo Customer Contact Center hoolyéhíjį' hodíílnih ninaaltsoos nanitingo bee néého'dolzinígíí hodoonihjį' bikáá' éí doodago kojį' hólne' Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). California marketplace báhígíí kojį' hólne' IFP On Exchange 1-888- 926-4988 (TTY: 711) éí doodago Small Business báhígíí kojį' hólne' 1-888-926-5133 (TTY: 711). Group Plans through Health Net báhígíí éí kojį' hólne' 1-800-522-0088 (TTY: 711).

Persian (Farsi)
خدمات زبان بدون هزینه. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید اسناد به زبان شما برایتان خوانده شوند. برای دریافت کمک، با مرکز تماس مشتریان به شماره روی کارت شناسایی یا طرح فردی و خانوادگی (IFP) Off Exchange به شماره: 1-800-839-2172 (TTY:711) تماس بگیرید. برای بازار کالیفرنیا، با IFP On Exchange شماره 1-888-926-4988 (TTY:711) یا کسب و کار کوچک 1-888-926-5133 (TTY:711) تماس بگیرید. برای طرح های گروهی از طریق Health Net، با 1-800-522-0088 (TTY:711) تماس بگیرید.

Panjabi (Punjabi)
ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਦੀ ਸੇਵਾ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਗਾਹਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ ਕਾਲ ਕਰੋ ਜਾਂ ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਯੋਜਨਾ (IFP) ਔਫ਼ ਐਕਸਚੇਂਜ 'ਤੇ ਕਾਲ ਕਰੋ: 1-800-839-2172 (TTY: 711)। ਕੈਲੀਫੋਰਨੀਆ ਮਾਰਕਿਟਪਲੇਸ ਲਈ, IFP ਔਨ ਐਕਸਚੇਂਜ ਨੂੰ 1-888-926-4988 (TTY: 711) ਜਾਂ ਸਮੌਲ ਬਿਜ਼ਨੇਸ ਨੂੰ 1-888-926-5133 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਹੈਲਥ ਨੈੱਟ ਰਾਹੀਂ ਸਾਮੂਹਿਕ ਪਲੈਨਾਂ ਲਈ, 1-800-522-0088 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Russian
Бесплатная помощь переводчиков. Вы можете получить помощь переводчика. Вам могут прочитать документы на Вашем родном языке. Если Вам нужна помощь, звоните по телефону Центра помощи клиентам, указанному на вашей карте участника плана. Вы также можете позвонить в отдел помощи участникам не представленных на федеральном рынке планов для частных лиц и семей (IFP) Off Exchange 1-800-839-2172 (TTY: 711). Участники планов от California marketplace: звоните в отдел помощи участникам представленных на федеральном рынке планов IFP (On Exchange) по телефону 1-888-926-4988 (TTY: 711) или в отдел планов для малого бизнеса (Small Business) по телефону 1-888-926-5133 (TTY: 711). Участники коллективных планов, предоставляемых через Health Net: звоните по телефону 1-800-522-0088 (TTY: 711).

Spanish
Servicios de idiomas sin costo. Puede solicitar un intérprete, obtener el servicio de lectura de documentos y recibir algunos en su idioma. Para obtener ayuda, comuníquese con el Centro de Comunicación con el Cliente al número que figura en su tarjeta de identificación o llame al plan individual y familiar que no pertenece al Mercado de Seguros de Salud al 1-800-839-2172 (TTY: 711). Para planes del mercado de seguros de salud de California, llame al plan individual y familiar que pertenece al Mercado de Seguros de Salud al 1-888-926-4988 (TTY: 711); para los planes de pequeñas empresas, llame al 1-888-926-5133 (TTY: 711). Para planes grupales a través de Health Net, llame al 1-800-522-0088 (TTY: 711).

Tagalog
Walang Bayad na Mga Serbisyo sa Wika. Makakakuha kayo ng interpreter. Makakakuha kayo ng mga dokumento na babasahin sa inyo sa inyong wika. Para sa tulong, tumawag sa Customer Contact Center sa numerong nasa ID card ninyo o tumawag sa Off Exchange ng Planong Pang-indibidwal at Pampamilya (Individual & Family Plan, IFP): 1-800-839-2172 (TTY: 711). Para sa California marketplace, tumawag sa IFP On Exchange 1-888-926-4988 (TTY: 711) o Maliliit na Negosyo 1-888-926-5133 (TTY: 711). Para sa mga Planong Pang-grupo sa pamamagitan ng Health Net, tumawag sa 1-800-522-0088 (TTY: 711).

Thai
ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังเป็นภาษาของคุณได้ หากต้องการความช่วยเหลือ โทรหาศูนย์ลูกค้าสัมพันธ์ได้ที่หมายเลขบนบัตรประจำตัวของคุณ หรือโทรหาฝ่ายแผนบุคคลและครอบครัวของเอกชน (Individual & Family Plan (IFP) Off Exchange) ที่ 1-800-839-2172 (โหมด TTY: 711) สำหรับเขตแคลิฟอร์เนีย โทรหาฝ่ายแผนบุคคลและครอบครัวของรัฐ (IFP On Exchange) ได้ที่ 1-888-926-4988 (โหมด TTY: 711) หรือ ฝ่ายธุรกิจขนาดเล็ก (Small Business) ที่ 1-888-926-5133 (โหมด TTY: 711) สำหรับแผนแบบกลุ่มผ่านทาง Health Net โทร 1-800-522-0088 (โหมด TTY: 711)

Vietnamese
Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu c ầu được đọc cho nghe tài liệu bằng ngôn ngữ của quý vị. Để được giúp đỡ, vui lòng gọi Trung Tâm Liên Lạc Khách Hàng theo số điện thoại ghi trên thẻ ID của quý vị hoặc gọi Chương Trình Bảo Hiểm Cá Nhân & Gia Đình (IFP) Phi Tập Trung: 1-800-839-2172 (TTY: 711). Đối với thị trường California, vui lòng gọi IFP Tập Trung 1-888-926-4988 (TTY: 711) hoặc Doanh Nghiệp Nhỏ 1-888-926-5133 (TTY: 711). Đối với các Chương Trình Bảo Hiểm Nhóm qua Health Net, vui lòng gọi 1-800-522-0088 (TTY: 711).

CA Commercial On and Off-Exchange Member Notice of Language Assistance

FLY017549EH00 (12/17)

Offshore Subcontracting Attestation: Participating Provider

If you are a Health Net of California, Inc., Health Net Community Solutions, Inc. and/or Health Net Life Insurance Company (Health Net) participating provider (also referred to as first-tier, downstream or related entities) using offshore subcontractors, indicate your business name and tax identification (ID) number below.
Name of participating provider (if applicable): **Tax ID:**
If you manage multiple participating providers, list the name(s) and tax IDs for whom you are completing this attestation or attach a separate sheet.
Enter your name, title, phone number, signature, and date that you completed this attestation.
Name: **Title:** **Phone number:** **Signature:** **Date:**

Do you utilize offshore subcontractors? The Centers for Medicare & Medicaid Services (CMS) defines *offshore subcontractor* as follows: "The term subcontractor refers to any organization that a Medicare Advantage Organization or Part D sponsor contracts with to fulfill or help fulfill requirements in their Part C and/or Part D contracts. Subcontractors include all first-tier, downstream and/or related entities. The term offshore refers to any country that is not within the United States or one of the United States territories (American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands). Examples of countries that meet the definition of 'offshore' include Mexico, Canada, India, Germany, and Japan. Subcontractors that are considered offshore can be either American-owned companies with certain portions of their operations performed outside the United States or foreign-owned companies with their operations performed outside the United States. Offshore subcontractors provide services that are performed by workers located in offshore countries, regardless of whether the workers are employees of American or foreign companies." Health Net policy prohibits the transfer or storage of data outside the United States.	**Response:** **Yes** **No**
Do you engage in offshore subcontracting that involves processing, handling or accessing protected health information (PHI)? If "No," the survey is complete and you do not need to complete or submit the attestation. If "Yes," continue completing the form and submit a copy via mail or fax to: Health Net Kristina Rodriguez Director, Provider Network Management Operations Email: Kristina.M.Rodriguez@healthnet.com This form must be completed in full for each new offshore subcontractor, and sent to Health Net within 20 calendar days from the date the contract is signed with the offshore subcontractor to the address or fax number provided above.	**Response:** **Yes** **No**

Offshore Subcontracting Attestation: Participating Provider

Part I. Offshore subcontractor information	
Offshore subcontractor name:	
Offshore subcontractor country:	
Offshore subcontractor address:	
Describe offshore subcontractor functions:	
State proposed or actual effective date for offshore subcontractor (Month, day, year):	

Part II. Precautions for PHI	
Describe the PHI that will be provided to the offshore subcontractor:	
Discuss why providing PHI is necessary to accomplish the offshore subcontractor objectives:	
Describe alternatives considered to avoid providing PHI and why each alternative was rejected:	

Offshore Subcontracting Attestation: Participating Provider

Part III. Attestation of safeguards to protect beneficiary information in the offshore subcontract		
Item	**Attestation**	**Response: Yes No**
III.1	Offshore subcontracting arrangement has policies and procedures in place to ensure that beneficiary PHI and other personal information remain secure.	
	Participating provider to provide a copy of the policies and procedures that document the process used to ensure the security of beneficiary PHI and other personal information. Copies are provided to Health Net along with this completed attestation.	
III.2	Offshore subcontracting arrangement prohibits subcontractor's access to data not associated with the sponsor's contract with the offshore subcontractor.	
III.3	Offshore subcontracting arrangement has policies and procedures in place that allow for immediate termination of the subcontract upon discovery of a significant security breach.	
	Participating provider to provide a copy of the policies and procedures that document the process used for the immediate termination of the subcontract upon discovery of a significant security breach. Copies are provided to Health Net along with this completed attestation.	
III.4	Offshore subcontracting arrangement includes all required Medicare Part C and Part D language, such as record retention requirements, compliance with all Medicare Part C and Part D requirements, etc.	
	Applicable to participating providers contracting with Health Net for the Medicare Advantage line of business – Participating provider to provide a copy of the provider's agreement (proprietary information removed) with the offshore subcontractor. A copy is provided to Health Net along with this completed attestation.	

Part IV. Attestation of audit requirements to ensure protection of PHI		
Item	**Attestation**	**Response: Yes No**
IV.1	Participating provider will conduct an annual audit of the offshore subcontractor.	
	Participating provider to provide a copy of the policies and procedures documenting the process used for conducting annual audits, for monitoring and tracking results, and resolving any identified deficiencies. Copies are provided to Health Net along with this completed attestation.	
IV.2	Audit results are used by the participating provider to evaluate the continuation of its relationship with the offshore subcontractor.	
IV.3	Participating provider agrees to share offshore subcontractors' audit results with Health Net or CMS upon request.	

ORDER OF BENEFITS FOR DEPENDENT CHILDREN

This chart illustrates the order in which benefits are applied when a dependent child is covered by more than one group health plan.

It assumes all parents and stepparents have coverage for the dependent children. If a parent or stepparent has not covered the dependent children or there is no stepparent, skip to the next individual listed.

PARENTS	PRIMARY	SECONDARY	THIRD	FOURTH
Married or never married, living together	Parent with birthday (month and day only) earlier in the year	Parent with birthday (month and day only) later in the year		
Married or never married, same birthday	Plan with earlier effective date	Plan with later effective date		
Married or never married, same birthday and same effective day	Charges are split equally among the plans.			
Joint custody, legally separated or divorced - no court decree	Parent with custody of the dependent	Spouse of parent (stepparent) with custody	Parent without custody	Spouse of parent (stepparent) without custody
Legally separated or divorced - with court decree	Parent with health care coverage responsibility	Spouse of parent (stepparent) with health care coverage responsibility	Other parent	Spouse of other parent (stepparent)

OUT-OF-POCKET MAXIMUM - BACK

The following are examples of Member-level and Family-level Out-Of-Pocket Maximum calculations.

Example 1
The Jones family is a five-member family. They have paid the following amounts in copayments in a calendar year:

Member-level Out-Of-Pocket Maximum = $1500
Family-level Out-Of-Pocket Maximum = $4500

MEMBER	COPAYMENTS
Member A	$1000.00
Member B	$ 60.00
Member C	$1500.00
Member D	$1500.00
Member E	$ 440.00
Total amount paid by this family =	$4500.00

As of the date that the Member-level Out-Of-Pocket Maximum ($1500) is satisfied by Members C and D, no additional copayments will be required from these Members for the remainder of the calendar year.

As of the date that the Family-level Out-Of-Pocket Maximum is satisfied ($4500), no additional copayments will be required from any Member of the family for the remainder of the calendar year.

Example 2
The Smith family is a four-member family. They have paid the following amounts in copayments in a calendar year:

Member-level Out-Of-Pocket Maximum = $1500
Family-level Out-Of-Pocket Maximum = $4500

MEMBER	COPAYMENTS
Member A	$1400.00
Member B	$1300.00
Member C	$1200.00
Member D	$ 600.00
Total amount paid by this family =	$4500.00

As of the date that the Family-level Out-Of-Pocket Maximum is satisfied ($4500), no additional copayments will be required from any member of the family for the remainder of the calendar year.

Example 3
The Johnson family is a five-member family. They have paid the following amounts in copayments in a calendar year:

Member-level Out-Of-Pocket Maximum = $1500
Family-level Out-Of-Pocket Maximum = $4500

MEMBER	COPAYMENTS
Member A	$1500.00
Member B	$ 0.00
Member C	$1500.00
Member D	$1500.00
Member E	$ 0.00
Total amount paid by this family =	$4500.00

As of the date that the Member-level Out-Of-Pocket Maximum ($1500) is satisfied by Member A, C and D, no additional copayments will be required from these Members for the remainder of the calendar year.

As of the date that the Family-level Out-Of-Pocket Maximum is satisfied ($4500), no additional copayments will be required from any Member of the family for the remainder of the calendar year.

OUT-OF-POCKET MAXIMUM EXAMPLE

This out-of-pocket maximum (OOPM) example applies to *most* plans.

An individual member, regardless of the contract type, is only required to satisfy the member-level copayment liability per calendar year. No additional copayments are required for a member as of the date the member-level copayment liability is satisfied.

A family-level OOPM is satisfied by the accumulation of all family members' copayments as illustrated below.

Example

The Jones family is a 5-member family. They are covered by Plan Y and have paid the following amounts in copayments in a calendar year:

Plan Y: Member-Level OOPM = $1500 Family-Level OOPM = $4500

MEMBER	COPAYMENTS PAID	MEMBER-LEVEL OOPM SATISFIED
Member 1	$ 1000.00	No
Member 2	$ 60.00	No
Member 3	$ 1500.00	Yes
Member 4	$ 1500.00	Yes
Member 5	$ 440.00	No
Total amount paid by this family =	$ 4500.00	

No additional copayments will be required from any member of the family as of the date that the family-level maximum copayment ($4500) is satisfied.

OUTPATIENT CALIFORNIA HEALTHNET COMMERCIAL AUTHORIZATION FORM

Complete and **Fax** to: 1-844-694-9165
Transplant **Fax** to: 1-833-769-1142

HMO

POS

PPO

Request for additional units. Existing Authorization Units

Standard requests - Determination within 5 business days of receiving all necessary information.

Urgent requests - I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 72 hours to avoid complications and unnecessary suffering or severe pain.

X URGENT REQUESTS MUST BE SIGNED BY THE REQUESTING PHYSICIAN TO RECEIVE PRIORITY.

*** INDICATES REQUIRED FIELD**

MEMBER INFORMATION

Last Name, First *Date of Birth (MMDDYYYY)

*Member ID

REQUESTING PROVIDER INFORMATION

Requesting Provider Contact Name

*Requesting NPI *Requesting TIN Phone

Requesting Provider *Address* *Fax

City, State, Zip

SERVICING PROVIDER / FACILITY INFORMATION

Same as Requesting Provider Servicing Provider Contact Name -

*Servicing NPI *Servicing TIN - Phone

Servicing Provider/Facility Name *Address* Fax

City, State, Zip

AUTHORIZATION REQUEST

***Primary** Procedure Code (CPT/HCPCS) (Modifier

Additional Procedure Code (CPT/HCPCS) (Modifier

***Start Date** OR Admission Date (MMDDYYYY)

*Diagnosis Code (ICD-10)

Additional Procedure Code (CPT/HCPCS) (Modifier

Additional Procedure Code (CPT/HCPCS) (Modifier

End Date OR Discharge Date (MMDDYYYY)

Total Units/Visits/Days

(Enter the Service type number in the boxes)

*OUTPATIENT SERVICE TYPE

412 Auditory
422 Biopharmacy
712 Cochlear Implants & Surgery
299 Drug Testing
922 Experimental and Investigational Services
205 Genetic Testing & Counseling
249 Home Health
390 Hospice Services
290 Hyberbaric Oxygen Therapy
395 Infertility Diagnosis or Treatment
211 OB Ultrasound
410 Observation
997 Office Visit/Consult
210 Orthotics
794 Outpatient Services
171 Outpatient Surgery
202 Pain Management
147 Prosthetics
428 Second Opinion
201 Sleep Study
993 Transplant Evaluation
209 Transplant Surgery
724 Transportation

Behavioral Health

533 BH Applied Behavioral Analysis
512 BH Community Based Services
515 BH Electroconvulsive Therapy
516 BH Intensive Outpatient Therapy
510 BH Medical Management
518 BH Mental Health /Chemical Dependency Observation
519 BH Outpatient Therapy
530 BH PHP
520 BH Professional Fees
522 BH Psychiatric Evaluation
521 BH Psychological Testing

DME

417 Rental
120 Purchase (Purchase Price)

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Rev.02242021
XD-PAF-1654

health net

Request for Necessary Medical Information for Prior Authorization

URGENT REQUEST FOR CONTINUING OCCUPATIONAL, PHYSICAL or SPEECH THERAPY

WARNING: THIS FAX CONTAINS PRIVATE AND CONFIDENTIAL INFORMATION

Patient Information

Patient Name	Subscriber ID #
Date of Birth	Today's Date

Provider Information

Facility Name	Facility Tax ID #
Telephone #	Fax
Requesting Physician Name	ICD-9 Code
Facility Contact Person	Telephone # of Contact Person

In order to process the prior authorization request for occupational, physical or speech therapy regarding the above patient, complete the information requested below and return this form to the Health Net Prior Authorization Department by fax at (800) 672-2135.

Please ensure that all information is legible and that only standard abbreviations are used. The information regarding dates of visits is very important in order to calculate benefits and availability of additional visits.

Occupational and Physical Therapy
1. What is the patient's diagnosis (describe in detail)?
2. What is the patient's dominant hand? Right or left?
3. What was the exact date of surgery and the exact type of surgery?
4. How many physical or occupational therapy visits has the patient had since original date of injury or surgery through last December 31?
5. How many physical or occupational therapy visits has the patient had since January 1 of this year and when was the last visit?
6. How many additional visits are being requested at this time and what will be the start date of the requested additional visits?

7. What are the exact physical or occupational therapy modalities being utilized at this time?	
8. What was the patient's range of motion at the onset of physical or occupational therapy?	
9. What was the patient's range of motion four weeks ago?	Date:
10. What was the patient's range of motion two weeks ago?	Date:
11. What is the patient's range of motion now?	Date:
12. What exercises has the patient been performing?	
13. How many repetitions and at what weight was the patient able to perform at the start of therapy?	Date:
14. How many repetitions and at what weight was the patient able to perform four weeks ago?	Date:
15. How many repetitions and at what weight was the patient able to perform two weeks ago?	Date:
16. How many repetitions and at what weight is the patient able to perform now?	Date:
17. What is the goal range of motion and goal strength?	
18. When do you anticipate the member will reach this goal?	
19. When do you anticipate the member will be transitioned to a home exercise program?	

Speech Therapy
1. Please provide the plan of care addressing the following: a. The date of onset or exacerbation of the disorder/diagnosis: b. Specific statements of long-term and short-term goals: c. Quantitative objectives measuring current age-adjusted level of functioning: d. A reasonable estimate of when the goals will be reached: e. The specific treatment techniques or exercises to be used in treatment: f. The frequency and duration of treatment:
2. How many speech therapy sessions have been provided this calendar year prior to this request?
3. Is there progress or improvement with the therapy?

Please attach any additional documentation supporting this request to the back of this form.

Fax the requested information to:

Health Net Prior Authorization Department
(**800) 672-2135**

Provider Dispute Resolution Request

Commercial and Medi-Cal

INSTRUCTIONS

- Please complete the form fields below. Fields with an asterisk (*) are required. Forms with incomplete fields may be returned and delay processing.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- For routine follow-up status, please call the appropriate telephone number below.
- Mail the completed form to the following address. Please note the specific address for all Medi-Cal appeals.

Health Net Commercial Provider Appeals Unit
PO Box 9040 Farmington, MO 63640-9040
Commercial Provider Services Center 1-800-641-7761

Health Net Medi-Cal Provider Appeals Unit
PO Box 989881 West Sacramento, CA 95798-9881
Medi-Cal Provider Services Center 1-800-675-6110

*Provider name:	*Provider tax ID #:
*Provider address	Contracted? ☐ Yes ☐ No

Provider type: ☐ Physician ☐ Mental health ☐ Hospital ☐ ASC/outpatient services ☐ SNF ☐ DME ☐ Rehab
☐ Home health ☐ Ambulance ☐ Other professional (please specify type of other) _____

***Claim information:** ☐ Single ☐ Multiple **"LIKE"** claims (complete attached spreadsheet) Number of claims _____

*Patient name:	Date of birth:

*Health Plan ID number:	*Subscriber ID/CIN number:	*Original claim ID/Submission ID number: (If multiple claims, use attached spreadsheet)
*Service from/to date:	Original claim amount billed:	Original claim amount paid:

Dispute type: ☐ Claim ☐ Appeal of medical necessity/utilization management decision ☐ Contract dispute
☐ Seeking resolution of a billing determination ☐ Disputing a request for reimbursement of overpayment ☐ Other

***Description of dispute:** Indicate reason for dispute, provider's position and reasoning: (Additional paper can be attached if necessary)

***Expected outcome:** (Please provide by claim if multiple.)

_____ Contact name (please print)

_____ Title

(____) _____ Area code and phone number

_____ Signature and date

_____ Email address

(____) _____ Area code and fax number

☐ **Check here if additional information is attached: (Please do not staple information.)**

For Health Plan Use Only
Case# _____
Provider# _____

Page ___ of ___

21-225a/FRM047551EC00 (3/21)

Commercial and Medi-Cal Provider Dispute Resolution Request, *continued*

INSTRUCTIONS (for use with multiple like claims only)

- Please complete the form fields below. Fields with an asterisk (*) are required. Forms with incomplete fields may be returned and delay processing.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- For routine follow-up status, please call the appropriate telephone number below.
- Mail the completed form to the following address. Please note the specific address for all Medi-Cal appeals.

Health Net Commercial Provider Appeals Unit
PO Box 9040 Farmington, MO 63640-9040
Commercial Provider Services Center 1-800-641-7761

Health Net Medi-Cal Provider Appeals Unit
PO Box 989881 West Sacramento, CA 95798-9881
Medi-Cal Provider Services Center 1-800-675-6110

Number	*Patient name		Date of birth	*Subscriber ID/CIN number	*Original claim ID/Submission ID number	*Service from/to date	Original claim amount billed	Original claim amount paid	*Expected outcome
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									

☐ **Check here if additional information is attached:**
(Please do not staple information.)

For Health Plan Use Only
Case# _____
Provider# _____

21-225a/FRM047551EC00 (3/21)

Provider Dispute Resolution Request

Individual Family Plan (IFP)

INSTRUCTIONS

- Please complete the form fields below. Fields with an asterisk (*) are required. Forms with incomplete fields may be returned and delay processing.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- For routine follow-up status, please call 1-800-641-7761.
- Mail the completed form to the following address.

  IFP Provider Disputes and Appeals Unit
  PO Box 9040
  Farmington, MO 63640-9040

INSTRUCTIONS

Please mark the member's line of business:

☐ HMO/POS
☐ PPO
☐ PureCare HSP
☐ PureCare One EPO
☐ CommunityCare HMO
☐ EnhancedCare PPO
☐ PPO Individual and Family

*Provider name:	*Provider tax ID #:
*Provider address	Contracted? ☐ Yes ☐ No

Provider type: ☐ Physician ☐ Mental health ☐ Hospital ☐ ASC/outpatient services ☐ SNF ☐ DME ☐ Rehab ☐ Home health ☐ Ambulance ☐ Other professional (please specify type of other) _____

***Claim information:** ☐ Single ☐ Multiple **"LIKE"** claims (complete attached spreadsheet) Number of claims _____

*Patient name:	Date of birth:

*Health Plan ID number:	*Subscriber ID/CIN number:	*Original claim ID/Submission ID number: (If multiple claims, use attached spreadsheet)
*Service from/to date:	Original claim amount billed:	Original claim amount paid:

Dispute type: ☐ Claim ☐ Appeal of medical necessity/utilization management decision ☐ Contract dispute ☐ Seeking resolution of a billing determination ☐ Disputing a request for reimbursement of overpayment ☐ Other

***Description of dispute:** Indicate reason for dispute, provider's position and reasoning: (Additional paper can be attached if necessary)

***Expected outcome:** (Please provide by claim if multiple.)

_____ Contact name (please print)

_____ Title

(____) _____ Area code and phone number

_____ Signature and date

_____ Email address

(____) _____ Area code and fax number

☐ **Check here if additional information is attached: (Please do not staple information.)**

For Health Plan Use Only
Case# _____
Provider# _____

20-690/FRM047550EC00 (9/20)

IFP Provider Dispute Resolution Request, *continued*

INSTRUCTIONS (for use with multiple like claims only)

- Please complete the form fields below. Fields with an asterisk (*) are required. Forms with incomplete fields may be returned and delay processing.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- For routine follow-up status, please call 1-800-641-7761.
- Mail the completed form to the following address.

  IFP Provider Disputes and Appeals Unit
  PO Box 9040
  Farmington, MO 63640-9040

Number	*Patient name		Date of birth	*Subscriber ID/CIN number	*Original claim ID/Submission ID number	*Service from/to date	Original claim amount billed	Original claim amount paid	*Expected outcome
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									

☐ **Check here if additional information is attached:**
(Please do not staple information.)

For Health Plan Use Only
Case# _____
Provider# _____

20-690/FRM047550EC00 (9/20)

SUBSCRIBER OOPM NOTIFICATION LETTER

(Current Date)

(Inside Address)

Dear _____:

We have reviewed your out-of-pocket maximum claim and have determined that you met your out-of-pocket maximum of $_____ for 20_____ on_____.

If you have paid copayments for professional services in excess of the maximum required, reimbursement should be refunded to you by your participating physician group (PPG). If you have paid copayments for hospital admissions in excess of the maximum required, you will receive reimbursement from Health Net of California.

If your contract should change during the year, you will be responsible for the additional copayment amount up to the maximum of the new contract. If you have any questions, please call Health Net Member Services at (818) 719-6800 or (800) 522-0088.

Sincerely,

Health Net

Health Net Transplant Performance Centers

			Line of Business				
Center	**Transplant**	**Type**	**HMO**	**Medicare**	**PPO/EPO**	**MEDI-CAL**	**EC PPO**
California Pacific Medical Center - San Francisco	**Kidney**	Adult	X	X	X	X*	Enhanced Care PPO utilizes OptumHealth Transplant Network
	Kidney-Pancreas	Adult	X	X	X	X	
	Liver	Adult	X	X	X	X	
	Pancreas	Adult	X	X	X	X	
	Liver-Kidney	Adult	X	X	X	X	
	Heart	Adult	X	X	X	X	
Cedars-Sinai Medical Center - Los Angeles	**Heart**	Adult	X		X		
	Kidney	Adult	X		X		
	Liver	Adult	X		X		
	Stem Cell	Adult	X		X		
		Autologous	X		X		
		Allogeneic Related & Unrelated	X		X		
Children's Hospital and Research Ctr at Oakland "Publicly know as UCSF Benioff Children's Hospital Oakland"	**Stem Cell**	Pediatric	X		X		
		Autologous	X		X		
		Allogeneic Related	X		X		
Children's Hospital of Los Angeles	**Heart**	Pediatric	X		X		
	Liver	Pediatric	X		X		
	Kidney	Pediatric	X		X		
	Stem Cell	Pediatric	X		X		
		Autologous	X		X		
		Allogeneic Related & Unrelated	X		X		
Children's Hospital of Orange County - Orange	**Stem Cell**	Pediatric	X		X		
		Autologous	X		X		
		Allogeneic Related & Unrelated	X		X		
Loma Linda University Medical Center - Loma Linda	**Heart**	Pediatric	X	X	X		
	Kidney	Adult	X	X	X		
		Pediatric	X	X	X		
	Kidney-Pancreas	Adult	X	X	X		
		Pediatric	X	X	X		
	Liver	Adult	X	X	X		
		Pediatric	X	X	X		
	Pancreas	Adult	X	X	X		
		Pediatric	X	X	X		
Lucile Packard Children's Hospital	**Heart**	Pediatric	X		X	X	
	Heart-Lung	Pediatric	X		X	X	
	Kidney	Pediatric	X		X	X	
	Kidney-Pancreas	Pediatric				X	
	Liver	Pediatric	X		X	X	
	Lung	Pediatric	X		X	X	
	Pancreas	Pediatric				X	
	Stem Cell	Pediatric	X		X	X	
		Autologus Allogeneic Related & Unrelated	X		X	X	
		Allogeneic Related & Unrelated	X		X	X	
Rady Childrens Hospital	**Kidney**	Pediatric	X		X		
	Stem Cell	Pediatric	X		X		
		Autologous	X		X		
		Allogeneic Related & Unrelated	X		X		
Scripps Health - San Diego	**Kidney**	Adult	X	X	X		
	Liver	Adult	X	X	X		
	Stem Cell	Adult	X	X	X		
		Autologous	X	X	X		
		Allogeneic Related & Unrelated	X	X	X		

Updated 1/27/2022

Health Net Transplant Performance Centers

			Line of Business				
Center	**Transplant**	**Type**	**HMO**	**Medicare**	**PPO/EPO**	**MEDI-CAL**	**EC PPO**
Sharp Healthcare System	**Heart**	Adult	X	X	X	X	Enhanced Care PPO utilizes OptumHealth Transplant Network
	Kidney	Adult	X		X	X	
Stanford University Hospital - Palo Alto	**Heart**	Adult	X	X	X	X	
	Heart-Lung	Adult	X	X	X	X	
	Kidney	Adult	X	X	X	X	
	Kidney-Pancreas	Adult	X	X	X	X	
	Liver	Adult	X	X	X	X	
	Lung	Adult	X	X	X	X	
	Pancreas after Kidney TP	Adult	X	X	X	X	
	Stem Cell	Adult	X	X	X	X	
		Autologous	X	X	X	X	
		Allogeneic Related & Unrelated	X	X	X	X	
Sutter Medical Center Sacramento	**Heart**	Adult	X	X	X	X	
	Stem Cell	Adult Allogeneic	X	X	X	X	
		Adult Autologous	X	X	X	X	
UC Davis - Sacramento	**Kidney**	Adult Cadaveric & Adult	X	X	X	X	
	Stem Cell	Adult	X	X	X		
		Autologous	X	X	X		
		Allogeneic Related & Unrelated	X	X	X		
UC San Diego - San Diego	**Kidney**	Adult	X	X	X	X	
	Heart	Adult	X	X	X		
	Liver	Adult	X	X	X		
	Lung	Adult	X	X	X		
	Stem Cell	Adult	X	X	X		
		Autologous	X	X	X		
		Allogeneic Related & Unrelated	X	X	X		
UCSF - SAN FRANCISCO	**Heart**	Adult	X	X	X		
		Pediatric	X		X		
	***Heart-Lung**	Adult	*	**	*		
		Pediatric	*		*		
	Kidney	Adult	X	X	X		
		Pediatric	X		X		
	Kidney-Pancreas	Adult	X	X	X		
	Liver	Pediatric	X		X		
		Adult	X	X	X		
	Lung	Adult	X	X	X		
	Pancreas	Adult	X	X	X		
	***Pancreas Autologous Islet Cell**	Adult	*	**	*		
	Stem Cell	Adult	X	X	X		
		Pediatric	X		X		
		Autologous	X	X	X		
		Allogeneic Related & Unrelated	X	X	X		

Health Net Transplant Performance Centers

			Line of Business				
Center	**Transplant**	**Type**	**HMO**	**Medicare**	**PPO/EPO**	**MEDI-CAL**	**EC PPO**
Ronald Reagan UCLA Medical Center.	**Heart**	Adult	X		X		Enhanced Care PPO utilizes OptumHealth Transplant Network
		Pediatric	X		X		
	Kidney	Adult	X		X		
		Pediatric	X		X		
	Kidney-Pancreas	Adult	X		X		
	Liver	Adult	X		X		
		Pediatric	X		X		
	Lung	Adult	X		X		
	Pancreas	Adult	X		X		
	Small Bowel	Adult	X		X		
		Pediatric	X		X		
	Stem Cell	Adult	X		X		
		Pediatric	X		X		
		Autologous	X		X		
		Allogeneic Related & Unrelated	X		X		
	Liver-Kidney	Adult	X		X		
		Pediatric	X		X		
Keck Hospital of USC.	**Heart**	Adult	X		X		
	Heart-Lung	Adult	X		X		
	Kidney	Adult	X		X		
	Liver	Adult	X		X		
	Lung	Adult	X		X		
	Kidney-Pancreas	Adult	X		X		
	Stem Cell	Adult	X		X		

Updated 1.27.22

X = Participating and Blank = Non Par

*	Transplant is individually negotiated by Letter of Agreement
**	Medicare LOB- Transplant is individually negotiated by Letter of Agreement
***	Medi-Cal LOB- Transplant is individually negotiated by Letter of Agreement

health net

Request for Necessary Medical Information for Prior Authorization

URGENT REQUEST FOR CONTINUING HOME HEALTH SERVICES

WARNING: THIS FAX CONTAINS PRIVATE AND CONFIDENTIAL INFORMATION

Patient Information

Patient Name	Subscriber ID #
Date of Birth	Today's Date

Provider Information

Facility Name	Facility Tax ID #
Telephone #	Fax
Requesting Physician Name	ICD-9 Code
Facility Contact Person	Telephone # of Contact Person

In order to process the prior authorization request for home health services regarding the above patient, complete the information requested below and return this form to the Health Net Prior Authorization Department by fax at (800) 672-2135.

Please ensure that all information is legible and that only standard abbreviations are used.

SERVICES TO BE PROVIDED
1. Type of services (for example, wound care, teaching, infusion):
2. Frequency of services:
3. How many visits are being requested?
4. How many visits have already been performed?
5. a. Start date of service: b. Anticipated completion date of services:

WOUND CARE
6. Current size of wound: Length_____Width_____Depth _____ Type_____ Amount of drainage_____

7. Type of wound care being performed:
8. Date and type of surgery or description of etiology of wound (for example, diabetic ulcer):

HOME INFUSION
9. Type of medication:
10. Frequency of services:
11. Is medication also being requested or is this request just for nursing? If medication is also being requested, please attach documentation describing patient's clinical diagnosis and medical records supporting the diagnosis, including applicable lab data.

HOME IV THERAPY
12. Type of medication:
13. Frequency of dosing:
14. Describe family/patient's ability/inability to self administer:
15. Diagnosis:

HOME HEALTH TEACHING
16. Document teaching needs, date teaching has been performed, and patient/family response to teaching:

ADDITIONAL QUESTIONS
17. Other services, please describe:
18. When will patient be independent in care? What steps are being taken to discharge from service and when is discharge anticipated?

Please attach physician’s order and documentation confirming homebound status and any additional documentation supporting this request to the back of this form.

Fax the requested information to:

Health Net Prior Authorization Department
(**800) 672-2135**

health net

Request for Necessary Medical Information for Prior Authorization

URGENT REQUEST FOR CONTINUING OCCUPATIONAL, PHYSICAL or SPEECH THERAPY

WARNING: THIS FAX CONTAINS PRIVATE AND CONFIDENTIAL INFORMATION

Patient Information

Patient Name	Subscriber ID #
Date of Birth	Today's Date

Provider Information

Facility Name	Facility Tax ID #
Telephone #	Fax
Requesting Physician Name	ICD-9 Code
Facility Contact Person	Telephone # of Contact Person

In order to process the prior authorization request for occupational, physical or speech therapy regarding the above patient, complete the information requested below and return this form to the Health Net Prior Authorization Department by fax at (800) 672-2135.

Please ensure that all information is legible and that only standard abbreviations are used. The information regarding dates of visits is very important in order to calculate benefits and availability of additional visits.

Occupational and Physical Therapy
1. What is the patient's diagnosis (describe in detail)?
2. What is the patient's dominant hand? Right or left?
3. What was the exact date of surgery and the exact type of surgery?
4. How many physical or occupational therapy visits has the patient had since original date of injury or surgery through last December 31?
5. How many physical or occupational therapy visits has the patient had since January 1 of this year and when was the last visit?
6. How many additional visits are being requested at this time and what will be the start date of the requested additional visits?

7. What are the exact physical or occupational therapy modalities being utilized at this time?	
8. What was the patient's range of motion at the onset of physical or occupational therapy?	
9. What was the patient's range of motion four weeks ago?	Date:
10. What was the patient's range of motion two weeks ago?	Date:
11. What is the patient's range of motion now?	Date:
12. What exercises has the patient been performing?	
13. How many repetitions and at what weight was the patient able to perform at the start of therapy?	Date:
14. How many repetitions and at what weight was the patient able to perform four weeks ago?	Date:
15. How many repetitions and at what weight was the patient able to perform two weeks ago?	Date:
16. How many repetitions and at what weight is the patient able to perform now?	Date:
17. What is the goal range of motion and goal strength?	
18. When do you anticipate the member will reach this goal?	
19. When do you anticipate the member will be transitioned to a home exercise program?	

Speech Therapy
1. Please provide the plan of care addressing the following: a. The date of onset or exacerbation of the disorder/diagnosis: b. Specific statements of long-term and short-term goals: c. Quantitative objectives measuring current age-adjusted level of functioning: d. A reasonable estimate of when the goals will be reached: e. The specific treatment techniques or exercises to be used in treatment: f. The frequency and duration of treatment:
2. How many speech therapy sessions have been provided this calendar year prior to this request?
3. Is there progress or improvement with the therapy?

Please attach any additional documentation supporting this request to the back of this form.

Fax the requested information to:

Health Net Prior Authorization Department
(**800) 672-2135**