Provider Manual - Combined

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Provider Manual

The Medi-Cal Operations Manual offers Health Net Community Solutions, Inc. (Health Net), CalViva Health, and Community Health Plan of Imperial Valley providers access to important information about plan benefits, limitations and administration processes to make sure members enrolled in the Medi-Cal managed care plan receive covered services when needed.

Health Net, CalViva Health, and Community Health Plan of Imperial Valley are regulated by the California Department of Health Care Services (DHCS) and the California Department of Managed Health Care (DMHC). The Health Net, CalViva Health, and Community Health Plan of Imperial Valley Medi-Cal plans are offered by Health Net, CalViva Health, and Community Health Plan of Imperial Valley under a contract with the DHCS.

CalViva Health contracts with DHCS to provide services to Medi-Cal managed care members under the Two-Plan model in all ZIP Codes in Fresno, Kings and Madera counties. The Operations Manual for CalViva Medi-Cal providers in Fresno, Kings and Madera counties is developed and maintained for CalViva Health by Health Net.

Community Health Plan of Imperial Valley contracts with DHCS to provide services to Medi-Cal managed care members under the Single-Plan model in Imperial County. The Operations Manual for Community Health Plan of Imperial Valley Medi-Cal providers in Imperial County is developed and maintained for Community Health Plan of Imperial Valley by Health Net.

In Los Angeles County, Health Net is a primary contractor with DHCS as the commercial plan under the Medi-Cal Managed Care Two-Plan Model. However, Health Net entered into a contract with Molina Healthcare as a subcontracting health plan to arrange for the provision of Medi-Cal services through Molina's provider network. Some Medi-Cal members in Los Angeles County are Health Net members, even if assigned to Molina. Except as noted, the policies, procedures and programs described in the Medi-Cal Operations Manual are applicable to all contracting providers, including those contracting through Molina.

The four provider types, Physicians, Participating Physician Groups (PPGs), Hospitals, and Ancillary, are listed at the top of each page. Unless specified within the body of the document, 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 DHCS laws and regulations and Health Net policies and procedures.

The contents of Health Net's Medi-Cal Operations Manual are in addition to your Provider Participation Agreement (PPA) and its addenda. When the contents of Health Net's Medi-Cal Operations Manual conflicts with the PPA, the PPA takes precedence.

Adverse Childhood Experiences (ACEs)

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

Prevent

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

ACEs Training and Self-Attestation Requirement for Billing

Effective July 1, 2020, Medi-Cal providers who have completed the two-hour online ACEs training and submitted their self-attestation to DHCS can continue or begin billing for ACEs screenings. Providers who missed the July 1 deadline can still complete the training, self-attest and begin billing the month of completing the attestation.

- **To get started,** register for the online training.
- **To self-attest,** complete the Department of Health Care Services (DHCS) Trauma Screening Training Attestation form.

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.

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 parent/caregiver
- PEARLS for ages 12–19, to be completed by a parent/caregiver
- PEARLS for teenagers ages 12–19, self-reported

For adults, use the ACEs assessment tool.

The ACEs 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	Permitted for periodic ACEs rescreening as determined appropriate and medically necessary, not more than once per year, per clinician (per managed care plan). Children should be screened periodically to monitor the possible accumulation of ACEs and increased risk for a toxic stress physiology.[1]
18 or 19	ACEs or PEARLS	Permitted for periodic ACEs rescreening as determined appropriate and medically necessary, not more than once per year, per clinician (per managed care plan). Children should be screened periodically to monitor the possible accumulation of ACEs and increased risk for a toxic stress physiology.[1]
20-64	ACEs screening portion of the PEARLS tool (Part 1) can also be used.	· **Age 20:** Permitted for periodic ACEs rescreening as determined appropriate and medically necessary, not more than once per year, per clinician (per managed care plan). Children should be screened periodically to monitor the possible accumulation of ACEs and increased risk for a toxic stress physiology. · **Adults ages 21 through age 64:** Permitted once in their adult lifetime (through age 64), per clinician (per managed care plan). Screenings completed while the person is

AGES	USE THIS TOOL	TO RECEIVE DIRECTED PAYMENT
		under age 21 do not count toward the one screening allowed in their adult lifetime. Adults should be screened at least once in adulthood, and though ACEs occur in childhood (by definition) and therefore do not change, patient comfort with disclosure may change over time, so re-screening for adults may be considered.[1]

[1]https://www.acesaware.org/learn-about-screening/billing-payment. Copyright © 2023 by the State of California Department of Health Care Services.

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

Treatment

The ACEs score determines the total reported exposure to the 10 ACEs categories indicated in the adult ACEs assessment tool or the top box of the pediatric PEARLS tool. ACEs 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 ACEs-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.

References

For more information, refer to:

- ACEs Aware treatment
- ACEs Screening Clinical Workflows and Assessment Algorithm

- ACEs Aware resources

Heal: 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.

The Live Beyond Campaign: Raising Awareness to Help Californians Heal from ACEs

The Office of the California Surgeon General has launched the Live Beyond campaign to raise awareness about ACEs and toxic stress, particularly targeting youth and young adults in California. The Live Beyond campaign focuses on increasing knowledge about ACEs, influencing attitudes toward seeking help, building skills for managing stress, and inspiring action to break the cycle of trauma. To learn more, visit the Live Beyond Campaign here.

Behavioral Health Services

Health Net Medi-Cal members enrollees can obtain individual and group mental health evaluation and treatment. Providers can call Behavioral Health Provider Services.

CalViva Health Medi-Cal members can obtain individual and group mental health evaluation and treatment. Providers should call Health Net if a member needs emergent or routine treatment services. Members should call CalViva Health Member Services if they need these services.

For Community Health Plan of Imperial Valley (CHPIV) Medi-Cal members:

CHPIV Medi-Cal members can obtain individual and group mental health evaluation and treatment. Providers should call Health Net if a member needs emergent or routine treatment services. Members should call CHPIV Member Service if they need these services.

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 Health Plan of Imperial Valley & CalViva Community Connect

Community Connect are powered by Findhelp formerly knows 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 and CHPIV** members should go to Findhelp, enter a ZIP code and click *Search* .
- **CalViva Health Medi-Cal** members should go to CalViva Findhelp, 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. CalViva Health Medi-Cal members should call CalViva Health Member Services if they need these 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 the site indicated below, then click *Sign Up* and complete the myStrength sign-up process with a brief wellness assessment and personal profile.

- **Health Net Members:** my Strength
- **CalViva Health Medi-Cal members:** my Strength CalViva

Appeals, Grievances and Disputes

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

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

Select any subject below:

- Member Appeals
- Provider Appeals and Dispute Resolution
- Grievances

Member Appeals

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

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

Select any subject below:

- Member Appeals Overview
- State Hearing Division

Member Appeals Overview

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

A member appeal is a request for reconsideration of a prior authorization denial for a service. Member appeals may be submitted by the member, or the provider on the member's behalf, verbally or in writing, within 60 calendar days of receipt of a denial for prior authorization or receipt of a notice of action (NOA) to the Health Net Medi-Cal Member Appeals and Grievances Department. Appeals received after the 60-day time frame are not considered. Upon request, Medi-Cal Member Services Department, Community Health Plan of Imperial Valley Member Services Department or CalViva Health Medi-Cal Member Services Department (for Fresno, Kings and Madera counties) representatives are available to assist members in writing an appeal. An appeal must include any additional or supporting information the member would like Health Net to consider.

Medi-Cal Pharmacy Benefit Carve Out - Medi-Cal Rx

Medi-Cal pharmacy benefits are administered through the Department of Health Care Services (DHCS) fee-for-service delivery system called Medi-Cal Rx. Health plan Medi-Cal pharmacy benefits and services transitioned to the State's responsibility under the pharmacy benefit program known as Medi-Cal Rx (DHCS APL 20-020). Appeals and grievances for these benefits and services are not Health Net's responsibility.

- Medi-Cal Rx member appeals – Appeals involving disagreement with benefit-related decisions, such as coverage disputes, disagreeing with and seeking reversal of a request for prior authorization involving medical necessity, etc., and are associated with a Notice of Action (NOA), should be directed to California Department of Social Services (CDSS) State Fair Hearing (SFH) and not to Health Net.

Medical beneficiaries are no longer required to exhaust any internal and/or administrative DHCS processes prior to requesting a SFH through CDSS. Additionally, under Medi-Cal Rx, Medi-Cal enrollees no longer have the right to apply for an Independent Medical Review (IMR) for pharmacy services carved out to Medi-Cal Rx (DMHC APL 20-035). If Health Net receives an appeal related to these services, it will redirect it to CDSS State Fair Hearing in a timely manner and in the manner outlined by DHCS.

- Member complaints and grievances – A Health Net or CalViva Health Medi-Cal member may file Medi-Cal Rx complaints and grievances at any time to the Medi-Cal Rx Customer Service Center (CSC), who will administer all aspects of the complaints and grievances processes and related procedures for Medi-Cal pharmacy benefits. Complaints or grievances may be filed with the Medi-Cal Rx CSC phone or in writing via fax. If the health plan receives a Medi-Cal Rx grievance or complaint, it will redirect those issues to the Medi-Cal Rx CSC.
- Provider prior authorization (PA) appeals – Providers, on behalf of a Medi-Cal beneficiary, may appeal Medi-Cal Rx PA denials, delays and modifications issued on or after January 1, 2022. Providers may submit appeals of PA adjudication results through their Medi-Cal Rx or by mail clearly identified as appeals.

Medi-Cal Rx will acknowledge each submitted PA appeal within three days of receipt and make a decision within 60 days of receipt. Medi-Cal Rx will send a letter of explanation in response to each PA appeal.

Providers who are dissatisfied with the decision may submit subsequent appeals. Medi-Cal providers may seek a judicial review of the appeal decision, as authorized under state law. For more information about the Medi-Cal Rx provider PA appeal process, please visit Medi-Cal Rx.

- Provider claim appeals – Provider claim appeals to resolve claim payment problems (e.g., resubmission, non-payment, underpayment, overpayment, etc.) for services provided on or after January 1, 2022, may be filed to Medi-Cal CSC. Providers must complete the Medi-Cal Rx provider appeal form and submit the completed form Medi-Cal Rx.

Once the Medi-Cal Rx provider appeal form is submitted, Medi-Cal Rx will acknowledge each appeal within 15 days of receipt and make a decision within 45 days of receipt.

The above information about appeals and grievances related to pharmacy was adapted from Department of Managed Health Care All Plan Letter 20-035, DHCS All Plan Letter 20-020 and the Medi-Cal Rx.

Notice of Action

Members may receive a written notice of adverse benefit determination as a notice of action (NOA) regarding a denial, delay, modification, or termination. If a member received a NOA, the following options are available:

- The member has 60 calendar days from the date on the NOA to file an appeal of the NOA with Health Net.
- The member may request an independent medical review (IMR) from the Department of Managed Health Care (DMHC) after first filing an appeal with Health Net, or right away if the member's health is in immediate danger or if the request was denied because treatment is considered experimental or investigational.

Availability of Member Assistance in Filing an Appeal

The member can ask for an appeal. Or, they can have someone like a relative, friend, advocate, doctor, or attorney to ask for one for them. This person is called an Authorized Representative. The members health plan can provide a form for them to identify their Authorized representative. The member, or their Authorized Representative, can send in anything they want their health plan to look at, to make a decision on their appeal. A doctor who is different from the doctor who made the first decision will look at the member’s appeal.

A provider may also submit an appeal on behalf of the member or an authorized representative, when the member is challenging a denial of a prior authorization request or a service. Appeals filed by the provider or authorized representative, on behalf of the member, require written consent from the member or authorized representative. Members have a right to access their medical records. Written authorization from the member or the member’s 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.

These appeals are considered member appeals, not provider appeals. They are processed in the same manner as an appeal submitted by a member:

- Health Net, not the participating physician group (PPG) or subcontractor, processes the appeal.

- Health Net's decision is final. There is no second-level appeal between Health Net and the PPG.
- Providers do not have the option of requesting a fair hearing with the Department of Social Services (DSS).

Health Net, its PPGs and participating providers will not discriminate against members who have filed an appeal in accordance with Title 28, CCR 1300.68(b)(8). Health Net does not take any punitive action against a provider who requests an expedited appeal or support's a member's appeal. Further, Health Net does not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice from advising or advocating on behalf of a member, who is his or her patient for:

1. The member's health status, care, or treatment options, including any alternative treatment that may be self-administered.
2. Any information the member needs in order to decide among all relevant treatment options.
3. The risks, benefits, and consequences of treatment or non-treatment.
4. The member's right to participate in decisions regarding his or her care, including the right to refuse treatment, and to express preferences about future treatment decisions.

Appeal Resolution Process

When the Health Net Medi-Cal Member Appeals and Grievances Department receives the appeal, it is assigned a case number, is researched and resolved. A written acknowledgment is mailed to the member within five calendar days of receipt of the written appeal. Within 30 days of receipt of a standard appeal and with 72 hours of receipt of an expedited appeal; members are sent a written Notice of Appeal Resolution (NAR), stating the decision made and the rationale for that decision.

If Health Net upholds the initial denial of coverage, the member has the following options:

- Member may apply to the DMHC for an Independent Medical Review (IMR) within 180 days from the date of the NAR letter or after exhausting the plan’s grievance and appeals process. However, the member may request an Independent Medical Review (IMR) from the DMHC right away if the member’s health is in immediate danger or if the request was denied because treatment is considered experimental or investigational; otherwise, the member must first file an appeal with the plan.
- The member may request a state hearing by phone or in writing from the California Department of Social Services (DSS) only after receiving an NAR and within 120 calendar days from the date of the NAR letter. Members may continue to receive benefits during the hearing process, and have the right to representation by legal counsel, a friend or other spokesperson during the process.

Notice of Appeals Resolution

Members may receive a written notice of appeals resolution (NAR), which is a formal letter informing a beneficiary that an adverse benefit determination has been overturned or upheld.

Expedited Appeals

Members can request an expedited appeal if his or her health or ability to regain maximum function could seriously be harmed by waiting for a standard service appeal. A member or provider, acting on behalf of a member and with written consent from the member, may file an expedited appeal either orally or in writing to resolve the expedited appeal within 72 hours of receipt.

Health Net must pay for disputed services if the member receives these services while the appeal is pending.

Health Net will continue benefits while a member appeal is pending for the following:

- Appeal involves the termination, suspension or reduction of previously authorized services.
- Member filed their appeal within the required timeframes.
- Covered services were ordered by an authorized provider.
- Period covered by the original authorization has not expired.
- Member files for continuing covered services within 10 calendar days of when the NOA was sent, or before the intended effective date of the proposed action.
- Until the member withdraws his or her appeal or request for a state hearing, the member fails to request a state hearing and continuation of covered services within 10 calendar days of when the NOA was sent, or the state hearing decision is adverse to the member.

State Hearing

Members may request a state hearing by phone or in writing from the California Department of Social Services (DSS) after receiving a NAR from Health Net stating that their member appeal is denied or if they have exhausted the appeals process. Members may request a state hearing up to 120 calendar days from the date on Health Net's NAR. Members may continue to receive benefits during the hearing process, and have the right to representation by legal counsel, a friend or other spokesperson during the process.

Within two business days of being notified by the Department of Health Care Services (DHCS) or DSS that a member has filed a request for a state hearing which meets the criteria for expedited resolution, Health Net delivers directly to the designated or appropriate DSS administrative law judge all information and documents which either support, or which Health Net considered in connection with, the action which is the subject of the expedited state hearing. If the NOA or NAR notices are not in English, fully translated copies shall be transmitted to DSS along with copies of the original NOA and NAR.

If the member is currently getting treatment and he or she wants to continue getting treatment, the member may ask for a state hearing within 10 days from the date that the NAR was postmarked or delivered or before the date Health Net benefits will end or stop. The member must state that he or she wants to continue treatment when he or she requests the state hearing.

The state must reach a decision for a standard state hearing and notify the member within 90 days of the date of the request. For an expedited state hearing, the state must reach its decision within three business days of receipt of the expedited state hearing request.

Medi-Cal members must first undergo Health Net's appeal process and arbitration must be concluded before they may submit a hearing request. Members may receive continued benefits during the hearing process. Members have the right to be represented by legal counsel, a friend or other spokesperson. Filing a grievance does not waive a member's right to a hearing.

Representation and Assistance Rules at A State Fair Hearing

The member can speak for themselves at the State Hearing. Or, they can have someone like a relative, friend, advocate, doctor, or attorney speak for them. If a member wants someone else to speak for them, they must add their name, address, and telephone number to the form or letter and sign the form telling the State Hearings Division that the person can speak for them. This person is called an Authorized Representative.

The member will not have to pay for an interpreter if one is needed. The State Hearings Division will get them one. If the member has a disability, the State Hearings Division can get them special accommodations free of charge to help them participate in the hearing.

Expedited Hearing

It could take up to 90 days to decide on a case. If waiting 90 days will hurt the member's health, they can request an expedited hearing. If the State Hearings Division approves their request for an Expedited Hearing, they may be able to get a hearing decision within 3 days from the date it receives the members case file from their health plan.

The member can ask for an Expedited Hearing by calling or sending the State Hearing form or a letter to the State Hearings Division. The member must explain how waiting for up to 90 days for a decision will harm their life, health or ability to get or keep maximum function. The member can also get a letter from their doctor to help show why they need an Expedited Hearing.

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 and Appeal Status
- Dispute Submission
- Inquiry Submission

Overview

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

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

- Appeal, challenge or request reconsideration of a claim (including a bundled group of similar claims) that has been denied or adjusted by Health Net.

- Respond to a contested claim that the participating provider does not agree requires additional information for adjudication. A contested claim is one for which Health Net needs more information in order to process the claim.
- Challenge a request by Health Net for reimbursement for an overpayment of a claim.
- Seek resolution of a billing determination or other contractual dispute with Health Net.
- Appeal a participating physician group's (PPG's) written determination following its dispute resolution process when the dispute involves an issue of medical necessity or utilization review, to Health Net for a de novo review, provided the appeal is made within 60 business days of the PPG's written determination.
- Challenge capitated PPG or hospital liability for medical services and payments that are the result of Health Net decisions arising from member grievances, appeals and other member services actions.
- Challenge capitation deductions that are the result of Health Net decisions arising from member billings, claims or member eligibility determinations.

Health Net does not charge providers of service who submit disputes to the Health Net Provider Appeals Unit or the Health Net Medi-Cal Appeals Unit for processing provider disputes and does not discriminate or retaliate against a participating provider who uses the provider dispute process. Further, providers participating through a Health Net PPG cannot be charged a processing fee when utilizing the PPG's provider dispute process.

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

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

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

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

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

Overview for Physicians

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

- Appeal, challenge or request reconsideration of a claim (including a bundled group of similar claims) that has been denied or adjusted by Health Net.
- Respond to a contested claim that the participating provider does not agree requires additional information for adjudication. A contested claim is one for which Health Net needs more information in order to process the claim.
- Challenge a request by Health Net for reimbursement for an overpayment of a claim.

- Seek resolution of a billing determination or other contractual dispute with Health Net.
- Appeal a written determination when the dispute involves an issue of medical necessity or utilization review, to Health Net for a de novo review, provided the appeal is made within 60 business days of the written determination.

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

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

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

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

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

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

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 and Appeal Status

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

Providers can contact the Health Net Medi-Cal Provider Services Center, Community Health Plan of Imperial Valley Provider Services Center or CalViva Health Medi-Cal Provider Services Center (for Fresno, Kings and Madera counties) or Molina Healthcare to check the status of a dispute or appeal.

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, providers may contact the Health Net Provider Services Department. Providers may also use any of the following claims and appeals address information:

- Submission of a new claim.
- Resubmission of contested claims with missing information (requested individual claim documents), including submission of a corrected billing (additional charges previously not submitted).
- Submission of provider appeals.

Providers may use their own spreadsheet or form when submitting provider inquiry requests to the Health Net Medi-Cal Provider Services Center, Community Health Plan of Imperial Valley Provider Services Center or CalViva Health Provider Services Center. Providers must include the following information to ensure appropriate research:

- Provider's full name
- Provider tax ID or NPI number
- Member's name
- Member's date of birth (DOB)
- Health Net identification (ID) card number
- Date of service
- Billed amount
- Claim number

Providers who participate in Health Net's Medi-Cal plan under a capitated agreement with a participating physician group (PPG) must submit inquiries to the PPG or affiliated health plan (Molina Healthcare in Los Angeles County) that processed the claim.

For Los Angeles County only: Molina Healthcare is Health Net's subcontracting health plan for the Medi-Cal managed care program in Los Angeles County. For Molina Healthcare Provider Services Department please contact Molina directly.

Grievances

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

Provider Grievances Process

A provider grievance is an oral or written expression of dissatisfaction or concern that does not involve a prior determination. Provider grievances include quality of care concerns, access to care concerns, complaints regarding delays of referrals or authorizations, patient dumping issues, and provider refusals to submit medical records. There are two types of provider grievances:

- administrative - concerns of a non-clinical nature
- clinical - concerns of a clinical nature

Provider grievances may be submitted orally or in writing within 180 days of the date of occurrence. The first step in registering a grievance is to call the Health Net Medi-Cal Provider Services Center, Community Health Plan of Imperial Valley Provider Services Center or CalViva Health Medi-Cal Provider Services Center (for Fresno, Kings and Madera counties).

The second step is to submit it in writing with the following information:

- a description of the problem, including all relevant facts
- names of involved people
- date of occurrence
- supporting documentation

Health Net participating providers are notified in writing of receipt of a grievance within five business days. A grievance received without all required information is returned to the submitting provider with instructions for resubmitting the grievance with the missing information. The provider must resubmit the completed grievance within 30 business days of receipt of the request for additional information.

Providers are informed in writing of resolution of the grievance within 30 business days. If resolution of the case exceeds 30 business days, Health Net will send the provider a letter of explanation by the 30th business day, documenting the reason for the delay and an estimated completion date for the resolution.

Resolution Process

A Health Net Medi-Cal Provider Services representative who receives the grievance forwards the information to a Health Net Medical Review Unit case coordinator. The case coordinator handles the grievance and corresponds with the provider, including requesting any additional information necessary. Upon receipt of all necessary information, the case coordinator forwards the grievance to the Health Net regional medical director responsible for the region for review and resolution of the grievance.

The Health Net regional medical director reviews all provider grievances. The medical director evaluates the grievance using multiple resources, criteria and guideline sets that include:

- Title 22, California Code of Regulations.
- Electronic Data Systems (EDS) Medi-Cal Provider Manual guidelines.
- Department of Health Care Services (DHCS) Manual of Criteria.
- Current Procedural Terminology (CPT) guidelines.
- InterQual Criteria sets (McKesson).
- Hospital Chargemaster Guide (Ingenix).
- Health Net Medi-Cal claims policies and procedures.

Upon completion of the medical director review and determination, the case is returned to the case coordinator who then notifies the provider in writing of the determination, the reason for the determination, actions taken, and a description of the provider's options if the provider is dissatisfied with the outcome.

Information gathered by Health Net, and as a result of the review of quality-related grievances that involve a provider, is considered confidential and protected from disclosure as quality of care-related peer review activities under California law. Provider grievances related to a request for reassignment or disenrollment of a Medi-Cal member are referred to the Health Net Medi-Cal Member Services Department.

If a member calls the Health Net call center, the representative will warm transfer the caller to Molina's Appeal and Grievance Department to determine if a new case should be opened.

Member Grievance Procedures

A member, or his or her physician or other representative, may file a grievance on behalf of the member anytime according to the current federal regulations, Title 42, CFR, Section 438.402(c)(i). Grievances filed by the member's physician or other representative, on behalf of the member, require written consent from the member or authorized representative. Members may submit grievances verbally or in writing by contacting the Health Net Medi-Cal Member Appeals and Grievances Department.

Members may obtain a member grievance/complaint form from their providers' office, or they may contact the Health Net Medi-Cal Member Services Department, Community Health Plan of Imperial Valley Member Services Department or CalViva Health Medi-Cal Member Services Department for assistance. The Member Grievance/Complaint form is available in the following languages for Health Net Medi-Cal members:

- Member Grievance/Complaint Form - Arabic (PDF)
- Member Grievance/Complaint Form - Armenian (PDF)
- Member Grievance/Complaint Form - Chinese (PDF)
- Member Grievance/Complaint Form Medi-Cal - English (PDF)
- Member Grievance/Complaint Form CalViva Health - English (PDF)
- Member Grievance/Complaint Form Community Health Plan of Imperial Valley - English (PDF)
- Member Grievance/Complaint Form - Farsi (PDF)
- Member Grievance/Complaint Form Health Net - Hmong (PDF)
- Member Grievance/Complaint Form CalViva Health - Hmong (PDF)
- Member Grievance/Complaint Form - Khmer (PDF)
- Member Grievance/Complaint Form - Korean (PDF)
- Member Grievance/Complaint Form - Russian (PDF)
- Member Grievance/Complaint Form Health Net - Spanish (PDF)
- Member Grievance/Complaint Form CalViva Health - Spanish (PDF)
- Member Grievance/Complaint Form Community Health Plan of Imperial Valley - Spanish (PDF)
- Member Grievance/Complaint Form - Tagalog (PDF)
- Member Grievance/Complaint Form - Vietnamese (PDF)

Once the Health Net Medi-Cal Appeals and Grievances Department receives the member grievance, it is sent to a grievance coordinator for investigation. Health Net provides the member with a written acknowledgment of the grievance within five calendar days of receipt.

The member is informed in writing of the grievance resolution within 30 calendar days. If a grievance cannot be resolved within 30 calendar days, a letter of explanation that includes the reason for the delay and an estimated date of completion is sent to the member.

If the member needs help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved, or a grievance that has remained unresolved for more than 30 days, the member may call the department for assistance.

Members have a right to access their medical records. Written authorization from the member or the member's 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.

DSS And DMHC Telephone Lines

Members who have a grievance against Health Net should contact Health Net and use its grievance process. However, members may also contact the California Department of Social Services (DDS) or the Department of Managed Health Care (DMHC) for assistance with an emergency grievance or with a grievance that has not been satisfactorily resolved by Health Net.

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

B

C

D

- Dental Services
- Dialysis
- Durable Medical Equipment
- Doula Services
- Dyadic Services

E

Enteral Nutrition

F

Family Planning

G

H

- Hearing/Hearing AID
- HIV Testing and Counseling
- Home Health Care
- Hospice Care

I

- Immunizations
- Incontinence
- Initial Health Appointment
- Injectables

J

K

L

Long-Term Care

M

Maternity

N

Nurse Midwife

O

Obesity

P

- Podiatry
- Preventive Services
- Primary Care
- Principle Exclusions and Limitations

Q

R

S

- Second Opinion by a Physician
- Subacute Care Facilities
- Street Medicine Services
- Support for Disabled Members

T

- Transgender Services
- Transplants
- Transportation

U

V

Vision

W

X

X-Ray and Laboratory Services

Y

Z

Cognitive Health Assessment

Provider Type: Physicians | Participating Physician Groups (PPG)

Medi-Cal providers must take required training, self-attest to having completed training and use approved screening tools to receive payment for conducting an annual cognitive health assessment for eligible members age 65 or older and who are not eligible for a similar assessment as part of an annual wellness visit under the Medicare program.

For more information on billing and payments for annual cognitive assessments, see the Department of Health Care Services (DHCS) All Plan Letter (APL) 22-025.

Training

You are eligible to receive the payment if you comply with both of the following:[1]

- Finish and attest to completing the cognitive health assessment training, as specified and approved by the DHCS. Training is available at the Dementia Care Aware website.
- Conduct the cognitive health assessment using a tool suggested by the DHCS.

Assessment tools

At least one cognitive assessment tool listed below is required. Cognitive assessment tools used to determine if a full dementia evaluation is needed include, but are not limited to:[1]

- **Patient assessment tools**
    - General Practitioner assessment of Cognition (GPCOG)
    - Mini-Cog
- **Informant tools** (family members and close friends)
    - Eight-item Informant Interview to Differentiate Aging and Dementia
    - GPCOG
    - Short Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE)

Based on the scores from these assessments, additional assessment or a specialist referral may be appropriate.

[1] Information taken or derived from DHCS APL 22-025, *Responsibilities for Annual Cognitive Health Assessment for Eligible Members 65 Years of Age or Older* (PDF).

Street Medicine Services

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

Health Net covers street medicine for Medi-Cal members experiencing unsheltered homelessness. The street medicine benefit covers up to the full array of services necessary to meet immediate needs, including but not limited to, preventive services, and the treatment of acute and chronic conditions.

Member eligibility verification

Providers are responsible for verifying benefits and member eligibility each time a member is scheduled to receive services.

Check eligibility through either of the following:

- The provider portal (preferred method) .
- The Automated Eligibility Verification System (AEVS).

Coordinating services

Street medicine providers are responsible for coordinating member care with the member's primary care physician (PCP) and/or participating physician group (PPG) and initiating specialist referrals, including behavioral health, Community Supports and social services, when needed.

Claims billing

Claims are paid based on the eligibility of the individual, for appropriate and applicable services within their scope of practice. Providers may bill Place of Service (POS) codes to Fee-for-Service Medi-Cal or the Plan when rendering medical services for street medicine. For more information on billing for street medicine refer to the Department of Health Care Services (DHCS) billing guidelines.

Subacute Care Facilities

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

Members in need of adult or pediatric subacute care services must be placed in a health care facility that is licensed for subacute care with the California Department of Public Health and providing the level of care commensurate with their medical needs.

Adult subacute care is a level of care that is defined as a level of care needed by a patient who does not require hospital acute care but who requires more intensive licensed skilled nursing care than is provided to the majority of patients in a skilled nursing facility.

Pediatric subacute care is a level of care needed by a person less than 21 years of age who uses a medical technology that compensates for the loss of a vital bodily function.

Subacute patients require special medical equipment, supplies and treatments such as ventilators, tracheostomies, total parenteral nutrition, tube feeding and complex wound management care.

Coordination of Care

The primary care physician (PCP) continues to provide care during the transition to subacute care, and coordinates with the Subacute attending physician to ensure continuity of care. This includes forwarding all pertinent records to the new PCP when identified and available to consult.

Long-Term Care for Permanently Institutionalized

Medi-Cal members who reside in a Subacute Care Facility for long-term care beyond the month of admission plus one month, are deemed permanently institutionalized. These members are reassigned from their participating physician groups (PPGs) to Health Net for utilization management upon Health Net's evaluation that the member is deemed permanently institutionalized and qualifies for reassignment. PPGs are responsible for subacute members until they are no longer listed on their monthly eligibility reports.

Health Net must authorize subacute long-term care services when a member has a medical condition that requires subacute level of care. Subacute care includes both skilled nursing care and non-skilled care, specific to out-of-home protective living arrangements with 24-hour supervised or observation care on an ongoing intermittent basis to abate deterioration.

Members in need of Subacute care services are placed in facilities providing the level of care commensurate with their medical needs.

Criteria for Adult Subacute Care Program

Adult subacute level of care refers to very intensive, licensed, skilled nursing care provided to members who have a fragile medical condition. To qualify for the adult subacute program, the member must require at least four hours of direct skilled nursing care per day and at least one of the following:

- Tracheostomy care with continuous mechanical ventilation for at least 50 percent of the day
- Tracheostomy care with suctioning and room air mist or oxygen as needed, and one of the six treatment procedures listed below; or
- Administration of any three of the six following treatment procedures:
    - total parenteral nutrition
    - inpatient physical, occupational or speech therapy at least two hours per day, five days per week
    - tube feeding (nasogastric or gastrostomy)
    - inhalation therapy treatments every shift and a minimum of four times per 24-hour period
    - intravenous (IV) therapy involving one of the following:
        - continuous administration of a therapeutic agent
        - hydration
        - frequent intermittent IV medication administration via a peripheral or central line (heparin lock)
    - wound debridement, packing and medicated irrigation with or without whirlpool treatment

One of the criteria Health Net uses to determine medical necessity is the Department of Health Care Services (DHCS) Manual of Criteria for Medi-Cal Authorization (PDF).

Criteria for Pediatric Subacute Care Program

To qualify for the pediatric subacute care program, the member must be under age 21 and need one of the following:

- Tracheostomy care with dependence on mechanical ventilation for a minimum of six hours each day
- Tracheostomy care requiring suctioning at least every six hours, room air mist or oxygen as needed, and dependence on one of the four (2-5) treatment procedures listed below
- Total parenteral nutrition or other intravenous nutritional support and one of the five treatment procedures listed below
- Skilled nursing care in the administration of any three of the five treatment procedures listed below

Treatment Criteria for Pediatric Subacute Care

1. Intermittent suctioning at least every eight hours and room air mist or oxygen as needed.
2. Continuous intravenous therapy, including administration of therapeutic agents necessary for hydration or of intravenous pharmaceuticals, or intravenous pharmaceutical administration of more than one agent via a peripheral or central line without continuous infusion.
3. Peritoneal dialysis treatment requiring at least four exchanges every 24 hours.
4. Tube feeding via nasogastric or gastrostomy tube.
5. Other medical technologies required continuously, which, in the opinion of the attending physician and Medi-Cal consultant, require the services of a professional nurse.

Additional Criteria

- The intensity of medical/skilled nursing care required by the member is such that the continuous availability of a registered nurse in the pediatric subacute unit is medically necessary to meet the member's health care needs and not be any less than the nursing staff ratios required.
- The member's medical condition must have stabilized so that the immediate services of an acute care hospital, including daily physician visits, are not medically necessary.
- The intensity of medical/skilled nursing care required by the member is such that, in the absence of a facility providing pediatric subacute care services, the only other medically necessary inpatient care appropriate to meet the member's health care needs under the Medi-Cal program is in an acute care licensed hospital bed.

One of the criteria Health Net uses to determine medical necessity is the Department of Health Care Services (DHCS) Manual of Criteria for Medi-Cal Authorization (PDF).

Second Opinion by a Physician

Physicians | Participating Physician Groups (PPG)

All requests for a second opinion meeting the California Health and Safety Code Section 1383.1 and 1383.5 require health plans to allow members to obtain second opinions in any of the following situations:

- Member questions the reasonableness or necessity of recommended surgical procedures
- Member questions a diagnosis or plan of care for a condition that threatens loss of life, limb, bodily function, or substantial impairment, including a serious chronic condition
- Clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating physician is unable to diagnose the condition, and the member requests an additional diagnosis
- Treatment plan is in progress, but is not improving the member's medical condition within an appropriate period of time given the diagnosis and plan of care
- Member has attempted to follow the plan of care or has consulted with the initial provider with serious concerns about the diagnosis or plan of care

Second opinion consultations include a history, an examination and a medical decision of some complexity. They do not include additional tests, which have to be approved separately.

Office visits, consultations with a participating physician, or a referral to a physician or qualified professional provider necessary for obtaining a second opinion, are covered.

Out-of-Network Requests

Members who initiate a request for a second or third opinion are limited to in-network providers, except where appropriate in-network providers are not accessible.

If the member refuses to see an in-network provider and is requesting an out-of-network provider, all requests for a second opinion from a non-participating provider, should be directed to the Health Net Member Services Department or the CalViva Health Medi-Cal Member Services Department or Community Health Plan of Imperial Valley Member Services Department.

Second Opinion Referral Responsibilities

The health plan and delegated participating physician groups (PPGs) provide timely referral for a second opinion consultation by an appropriately qualified health care professional when the second opinion is requested by a member or the member's physician. An appropriately qualified health care professional is a primary care physician (PCP) or specialist acting within the PCP's or specialist's scope of practice and possessing clinical background, training and expertise related to the particular illness, disease or other condition associated with the request for a second opinion. Second opinion referrals are approved for a one-time-only consultation. All tests, lab and X-ray services must be directed back to the member's PPG or PCP for coordination. All care must be performed or authorized by the PPG or PCP in order to be covered. There are few, if any, circumstances under which second opinion requests should be denied.

PPGs delegated for utilization management (UM):

- Provide second opinions by an appropriately qualified health care professional (of the same or equivalent specialty) of the member's choice, from the PPG's network
- Make every effort to accommodate the member within the PPG network
- Must consider all participating specialists for second opinion referrals

- Should instruct members who request an out-of-network second opinion and refuse to accept redirection in-network, to contact the Health Net Member Services Department the CalViva Health Medi-Cal Member Services Department or Community Health Plan of Imperial Valley Provider Services Center for further assistance

Health plan:

- Authorizes second opinions from appropriately qualified health care professional (of the same or equivalent specialty) of the member's choice from the plan's network when appropriate
- May limit referrals to its network providers if criteria for appropriately qualified health care professionals are met within the network. The health plan authorizes a second opinion by an appropriately qualified out-of-network health care professional when no participating health plan provider is available

Access to Sensitive Services

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

This section contains general member benefit information on access to sensitive and minor consent services, as well as confidentiality requirements.

Select any subject below:

- Confidentiality
- Coverage and Services
- Freedom of Choice
- Minor's Consent for Services
- Sensitive Services

Confidentiality

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

All Health Net employees and participating providers must maintain the confidentiality of member information pertaining to the member's access to sensitive services.

Freedom of Choice

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

Members have the freedom of choice to receive timely, confidential services for family planning, diagnosis and treatment for sexually transmitted infections (STIs) and HIV counseling and testing services from any family planning provider without prior authorization. Further, members may receive timely and confidential referral for drug and alcohol treatment services, refer to the Public Programs section for additional information.

Medi-Cal-only members under age 18 may obtain sensitive services without parental consent.

Minor's Consent for Services

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

Members under age 18 may access and obtain minor consent services without parental consent and without prior authorization of coverage. Minor consent services are related to covered services of a sensitive nature as shown in the table below and are categorized by age as follows:

Covered Services	Minor may consent if age 12 and over	Minor may consent if under age 12
Family planning (prevention and treatment of pregnancy, except sterilization)	Yes	Yes
Abortion* (termination of pregnancy)	Yes	Yes
Sexual assault, including rape	Yes	Yes
Infectious, contagious, communicable diseases (diagnosis and treatment)	Yes	No
Sexually transmitted diseases (prevention, diagnosis and treatment)	Yes	No
AIDS/HIV (prevention, diagnosis and treatment)	Yes	No
Drug and alcohol abuse	Yes	No

Covered Services	Minor may consent if age 12 and over	Minor may consent if under age 12
Outpatient behavioral health treatment	Yes	No
Residential shelter services and other support services	Yes	No
Partner violence	Yes	No

*American Academy of Pediatrics v. Lungren, 16 Cal. 4th 307 (1997)

Members may access most services from any qualified provider, in or out-of-network, except as follows:

- Obstetrical care for pregnancy - must be accessed through an in-network provider (pregnancy testing is considered to be a family planning service and may be obtained from any qualified provider in or out-of-network).
- Drug and alcohol treatment - members are entitled to confidential, timely referral to the county drug and alcohol program, refer to the Public Programs topic for additional information.
    - Minors ages 16 or older may consent to receive medications that use buprenorphine for opioid use disorder as narcotic replacement therapy without parent or guardian consent. Assembly Bill (AB) 816 (2023) revised Family Code Section 6929 and added Family Code Section 6929.1 that expands minor consent to include narcotic replacement therapy only in a detoxification setting. Parent or guardian consent is necessary for maintenance narcotic replacement therapy.
- Behavioral health care - refer to the Public Programs topic for additional information. Members ages 12 or older who are mature enough to participate intelligently are entitled to timely, confidential referral to the local mental health program.

Sensitive Services

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

Sensitive services include those services related to treatment for injuries resulting from sexual assault, drug or alcohol abuse treatment, pregnancy, family planning, HIV counseling and testing, pregnancy termination, outpatient mental health treatment and diagnosis, residential shelter services, intimate partner violence, and treatment of sexually transmitted infections (STIs) for children under age 18.

Reproductive rights, privacy and the exchange of information

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

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

State law specifically states:[1]

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

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

Legally protected health care activity includes, but is not limited to:

- Reproductive health care services,
- Gender-affirming health care services, and
- Gender-affirming mental health care services.

Sensitive services include, but are not limited to:

- Services related to mental/behavioral health,
- Sexual and reproductive health,
- Sexually transmitted infections,
- Substance use disorder,
- Gender affirming care, and
- Intimate partner violence.

Requirements for providers

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

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

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

Coverage and Services

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

Members may access sensitive services in a timely manner and without barriers. Prior authorization is not required for access to certain services. Members may access most sensitive services from any qualified provider, in- or out-of-network, except obstetrical care for pregnancy and services related to substance abuse and mental health. The primary care physician (PCP) should encourage members to access in-network providers for services whenever possible. This process improves coordination of care and has a positive impact on health outcomes. Out-of-network providers must demonstrate reasonable efforts to coordinate services with a member's PCP or obtain the member's written refusal to do so. Health Net only covers out-of-network provider services that are within the definition of sensitive services.

Members should receive medical care according to the nature of the medical problem. The member or PCP should make the determination of timely access. Members can receive family planning services, including pregnancy testing, sexually transmitted infection (STI) diagnosis and treatment and HIV counseling and testing from participating or non-participating providers. Refer to the Family Planning and HIV Testing and Counseling discussions under the Benefits topic and the Sexually Transmitted Infections discussion under the Public Programs topic for additional information.

Although pregnancy testing is considered to be a family planning service and may be obtained from any qualified provider, in- or out-of-network, obstetrical care for pregnancy must be arranged through in-network providers. Refer to the Maternity discussion under the Benefits topic for additional information.

Refer to the Alcohol and Drug Treatment Services and Mental Health under Public Programs topic for additional information.

AIDS

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

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

Select any subject below:

- AIDS Waiver Program
- AIDS/HIV Injectable Medications

Medi-Cal Waiver Program (formerly AIDS Waiver Program)

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

Refer to the Medi-Cal Waiver Program description under Public Programs for additional information.

AIDS/HIV Injectable Medications

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

For Medi-Cal members, certain medications for HIV and AIDS are excluded from Health Net's coverage responsibilities. For a list of excluded medications, refer to the Excluded Medications for HIV and AIDS discussion in the AIDS Waiver Program section under the Public Program topic.

Alcohol and Drug Abuse

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

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

Select any subject below:

Medication Assisted Treatment

Medications for addiction treatment also known as medication-assisted treatment (MAT) are covered when delivered in primary care offices, emergency departments, inpatient hospitals, and other contracted medical settings.

Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment

Provider Type: Physicians | Participating Physician Groups (PPG)

Alcohol and drug treatment services are excluded from Health Net's coverage responsibilities under Health Net's Medi-Cal managed care contract. These services are administered by Counties and overseen by the state of California.

Health Net, its affiliated health plans and subcontracting providers are available to coordinate referrals for members requiring substance use treatment and services. Members receiving services under this program remain enrolled in Health Net. Participating primary care physicians (PCPs) are responsible for maintaining continuity of care for the member. Additionally, participating providers must maintain documentation of Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) services provided to members. When a member transfers from one PCP to another, the receiving PCP must attempt to obtain the member’s prior medical records, including those pertaining to the provision of preventive services. Member medical records must include the following:

- The service provided (e.g., screen and brief intervention).
- The name of the screening instrument and the score on the screening instrument (unless the screening tool is embedded in the electronic health record).
- The name of the assessment instrument (when indicated) and the score on the assessment (unless the screening tool is embedded in the electronic health record). and
- If and where a referral to an alcohol use disorder (or substance use disorders program was made.

Alcohol Misuse Screening and Behavioral Counseling

Consistent with U.S. Preventive Services Task Force (USPSTF) Grade A or B recommendations, AAP/Bright Futures, and the Medi-Cal Provider Manual, Managed Care Plans (MCPs) must provide alcohol and drug SABIRT services for members 11 years of age and older, including pregnant women. These services may be provided by providers within their scope of practice, including, but not limited to, physicians, physician assistants, nurse practitioners, certified nurse midwives, licensed midwives, licensed clinical social workers, licensed professional clinical counselors, psychologists and licensed marriage and family therapists.

Screening

Alcohol and drug use screening must be conducted using validated screening tools. Validated screening tools include, but are not limited to:

- Alcohol use disorders identification test (AUDIT).
- Alcohol use disorders identification test (Audit-C).
- Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) for non-pregnant adolescents.
- Cut down-annoyed-guilty-eye-opener adapted to include drugs (CAGE-AID).
- Drug abuse screening test (DAST-10).
- Drug abuse screening test (DAST-20).
- Michigan alcoholism screening test geriatric (MAST-G) alcohol screening for geriatric population.
- National institute on drug abuse (NIDA) quick screen for adults.
- The single NIDA quick screen alcohol-related questions can be used for alcohol use screening.
- NIDA-modified alcohol, smoking and substance involvement screening test (NM-ASSIST).
- Parents, partners, past and present (4Ps) for pregnant women and adolescents.
- Tobacco alcohol, prescription medication, and other substances (TAPS).

Brief Assessment

When a screening is positive, validated assessment tools should be used to determine if

alcohol use disorder (AUD) or substance use disorder (SUD) is present. Validated alcohol and drug assessment tools may be used without first using validated screening tools. Validated assessment tools include, but are not limited to:

- NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test (NM-ASSIST)
- Drug Abuse Screening Test (DAST)-20
- Alcohol Use Disorders Identification Test (AUDIT)

Brief Interventions and Referral to Treatment

For members with brief assessments that reveal unhealthy alcohol use, brief misuse counseling should be offered. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, must be offered to members whose brief assessment demonstrates probable AUD or SUD. Alcohol and/or drug brief interventions include alcohol misuse counseling and counseling a member regarding additional treatment options, referrals, or services. Brief interventions must include the following:

- Provide feedback to the patient regarding screening and assessment results;
- Discuss negative consequences that have occurred and the overall severity of

- the problem;
- Support the patient in making behavioral changes; and
- Discuss and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated.

Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care

The USPSTF recommends that clinicians screen adults ages 18 or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.

The following HCPCS codes may be used to bill for these services:

- G0442 - annual alcohol misuse screening, 15 minutes
- G0443 - brief face-to-face behavioral counseling for alcohol misuse, 15 minutes

Code G0442 is limited to one screening per year, any provider, unless otherwise medically necessary. Code G0443 may be billed on the same day as code G0442. Code G0443 is limited to three sessions per recipient per year, any provider, unless otherwise medically necessary.

Treatment Referral

Providers are responsible for referring members who meet criteria for alcohol and drug disorders to a county drug program for services. These services are not covered by Health Net. A list of county contacts for local substance use disorder treatment information and referrals is available on the DHCS website at DHCS website, under Referral to Treatment.

Documentation Requirements

Member medical records must include the following:

- The service provided (e.g., screen and brief intervention);
- The name of the screening instrument and the score on the screening instrument
- (unless the screening tool is embedded in the electronic health record);
- The name of the assessment instrument (when indicated) and the score on the
- assessment (unless the screening tool is embedded in the electronic health record); and
- If and where a referral to an AUD or SUD program was made.

PCPs must maintain documentation of SABIRT services provided to members. When a member transfers from one PCP to another, the receiving PCP must attempt to obtain the member’s prior medical records, including those pertaining to the provision of preventive services.

Acupuncture

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

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

Select any subject below:

- Acupuncture Services

Acupuncture Services

Provider Type: Physicians | Participating Physician Groups (PPG)

Health Net members may only access acupuncture services and treatments through American Specialty Health Plans, Inc. (ASH Plans).

Acupuncture outpatient services are limited to two services in a month, in combination with audiology, chiropractic, occupational therapy, and speech therapy services (limits do not apply to children under 21). Acupuncture services are limited to treatment performed to prevent, modify or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition. Authorization is not required for acupuncture services for up to two visits per month. Prior authorization is required if additional visits are needed through ASH (see below for link) during the same month.

Medi-Cal members may self-refer for acupuncture (first two services per month) for certain conditions, illnesses or injuries only covered in conjunction with services from a medical doctor (for example, chronic pain or nausea related to chemotherapy). Additional appointments require referral.

Participating physician groups (PPGs) and direct network providers must only refer Medi-Cal members to ASH Plans for acupuncture services.

Los Angeles County members assigned to Molina

This is not applicable to Health Net members assigned to Molina. Contact Molina about acupuncture services.

Ambulance

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

This section contains general member benefit information on ambulance services.

Select any subject below:

- Transportation

Transportation

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

Medi-Cal members are entitled to non-medical transportation (NMT) and non-emergency medical transportation (NEMT) benefits. Modivcare™ is Health Net's capitated provider for all covered non-emergency medical transportation (NEMT) and non-medical transportation (NMT) services for members assigned to a direct network provider or to shared-risk participating physician groups (PPGs). Shared-risk PPGs are PPGs that are delegated for utilization management but not financially at risk for transportation services. All referral sources (PPGs, hospitals, skilled nursing facilities, etc.) are required to contact Modivcare to arrange for transportation services. Failure to do so may result in the denial of the claim for which the PPG or hospital may be liable. For members assigned to Dual Risk PPGs, please refer to the section below. A Physician Certification Statement (PCS) form is required for all NEMT services.

Health Net is responsible for NMT to Medi-Cal services, including services that are carved-out, including but not limited to dental services, specialty mental health services and pharmacy services. Members are instructed to contact the Medi-Cal Member Services Department , Community Health Plan of Imperial Valley Member Services Department or CalViva Health Medi-Cal Member Services Department (for Fresno, Kings and Madera counties) to request NMT services.

Dual-risk PPGs and hospitals

PPGs or hospitals that have risk for NEMT in the Division of Financial Responsibility (DOFR) must authorize and coordinate with their transportation provider for medically necessary services in a timely manner. Failure to do so will result in the plan approving and arranging the transportation and processing a capitation payment deduction. A Physician Certification Statement (PCS) form is required for all NEMT services. A PCS process must be followed to collect the PCS form and arrange NEMT services.

Participating physician groups and hospitals that have risk for NEMT in the Division of Financial Responsibility (DOFR) must authorize and coordinate with their transportation provider to ensure Medi-Cal members have 24-hour access to NEMT to a pharmacy or urgent care facility that is open 24 hours a day.

Health Net provides NMT through Modivcare for medically necessary covered services and all Medi-Cal covered services.

Coverage Requirements

NEMT services are covered when the member's condition is such that ordinary means of transportation are medically inadvisable. Such transportation is covered only for the purpose of obtaining needed Health Net-covered service. Coverage is limited to the least costly medical transportation available to adequately meet the

member's medical needs. Modivcare will send a physician certification (PCS) form to physicians to indicate approval for level of service. A PCS form is required before NEMT can be provided, therefore, it is very important for ordering providers to return the completed and signed form.

NMT services are covered for members to obtain medically necessary Medi-Cal services, including carve out services, including but not limited to, specialty mental health, substance use disorder, pharmacy, dental, and any other benefits covered by FFS Medi-Cal.

NEMT and NMT services include transportation for the member and one attendant, such as a parent, guardian or spouse, and must be requested at the time of the initial transportation arrangement.

With written consent of a parent or guardian, NEMT and NMT may be arranged for a minor under age 18 who is unaccompanied by a parent or guardian. Health Net provides transportation services for unaccompanied minors under age 18 when state or federal law does not require parental consent for the minor's services. All necessary written consent forms, such as Consent for Minors to Travel without an Escort Form (PDF), must be received prior to arranging transportation for an unaccompanied minor and must be provided to Health Net.

Non-Emergency Medical Transportation

Non-emergency medical transportation (NEMT) includes ambulances, wheelchair vans and gurney vans and is provided when medically necessary and the patient is not ambulatory.

NEMT is a covered Medi-Cal benefit when the member needs to obtain medically necessary covered services and when prescribed in writing via the PCS form signed by a physician, physician assistant (PA), nurse practitioner (NP), certified nurse midwife (CNM), dentist, podiatrist, or mental health or substance use disorder provider. NEMT under Medi-Cal is covered only when the patient's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated. Additionally, NEMT is covered for patients who cannot ambulate or are unable to stand or walk without assistance, including those using a walker or crutches. This includes door-to-door assistance for all members receiving NEMT services.

The physician is required to document the member's limitations and provide specific physical and medical limitations that preclude the member's ability to reasonably ambulate without assistance or to be transported by public or private vehicles. NEMT may be authorized for visits up to 12 months in advance. A new PCS form is required every 12 months if NEMT is continued to be utilized.

NEMT necessary to obtain medical services is covered subject to the written authorization of a licensed practitioner consistent with their scope of practice. Additionally, if the non-physician medical practitioner is under the supervision of a physician, then the ability to authorize NEMT also must have been delegated by the supervising physician through a standard written agreement.

PAs, NPs and CNMs may sign authorization forms required by the department for covered benefits and services that are consistent with applicable state and federal law and are subject to the supervising physician and PA/NP/CNM being enrolled as Medi-Cal providers pursuant to Article 1.3 (commencing with Section 14043) of Chapter 7 Part 3 of Division 9 of the Welfare and Institutions Code (W I Code).

The NEMT modalities, in accordance with the Medi-Cal Provider Manual, are:

- NEMT ambulance services which include:
    - Transfers between facilities for members who require continuous intravenous medication, medical monitoring or observation.

- Transfers: 1) from an acute care facility to another acute care facility, immediately following an inpatient stay at the acute level of care, 2) to a skilled nursing facility or 3) to a licensed intermediate care facility.

- Litter van services, when the member's medical and physical condition does not meet the need for NEMT ambulance services but meets both of the following:
  - The member must be transported in a prone or supine position because the member is incapable of sitting for the period of time needed for transport.
  - Specialized safety equipment is required over and above that which is normally available in passenger cars, taxi cabs or other forms of public conveyance.
- Wheelchair van services, when the member's medical and physical condition does not meet the need for litter van services, but meets any of the following:
  - The member is incapable of sitting in a private vehicle, taxi or other form of public transportation for the period of time needed to transport.
  - The member must be transported in a wheelchair or assisted to and from a residence, vehicle and place of treatment because of a disabling physical or mental limitation.
  - Specialized safety equipment is required over and above that which is normally available in passenger cars, taxicabs or other forms of public conveyance.
- NEMT by air (requires Health Net authorization and Letter of Agreement) only under the following conditions:
  - Transportation by air is necessary because of the member's medical condition or because practical considerations render ground transportation not feasible.

Physician Certification Statement Form - Request for Transportation

Use the Physician Certification Statement Form – Request for Transportation – Health Net (PDF), Physician Certification Statement Form – Request for Transportation – CalViva Health (PDF) or Physician Certification Statement Form – Request for Transportation – Community Health Plan of Imperial Valley (PDF) to document the specific transportation restrictions of a member due to a medical condition, and request non-emergency medical transportation (NEMT) for Medi-Cal members. A physician certification statement (PCS) form is not required for non-medical transportation (NMT).Providers who may complete and sign the PCS form include:

- Physician
- Dentist
- Podiatrist
- Physician assistants (PAs)
- Nurse practitioners (NPs)
- Certified nurse midwives (CNMs)
- Mental health or substance use disorder providers

Non-Medical Transportation

Modivcare can also arrange non-medical transportation (NMT), including rideshare, passenger car, taxi or other forms of public/private conveyances for certain ambulatory members needing transportation assistance when services are covered or for any Medi-Cal covered service, as follows:

NMT includes transportation for medically necessary appointments or for any Medi-Cal covered service, and may be provided by rideshare, passenger car/sedan, taxicab, paratransit, such as Access, or fixed route transportation, such as a bus, and mileage reimbursement.

- Passenger car/sedan, taxi (ambulatory curb-to-curb): Member is ambulatory and can walk to the curb and board and exit the vehicle unassisted but cannot utilize the bus or train (curb-to-curb).
- Rideshare, passenger car/sedan (ambulatory door-to-door): Member is ambulatory and can walk but requires driver assistance from residence to the medical appointment. Member may use:
- Wheelchair, able to transfer from a folding wheelchair without assistance. Note, if assistance is required, choose wheelchair van under NEMT.
- Walker.
- Cane.
- Crutches.
- Paratransit services: Member is ambulatory and can walk to the curb and board and exit the vehicle unassisted but cannot utilize the bus (curb-to-curb).
- Mass transit: Member is ambulatory and is able to use public transportation and may be medically able to walk up to a half mile to a bus stop (curb-to-curb).
- Mileage reimbursement: Member is ambulatory and has access to other means of transportation such as a working vehicle in the home, family member or neighbor. Member may request mileage reimbursement at the time the trip is scheduled (curb-to-curb).

NMT services include: round-trip transportation for a member by rideshare, passenger car, taxicab, or any other form of public or private conveyance (private vehicle), as well as mileage reimbursement (at the time transportation is arranged), bus passes, taxi vouchers, or train tickets for medical purposes.

Round-trip NMT is available for the following:

- medically necessary covered services
- members picking up drug prescriptions
- members picking up medical supplies, prosthetics, orthotics, and other equipment
- dental services
- mental health services
- substance abuse services
- all Medi-Cal covered services

Ground Emergency Medical Transportation (GEMT)

Participating physician groups (PPGs) and hospitals must submit a list of their contracted ground emergency medical transportation (GEMT) providers annually. This applies to Medi-Cal providers contracted under a global and dual risk arrangement. The list is due annually no later than March 31.The list will help identify non-contracted GEMT providers for automated payments that meet the requirements under the Department of Health Care Services' Public Provider Ground Emergency Medical Transport (PP-GEMT) and GEMT quality assurance fee (QAF) programs. At a minimum, include the following information on the list:

- Provider name.
- Provider type (PPG or Hospital).
- Risk type (Dual or Global).
- GEMT provider name.
- GEMT National Provider Identifier (NPI) number.

PPGs and hospitals can send their list to their assigned Provider Relations & Contracting Specialist (PRCS).

Transportation

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

Physician Certification Statement Form - Request for Transportation

Refer to Ambulance for Transportation information.

Autism Spectrum Disorders

Provider Type: Physicians | Participating Physician Groups (PPG)

Autism Spectrum Disorders (ASDs) include the former diagnoses of Pervasive Developmental Disorder Not Otherwise Specified (PDD-NOS), Asperger's Syndrome and Autism. Autism is a developmental disorder that presents in the first few years of life and profoundly interferes with the individual's lifelong functioning.

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

Screening

Autism is characterized by impairment in three core areas:

- Social interactions
- Verbal and nonverbal communication
- 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 its recommendations for preventive pediatric care. Additional follow up in six months for borderline development of autism screening results, such as a 30-month visit, are the providers' clinical decision. Moreover, parental concerns about their child's development should lead to a careful assessment of development at any pediatric visit.

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. Additional AAP autism resources are available at healthychildren.org

Diagnostic Evaluation

If a child exhibits the above behavioral impairments and has an abnormal developmental screening, the next step is referral to one or more medical and behavioral specialists who can include a developmental pediatrician, child psychiatrist, speech and language pathologist, and other ancillary clinical specialists, such as physical therapists and occupational therapists, as needed. These specialists provide input to the primary care physician (PCP) or psychologist for a diagnosis of ASD.

A thorough evaluation for ASD may include the following:

- Parents and/or caregiver interview, including interviews of 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, including:

- Pervasive Developmental Disorders Screening Test-II (PDDST-II) for children from birth to age three.
- Checklist of Autism in Toddlers (CHAT) for children age 18 months.
- Modified Checklist for Autism in Toddlers (M-CHAT™) for children starting at age 16 months. (Spanish, Turkish, Chinese, and Japanese versions are available.) A revised version, M-CHAT-R,™ is also available.
- Screening Test for Autism in Two-Year-Olds (STAT).
- Social Communication Questionnaire (SCQ) for children ages four and older.

Upon diagnosis, children often are referred to a provider of Applied Behavioral Analysis for a functional behavioral assessment. If the assessment reveals that the child can benefit from ABA treatment a request for authorization is submitted to Health Net. Upon authorization, children may receive ABA services for a period of time spanning from a few months to a few years, depending on the child’s level of impairment and response to treatment. Additionally referral to a local Regional Center may be appropriate. Children may also receive school-based services based on recommendations in an Individualized Education Plan (IEP).

Medical Services

Medical services for the treatment of ASD may include physical therapy (PT), occupational therapy (OT), speech therapy (ST), and/or specialty management for comorbid disorders, such as seizure disorders.

Health Net covers medical services for the treatment of ASD. Parents or legal guardians of the member with ASD can ask for one physician to lead the care plan and coordinate services with other physicians and specialists. PT and ST are limited benefits under the Medi-Cal program, based on Title 22, California Code of Regulations (CCR), Section 51309 (rehabilitation benefits) states that:

- Physical therapy services shall include physical therapy evaluation, treatment planning, treatment, instruction, consultative services, and application of topical medications. Services do not include the use of Roentgen rays or radioactive materials or the use of electricity for surgical purposes including cauterization. Services are limited to treatment immediately necessary to prevent or to reduce anticipated hospitalization or to continue a necessary plan of treatment after discharge from the hospital.
- Such services, except physical therapy, are subject to the limitations set forth in Section 51304(a): Program coverage of services is limited to a maximum of two services from among those services set forth in those sections in any one calendar month.
    - Members under age 21 have access to additional medically necessary therapy visits, subject to prior authorization.
- Provision of the services is with the expectation that the beneficiary will improve significantly in a reasonable and generally predictable period of time or to establish an effective maintenance program in connection with a specific disease state.
- The service is reasonable and medically necessary for the treatment of the beneficiary's condition.

The regional center assesses each referral, and if the member is eligible for regional center programs, outlines a case-specific plan of therapy and other services, taking into account the benefits and availability of services through the health plan and Local Education Authority (school district). The benefit for OT is limited to two visits per month (this limit does not apply to children under age 21). PT and OT services must be coordinated with the regional center or school district for a coordinated approach to maximize benefits.

Behavioral Health Therapy Services

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

For assistance with specific member referrals, contact the Health Net Provider Services Center, Community Health Plan of Imperial Valley Provider Services Center or CalViva Health Medi-Cal Provider Services Center for Fresno, Kings and Madera counties.

Educational Services

An important potential source of help for educational services for children with autism is the public school system. Under Federal Public Law 94-142 (the Individuals with Disabilities Education Acts of 1990 and 1997), each school is required to provide handicapped children with free, appropriate education through age 21. The school is required to evaluate each child and, with the parents, develop an 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 applied behavioral analysis (ABA), intensive behavioral intervention (BI), discrete trials training, early intensive behavioral intervention (EIBI), intensive intervention programs, Picture Exchange Communication Systems (PECS), facilitated communication, Treatment and Education of Autistic and Related Communication of Handicapped Children (TEACCH), or floortime.

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.

Case Management/Care Coordination

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

Coordination of Care

Health Net expects all providers involved in the treatment of a member with ASD to coordinate the care and treatment they are providing, and maintain appropriate communication. The PCP has primary responsibility for providing and maintaining the medical home for these children. Communication with other providers and the member's caregivers 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, county mental health, and regional centers regarding educational, therapeutic and psychiatric services helps ensure the member with ASD receives the full range of benefits allowed under legislation and regulations in California.

Resources

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

- Health Net website
- AAP recommendations for preventive care - https://brightfutures.aap.org
- Other AAP resources - www.healthychildren.org/English/health-issues/conditions/Autism/Pages/Autism-Spectrum-Disorder.aspx
- Regional centers contact information - www.dds.ca.gov/rc/listings/
- Early Start Program - www.dds.ca.gov/services/early-start/early-start-publications-resources-and-program-guidance/program-guidance-materials/
- Individual with Disabilities Education Act - https://sites.ed.gov/idea

Behavioral Health

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

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

Select any subject below:

Overview

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

Health Net Medi-Cal members obtain the following mental health services through Health Net

- Individual and group mental health evaluation and treatment (psychotherapy)
- Psychological testing to evaluate a mental health condition
- Outpatient services that include laboratory work, medications and supplies
- Outpatient services for the purposes of monitoring medication therapy
- Psychiatric consultations

Members do not need to contact their primary care physician (PCP), participating physician group (PPG) or attending physician to request a referral for mental health care services. Health Net members may obtain these services directly through our extensive behavioral health network by calling the member services phone number listed on their identification card (ID). Participating providers may also contact Behavioral Health Provider Services for assistance with mental health services referrals.

Prior authorization is not required for initial assessment for outpatient behavioral health services.

PCPs may refer members to marriage and family therapists, social workers, professional counselors, psychologists, and psychiatrists for services, as follows:

- Marriage and family therapists, social workers, professional counselors, and psychologists can:
  - Diagnose, treat and consult for the management of mild to moderate emotional problems for which the PCP or member feels the need for consultation.
  - Evaluate cases for which a member would benefit from psychotherapy in addition to psychotherapeutic medication.
  - Conduct psychological testing for clarification of diagnosis to establish a treatment plan (psychologists).
- Psychiatrists can:
  - Diagnose, treat and recommend a medication regimen in difficult or complex cases, including cases of depression that do not respond to a 60-day trial of selective serotonin re-uptake inhibitor (SSRI) medications or other antidepressants.

- Evaluate cases in which members report feeling suicidal or homicidal, severe anxiety states, clear somatoform disorders, schizophrenic disorders where Clozaril® or risperidone is being considered, and bipolar disorder where lithium, carbamazepine or valproic acid may be needed.

PCPs are responsible for coordinating referrals for members requiring specialty or inpatient mental health services to county mental health plans (CMHPs). PCPs retain responsibility for coordination of ongoing care for co-existing medical and mental health needs and provision of medically necessary medications.

The Mental Health Services Division (MHSD) oversees CMHPs and each county is required to provide access to specialty mental health services for Medi-Cal members. Refer to the MHSD Medical Necessity Criteria document for additional information about criteria for specialty mental health services.

5150 Holds

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

Under Section 5150 of the California Welfare and Institutions Code, a person who may be dangerous to self or others can be taken into custody and placed in an approved facility for a 72-hour treatment and evaluation. This is commonly referred to as a "5150 hold." 5150 holds are considered emergencies and should be handled like any other emergency inpatient hospitalization where the member cannot be immediately transferred.

For Medi-Cal members, all facility-based care for behavioral health and substance use disorders is administered by their respective county behavioral health department(s). Emergency services in which the member is not admitted to an inpatient psychiatric facility are covered by Health Net.

Chiropractic

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

This section contains general member benefit information on chiropractic services.

Select any subject below:

- Coverage Explanation

Coverage Explanation

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

With the exception of members who are under age 21, pregnant, or residents in a skilled nursing facility or long-term care, chiropractic benefits of manual manipulation of the spine to correct sprain, strain or dislocation of the spine or neck are covered for Medi-Cal members only when provided by a contracted county hospital outpatient department and hospital outpatient clinic, contracted Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) provider and other contracted chiropractic providers. Referrals may be needed for out-of-network FQHC, RHCs and IHCPs. Chiropractic services are:

- Limited to a maximum of two services per month, in combination with audiology, acupuncture, occupational therapy, and speech therapy services. Limits do not apply to members who are children under age 21, pregnant or residents in skilled nursing facility or long-term care.
- Limited to treatment of the spine by means of manual manipulation (only one chiropractic manipulative treatment is reimbursable when billed by the same provider, for the same recipient and date of service)

Maintenance care is not considered to be medically reasonable and necessary, and is not covered.

Health Net and its delegated participating physician groups (PPGs) apply Medi-Cal coverage criteria when determining whether a referral to an FQHC or RHC chiropractor or other contracted chiropractic providers is warranted.

A chiropractor may use an X-ray or other diagnostic test, performed for diagnostic purposes, to demonstrate medical necessity before commencing treatment; however, these diagnostic tests or X-rays are not covered when ordered, taken or interpreted by a chiropractor. Therefore, if the existence of subluxation is not known, an evaluation to determine subluxation should be considered prior to issuing a denial of chiropractic treatment.

Coverage for chiropractic services is limited to those services performed by a doctor of chiropractic, osteopathy or medicine licensed by the state of California.

The following information is required for appropriate billing of chiropractic services.

- Primary diagnosis must indicate chiropractic-related care. Primary diagnosis must be indicated by an approved chiropractic diagnosis code from the ICD-10-CM table below. If the relevant diagnosis code is not in the primary diagnosis code position, the claim will be denied.
- CPT code must be one of the codes shown in the CPT code table below. Evaluation and management (E M) codes are not reimbursable.

CPT Codes and Rates for Chiropractic Services

Chiropractic services are reimbursed as follows:

CPT code	Type of visit	Maximum allowance
98940	Chiropractic manipulative treatment (CMT); spinal, one to two regions	$16.72
98941	Chiropractic manipulative treatment (CMT); spinal, three to four regions	$16.72

CPT code	Type of visit	Maximum allowance
98942	Chiropractic manipulative treatment (CMT); spinal, five regions	$16.72

ICD-10-CM Diagnosis Codes Required for Chiropractic Services

Providers may be reimbursed for chiropractic services when billed in conjunction with one of the following ICD-10-CM diagnosis codes.

Chiropractic Services

ICD-10-CM Code	Description
M50.11-M50.13	Cervical disc disorder with radiculopathy
M51.14-M51.17	Intervertebral disc disorders with radiculopathy
M54.17	Radiculopathy, lumbosacral region
M54.31, M54.32	Sciatica
M54.41, M54.42	Lumbago with sciatica
M99.00-M99.05	Segmental and somatic dysfunction
S13.4	Sprain of ligaments of cervical spine

Chiropractic Services

ICD-10-CM Code	Description
S16.1	Strain of muscle, fascia and tendon at neck level

ICD-10-CM Code	Description
S23.3	Sprain of ligaments of thoracic spine
S29.012	Strain of muscles and tendon of back wall of thorax
S33.5	Sprain of ligaments of lumbar spine
S33.6	Sprain of sacroiliac joint
S33.8	Sprain of other parts of lumbar spine and pelvis
S39.012	Strain of muscle, fascia and tendon of lower back

Clinical Trials

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

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

Select any subject below:

- Clinical Cancer Trial
- Routine Care Costs for Qualifying Clinical Trials

Clinical Cancer Trial

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

Medi-Cal members are eligible for participation in cancer clinical trials. These trials are for treatment with a drug that is exempt from federal regulation in relation to a new drug application, or is approved by one of the following:

- National Institutes of Health (NIH)
- Food and Drug Administration (FDA) as an investigational new drug application

- Department of Defense (DOD)
- Veterans' Administration (VA)

Health plans or delegated participating physician groups (PPGs) must cover all medically necessary routine patient care costs related to a clinical trial for a member diagnosed with cancer whose physician has recommended participation in the clinical trial, and who has been accepted for participation in a nationally recognized phase I, II, III, or IV clinical trial for cancer. Routine patient care costs refers the costs associated with the provision of health care services, including drugs, items, devices, and services that would otherwise be covered under the plan or contract if those drugs, items, devices, and services were not provided in connection with an approved clinical trial program.

The California Department of Health Care Services (DHCS) has not contracted with Health Net to provide managed health care services or treatment for a member with a California Children's Services (CCS)-eligible condition; such coverage is carved out from Health Net coverage responsibilities and must be authorized by and provided through the CCS Program. Medi-Cal members under age 21 are eligible for participation in cancer clinical trials when authorized by the CCS program. Members under age 21 who are candidates for cancer clinical trials can be referred to the county CCS office for authorization to participate in the cancer clinical trial. Health Net's care managers assist primary care physicians (PCPs) , specialists and members in ensuring timely referral to the CCS program.

CCS coverage is dependent on the timeliness of referral to CCS. Refer to the CCS Program Description for information on participating provider responsibilities for referring potential eligible members to CCS and for identifying CCS-eligible conditions.

The Health Net prior authorization letter for a cancer clinical trial identifies items and services, which are considered part of the cancer clinical trial to the extent they are known at the time of the initial review. These items and services are covered by the study entity.

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

Refer to definition of clinical trials for more information.

Phase I, II, III, IV Clinical Trials

Trial Phase	Description
Phase I	Determine toxicity through a continuum of modest dosing to determine safe levels for humans (classically considered the "first in human" studies)

Trial Phase	Description
Phase II	Begin to evaluate the effectiveness of the treatment
Phase III	Compare the new regimen to standard care to evaluate relative efficacy and therapeutic value
Phase IV	Post-marketing studies to delineate additional information, including the medication's risk, benefits and optimal use

Exclusions and Limitations

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

- Medications or devices not approved by the FDA
- Travel, housing, companion expenses, and other non-clinical expenses
- Items or services used solely for data collection and analysis. Health Net does not cover imaging or lab tests beyond those reasonably necessary for routine care
- Health care services customarily provided free of charge by the research sponsors of the clinical trial
- Any medication, item, device, or service that is specifically excluded from coverage under the medical plan

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

Utilization Management Process

The following information applies only to participating physician groups (PPGs) and physicians.

Participating physician groups (PPGs) or directly contracting physicians should use the following process when requesting that Health Net provide prior authorization for a Health Net member to participate in a cancer clinical trial:

- Request a copy of the clinical protocol summary sheet and other pertinent documents
- Identify the sponsor of the clinical trial

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

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

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

Qualified Individual

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

- Diagnosis of cancer
- Eligible to participate in an approved clinical trial according to the trial protocol
- Member's provider supplies medical and scientific documentation establishing that the member's participation in such a trial would be appropriate based upon them meeting the guidelines and eligibility criteria

For information n Medi-Cal members under 21 years of age, refer to Coverage Explanation - Cancer Clinical Trial in this section.

Routine Care Costs for Qualifying Clinical Trials

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

When a prior authorization request is required for routine care costs, for items and services that are furnished as part of a qualifying clinical trial, requests are considered urgent and processed within 72 hours after the necessary clinical information is received.

To obtain urgent status when submitting the request for authorization to the Prior Authorization Department for Medi-Cal, either:

- Attach the downloaded Medicaid Attestation Form (PDF) **or**
- Indicate ‘Routine Care Cost Services Associated with the Clinical Trial” on the appropriate Prior Authorization Request Form.

Refer to the Medi-Cal Prior Authorization Requirements for a complete list of services that require prior authorization.

Cosmetic and Reconstructive Surgery

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

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

Select any subject below:

Overview

Provider Type: Physicians | Participating Physician Groups (PPG)

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

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

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

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

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

- Denial of the proposed surgery if there is another more appropriate surgical procedure that is approved for the member
- Denial of the proposed surgery or surgeries if the procedure or procedures, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery, offer only minimal improvement in the member's appearance
    - The determination of whether a surgery will produce only minimal improvement should be based upon the standard of care, as practiced by physicians specializing in reconstructive surgery or other licensed physicians competent to evaluate the specific clinical issues involved in the care rendered

- Denial of payment for procedures performed without prior authorization
- For services provided by the Medi-Cal program (Chapter 7 (commencing with Section 14000), Part 3 of Division 9 of the Welfare and Institutions Code), denial of the proposed surgery if the procedure offers only a minimal improvement in the appearance of the member, as may be defined in any regulations that may be promulgated by the California Department of Health Care Services (DHCS)

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

Breast Cancer Reconstructive Surgery

Provider Type: Physicians | Participating Physician Groups (PPG)

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

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

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

A subsequent request for additional surgery to change the previously achieved symmetry is considered cosmetic unless the subsequent surgery is medically necessary or is being performed again to achieve symmetry after subsequent surgery has been performed on the diseased breast. Such cosmetic surgery is not a covered benefit.

Cleft Palate Diagnoses

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

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

Cleft palate reconstruction services require prior authorization.

Dental Services

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

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

Select any subject below:

- Dental Screening and Services

Dental Screening and Services

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

Medi-Cal members are entitled to dental screenings/oral health assessments, as described in the periodic health exam schedule.

Dental services other than dental screenings are not covered under Health Net's Medi-Cal plans. Health Net is not financially responsible for covering dental services under any circumstances, including when they are provided as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/Medi-Cal for Kids & Teens service. Health Net's participating primary care physicians (PCPs) refer members for dental services to Medi-Cal dental providers.

Medical services

Health Net covers the following medical services related to non-covered dental services:

- Contractually covered prescription medications.
- Medically necessary laboratory services.
- Pre-admission physical examinations required for admission to an outpatient surgical center or an inpatient hospitalization required for a dental procedure.
- Facility fees for inpatient and outpatient services (such as ambulatory surgery center) that are prior authorized.
- Physician administered anesthesia services such as intravenous (IV) sedation and general anesthesia for inpatient and outpatient services.
- Covered medical services related to dental services that are not provided by dentists or dental anesthetists.
- Fluoride varnish, up to three times in a 12-month period, for Medi-Cal members under age six.

Dental services

Each dental plan, and full-service plan offering coverage for dental services, must ensure that contracting dental provider networks have adequate capacity and availability of licensed health care providers to offer members appointments for covered dental services in accordance with the following requirements, based on California Department of Managed Health Care (DMHC) regulations (Section 1300.67.2.2, et. Seq. of Title 28 of the California Code of Regulations) concerning timely access standards:

- Urgent appointments within the dental plan network are offered within 24 hours of the time of request for appointment, when consistent with the member's individual needs and as required by professionally recognized standards of dental practice.
- Non-urgent appointments are offered within four weeks of the request for appointment, except as provided in subsection (c)(6)(C).
- Preventive dental care appointments are offered within four weeks of the request for appointment.

IV MODERATE SEDATION AND DEEP SEDATION/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 dental provider.

However, medically necessary physician administered general anesthesia and IV sedation and associated facility charges for non-covered dental services rendered in a hospital (inpatient or outpatient) or ambulatory surgery center setting are covered if under one or more of the following circumstances:

1. member is under age seven,
2. member is developmentally disabled, regardless of age,
3. member's health is compromised and physician administered anesthesia is medically necessary for dental services, regardless of member's age, or
4. dental services are medically necessary and behavior modification and local anesthesia have failed or are not possible.

Coverage Criteria

Behavior modification and local anesthesia must generally be attempted first, but may not be required in certain situations, depending on the medical needs of the member. Thereafter, minimal sedation must then be considered or determined not feasible based on the medical needs of the member, and is not always required depending on the medical needs of the member.If the provider provides clear medical record documentation of both number 1 and number 2 below, then the member must be considered for IV moderate sedation or deep sedation/general anesthesia.

1. Use of local anesthesia to control pain failed or was not feasible based on the medical needs of the member.
2. Use of minimal sedation, either inhalation or oral, failed or was not feasible based on the medical needs of the member.

If the provider documents any one of numbers 3 through 6 below, then the member must be considered for IV moderate sedation or deep sedation/general anesthesia.

1. Use of effective communicative techniques and the inability for immobilization (member may be dangerous to self or staff) failed or was not feasible based on the medical needs of the member.

2. Member requires extensive dental restorative or surgical treatment that cannot be rendered under local anesthesia or minimal sedation.
3. Member has acute situational anxiety due to immature cognitive functioning.
4. Member is uncooperative due to certain physical or mental compromising conditions.

The procedures are ranked from low to high profundity as follows:

1. minimal sedation via inhalation or oral anesthetics
2. non-intravenous conscious sedation
3. IV moderate sedation
4. deep sedation/general anesthesia

Members with certain medical conditions such as, but not limited to: moderate to severe asthma, reactive airway disease, congestive heart failure, cardiac arrythmias and significant bleeding disorders, uncontrolled seizures and sleep disordered breathing, should be treated in a hospital setting or a licensed facility capable of responding to a serious medical crisis, as determined most appropriate by the provider.

In compliance with 42 CFR 455.410, all ordering or referring physicians or other professionals providing Medi-Cal services must be enrolled as an original fee-for-service (FFS) Medi-Cal provider. All providers, such as the selected anesthesiologist must also meet standards for participation in the FFS Medi-Cal program at the time services are prescribed, ordered or rendered.

Prior Authorization Requirements

Requests for authorization (RA)/prior authorization (PA)/Treatment Authorization Requests (TAR) is required for physician-administered anesthesia services or IV sedation. Member selection for dental procedures under physician-administered deep sedation/general anesthesia or IV moderate sedation considers medical history, physical status, and indications for anesthesia management.

The dental provider in consultation with the anesthesiologist is responsible for determining whether a member meets the minimum criteria necessary for receiving deep sedation/general anesthesia and/or IV moderate sedation. In addition:

- The dental provider submits the RA/PA/TAR to the dental carrier for the dental procedure and works in collaboration with the anesthesiologist to determine whether the patient meets the minimum criteria for receiving IV moderate sedation, deep sedation/general anesthesia.
- The physician who renders the IV moderate sedation, deep sedation/general anesthesia is responsible to submit the RA for deep sedation/general anesthesia or IV moderate sedation to Health Net or to the member's delegated participating physician group (PPG). The RA must:
    - State the criteria indications, such as failed attempts of conscious sedation, local anesthesia and other mechanisms, or why prior attempts could not be attempted and include the planned location of the service.
    - The provider performing the IV moderate sedation, deep sedation/general anesthesia, must provide documentation and a copy of the approved RA/PA/TAR to request PA prior to delivering deep sedation/general anesthesia or IV moderate sedation.

- Prior to delivering anesthesia services being rendered, the provider must have a copy of a complete history and physical examination and the indication for IV moderate sedation or deep sedation/general anesthesia. Additionally, and not as a prerequisite to authorization, the provider and primary care physician must fulfill the requirements for chart documentation which, in addition to the above, includes diagnosis, treatment plan and documentation of perioperative care (preoperative, intraoperative and postoperative care) for the dental procedure.

[1]Information taken or derived from APL 23-028 Attachment A, Policy for Intravenous Moderate Sedation and Deep Sedation/General Anesthesia.

Delegated PPG Response to Prior Authorization Requests

Delegated participating physician groups (PPGs) must respond to PA requests submitted for general anesthesia or IV sedation as outlined above and render a utilization management decision in a timely manner in accordance with the PPG's Provider Participation Agreement (PPA). If additional clinical information is required, the member and providers must be notified in writing within the applicable regulatory time frame. The PPG is also responsible for communicating the decision to the member and providers within the applicable regulatory time frame from the date of the original receipt of the request.

The member's PCP provides any necessary pre-operative history and physical examination and necessary laboratory or other medically necessary ancillary services. Both the dentist and anesthesiologist must have privileges at the selected place of service (such as the hospital (outpatient, inpatient or ambulatory surgery center), or a Letter of Agreement (LOA) needs to be initiated by the PPG in order to authorize and provide services at the designated facility site.

PCP Responsibilities

The primary care physician (PCP) must conduct a dental assessment for members under age 21 to check for normal growth and development and the absence of tooth and gum disease at the time of the initial health appointment (IHA) and at each preventive, well-child screening examination visit according to the periodic health examination schedules.

A dental screening for children under age three includes, but is not limited to, an examination of the mouth and gums; and anticipatory guidance on proper feeding practices and on cleaning the mouth to remove bacteria. For children over age three the screening includes, but is not limited to, an examination of the mouth, teeth and gums; prescription for fluoride supplementation if drinking water is not adequately fluoridated; and anticipatory guidance in the prevention of dental caries, orofacial injury and disease, proper oral hygiene practices, and consideration of dental sealants.

PCPs are also responsible for performing a dental screening exam on adult members as part of the initial health appointment and at scheduled periodic health assessments, and to encourage them to receive an annual dental exam. All screenings, referrals and the reason for the referral must be documented in the member's medical record.

Mandatory Referral

The PCP must make a mandatory dental referral following the member’s initial dental health screening starting at age three, or earlier, if dental problems are identified and continue to refer the member on subsequent, annual dental health screenings if warranted at the time by any new or ongoing dental issues identified. The PCP must provide a topical fluoride varnish to the member’s teeth during their exam. A referral to a dentist or orthodontist should be made if the member has severe malocclusion within six months of the first tooth erupting or no later than the member's first birthday. All screenings, referrals and the reason for the referral must be documented in the member's medical record.

Providers or members may call Denti-Cal for a list of three Denti-Cal providers in their ZIP Code (Los Angeles and Sacramento County members may also obtain services from a Health Net Dental provider, if applicable). Members who need interpreter assistance to locate a dentist may call Health Net's Medi-Cal Member Services

Department, Community Health Plan of Imperial Valley Member Services Department or CalViva Health Medi-Cal Member Services Department (for Fresno, Kings and Madera counties).

Dialysis

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

This section contains general member benefit information on dialysis.

Select any subject below:

- Out-of-State Dialysis

Out-of-State Dialysis

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

If an end-stage renal disease (ESRD) member receiving dialysis informs the participating physician group (PPG) 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 must:

- Authorize dialysis services by other providers
- Arrange for the services to be performed by providers in the member's temporary location
- Inform the member that 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 that, if travel plans change and additional time is needed, the member must inform the PPG. If the member extends the duration of the trip and informs the PPG, 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 the PPG service area. Dialysis services are not covered if received outside the United States, except emergency services requiring hospitalization are covered outside the United States in Canada or Mexico.

Medi-Cal members diagnosed with ESRD are eligible for Medicare coverage after a four-month waiting period. If a Medi-Cal member requires dialysis and is under age 21 years, the member must be referred to the California Children's Services (CCS) program. Health Net's care managers assist primary care physicians (PCPs) in ensuring timely referral to the CCS program. Refer to the CCS Program Overview for information on participating providers' responsibilities for referring potential eligible members to CCS and for identifying CCS-eligible conditions.

If the Medi-Cal member is over age 21 for chronic hemodialysis or chronic peritoneal dialysis, the member becomes eligibile for Medicare and the PPG, Health Net or the dialysis center should initiate the Medicare application. Health Net only provides dialysis until Medicare eligibility becomes effective. Given that Medicare is

the primary payer before Medi-Cal, PPGs should verify Medicare eligibility and enrollment for any Medi-Cal member diagnosed with ESRD prior to authorizing and billing for dialysis services.

Doula Services

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

Per State Plan Amendment (SPA) 22-0002, doula services are provided as preventive services pursuant to Title 42 Code of Federal Regulations (CFR) Section 440.130(c).

The Department of Health Care Services (DHCS) issued a statewide standing recommendation that all Medi-Cal members who are pregnant or were pregnant within the past year would benefit from receiving doula services from a Medi-Cal enrolled doula provider. The recommendation fulfills the federal requirement for a physician or other licensed practitioner of the health arts acting within their scope of practice to provide a written recommendation for preventive services. Doulas provide person-centered, culturally competent care that supports the racial, ethnic, linguistic, and cultural diversity of members while adhering to evidence-based best practices.

Doula services are aimed at preventing perinatal complications and improving health outcomes for birthing parents and infants.

This section contains general information on doula services. Doula services are aimed at preventing perinatal complications and improving health outcomes for birthing parents and infants.

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

Eligibility requirements

The member must be active and enrolled in the Medi-Cal Plan.

- Doulas must verify eligibility for the month of service by contacting the Plan or looking the member up in the provider portal.
- The member must be pregnant or have been pregnant within the past year and would benefit from doula services.

Documentation requirements

Additional visits during the postpartum period require a recommendation from a licensed practitioner of the healing arts. Up to nine postpartum visits can be added.

Initial Set of Services:

Members can receive doula services virtually or in-person in any setting, such as home, office, hospital, or an alternative birthing center. All visits are limited to one per day, per member.

The initial recommendation authorizes the following:

- One initial visit.
- Additional visits – up to eight given in any combination of prenatal and postpartum visits.
- Labor and delivery support – including labor and delivery resulting in miscarriage, stillbirth and abortion.
- Postpartum – up to two extended three-hour visits. These visits do not require the member to meet any criteria or receive a separate recommendation.

Assistive services during visits

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

Note: If a doula teaches classes, the classes can be offered at no cost to a member receiving services from the doula.

Coordinating services

Doulas should work with the member’s primary care physician (PCP) or contact the Plan if the member needs additional support.

Non-covered doula services

The following are not covered under doula services:

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

Durable Medical Equipment

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

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

Select any subject below:

Coverage

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

Durable medical equipment (DME) is a covered benefit and subject to prior authorization and coordination. DME is subject to coordination with California Children's Services (CCS), as appropriate for applicable diagnosis. Apria Healthcare is the preferred provider for DME services.

Orthotics

Health Net covers orthotic and prosthetic devices and services that are medically necessary and prescribed by physician, podiatrist, dentist, or non-physician medical provider. They include implanted hearing devices, breast prosthesis/mastectomy bras, compression burn garments, and prosthetics to restore function or replace a body part, or to support a weakened or deformed body part.

Orthotic services are not available through Health Net's preferred DME provider (Apria). They may be obtained through prosthetic and orthotic providers, such as Linkia, LLC.

Exclusions and Limitations

The following information applies only to participating physician groups (PPGs), physicians and ancillary providers.

Durable medical equipment (DME) is a covered benefit on most health plans. Additional non-covered items are:

- Comfort, convenience, or luxury equipment, features, and supplies, except retail-grade breast pumps as described in this chapter under “Breast pumps and supplies” in “Maternity and newborn care”

- Items not intended to maintain normal activities of daily living, such as exercise equipment including devices intended to provide more support for recreational or sports activities
- Hygiene equipment, except when medically necessary for a member under age 21
- Nonmedical items such as sauna baths or elevators
- Modifications to your home or car
- Devices for testing blood or other body substances (diabetes blood glucose monitors, continuous glucose monitors, test strips, and lancets are covered by Medi-Cal Rx)
- Electronic monitors of the heart or lungs except infant apnea monitors
- Repair or replacement of equipment due to loss, theft, or misuse, except when medically necessary for a member under age 21
- Other items not generally used mainly for health care

Coverage Criteria for Wheelchairs and Seating and Positioning Components

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

Health Net ensures that medically necessary wheelchairs and seating and positioning components (SPCs) are provided to Medi-Cal members in a timely manner and in accordance with applicable laws and policies. Specifically, for wheelchairs and SPCs, criteria for medical necessity must include a medical evaluation of the member and review of the equipment to ensure that the member has appropriate mobility in or out of the home.

Health Net covers medically necessary equipment, regardless of whether the needed equipment will be used inside or outside the member's home. A prescription for a wheelchair or SPC is not to be denied solely on the grounds that it is for use outside the home, when determined to be medically necessary for the member's medical condition.

Face-to-Face Examination

The member must have a face-to-face examination by a licensed clinician and an evaluation performed by a qualified provider who has specific training or experience in wheelchair evaluation and ordering, as applicable, and as defined in Welfare and Institutions Code Section 14105.485. PPGs are to perform prior authorization in accordance with Title 22, California Code of Regulations (CCR), Section 51321. Refer to the criteria in All Plan Letter (APL) 15-081 (PDF) to confirm medical necessity of wheelchairs and SPCs.

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.

Dyadic Services

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

Dyadic Services denote a family and caregiver-focused Model of Care intended to address developmental and Behavioral Health conditions of Children as soon as they are identified. Dyadic services include dyadic behavioral health (DBH) well-child visits, dyadic comprehensive community support services, dyadic psychoeducational services, and dyadic family training and counseling for child development. The DBH well-child visit is provided for both child (members under age 21) and parent(s)/caregiver(s) together, preferably within the pediatric primary care setting the same day as the medical well-child visit. Dyadic services screen for behavioral health problems, interpersonal safety, tobacco and substance misuse and social drivers of health (SDOH), such as food insecurity and housing instability, and include referrals for appropriate follow-up care.

Facilities or clinics that offer integrated physical health and behavioral health services, such as Community Health Centers and Federally Qualified Health Centers (FQHCs), are able to conduct the medical well-child visit, the DBH well-child visit and some or all of the ongoing dyadic services. Physicians who do not offer integrated behavioral health services are able to initiate dyadic services by conducting the medical well-child visit and making referrals to behavioral health providers for the DBH well-child visit and ongoing dyadic services.

ELIGIBILITY REQUIREMENTS

Members under age 21 and their parent(s)/caregiver(s) are eligible for DBH well-child visits when:

- Delivered according to the Bright Futures/American Academy of Pediatrics periodicity schedule for behavioral/social/emotional screening assessment.
- Medically necessary, in accordance with Medi-Cal's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standards.
- The child must be enrolled in Medi-Cal. The parent(s) or caregiver(s) does/do not need to be enrolled in Medi-Cal or have other coverage so long as the care is for the direct benefit of the child.

REFERRAL TO BEHAVIORAL HEALTH SERVICES

Primary care physicians (PCPs) or sites that do not offer behavioral health services can initiate dyadic services by conducting the medical well-child visit and referring members to Health Net to connect with a dyadic services provider who will conduct the DBH well-child visit and determine needs for ongoing dyadic services.

CLAIMS SUBMISSION

Provider sites with integrated physical health and behavioral health services, such as Community Health Centers, FQHCs, and some primary care sites, will be able to administer the medical well-child visit, the DBH well-child visit and some or all of the additional dyadic services (depending on scope of practice). In such cases, integrated provider sites will bill the Plan for the medical well-child visit and dyadic service(s).

Enteral Nutrition

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

Enteral nutrition products are a conditional benefit under the Health Net Medi-Cal program. Prior authorization is required. Enteral nutrition products are used as a treatment plan for conditions that do not accept the full use of regular food. This is subject to Medi-Cal's list of enteral nutrition products and utilization controls.

Coverage for enteral nutrition products, including therapeutic infant formula, must meet medical necessity criteria. It cannot be a convenience item or used in place of food for social and economic reasons. If regular foods are available to provide needed nutrients and calories, then enteral nutrition becomes a convenience item, which is not covered.

Enteral Nutrition products may also be covered under Medi-Cal Rx program when billed under the Pharmacy benefit. Visit Medi-Cal Rx for more information.

Benefits for Members Ages 21 and Over

The Department of Health Care Services (DHCS) and Health Net may deem a nutrition product taken by mouth a medically necessary benefit for patients ages 21 and over. This applies to certain diagnoses, such as intestinal malabsorption and inborn errors of metabolism among others. It can also apply to medical conditions where enough nutrition is not achieved with dietary changes or from soft or pureed foods.

Benefits for Members Under Age 21

Members under age 21 are covered by the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Enteral nutrition is a covered benefit for California Children's Services (CCS) eligible diagnoses, such as malabsorption, genetic disorders and inborn errors of metabolism. If the member qualifies for coverage under the CCS program, then CCS-approval should be obtained for medically necessary enteral nutrition. Information on Lactation Education and Support Services is located in the Maternity section.

Prior Authorization Process

Prior authorization is required for enteral nutrition products and supplies. Providers participating through a participating physician group (PPG) should follow the PPG's guidelines for prior authorization.

Fee-for-service (FFS) providers must complete the Pharmacy Prior Authorization Form for members.

The CCS program also requires a Service Authorization Request (SAR) for enteral products for CCS-eligible conditions.

Products billed must be identical to products authorized.

Authorization Time Frames

Decisions regarding enteral nutrition products are performed timely. They are based on the member's medical condition within the following time frames:

Type of Request	Time Frame
Emergency requests	Emergency requests occur when prescribing providers determine the product is required immediately to prevent serious disability or death. Prior authorization is not required when there is truly an emergency requiring immediate treatment.
Urgent requests	72 hours of receipt of all the information reasonably necessary to make a decision. Urgent requests occur when the requesting provider or Health Net determines that following the standard time frame could seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum functions.
Non-emergent/routine requests	5 business days of receipt of all the information reasonably necessary to make a decision. Routine requests are for treatment plans already in place.

If a decision about enteral nutrition products is delayed past these time periods, the request is considered approved.

Family Planning

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

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

Select any subject below:

- Overview

Overview

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

Members have the right to access family planning services without prior authorization from any qualified Medi-Cal enrolled participating or non-participating family planning provider in or out of Health Net's service area. A qualified Medi-Cal enrolled family planning provider includes a member's primary care physician (PCP) and other participating or non-participating providers, including obstetricians/gynecologists (OB/GYNs), nurse midwives, nurse practitioners (NPs), physician assistants (PAs), federally qualified health centers (FQHCs), Indian Health Clinics (IHCs), Rural Health Centers (RHCs), and county family planning providers.

Capitated participating physician groups (PPGs) are responsible for payment of claims to all qualified family planning providers for appropriate billable services covered by the Department of Health Care Services (DHCS) Medi-Cal fee-for-service (FFS) program, including office visits, laboratory tests, and Medi-Cal approved contraceptive medications, devices and supplies. Refer any problems involving claims payment responsibility to a Health Net provider network management representative.

Problem Resolution

Any conflicts concerning provision of family planning services, excluding member or provider grievances or appeals, should be referred to Health Net's public programs administrators for resolution. During any problem periods, a Health Net care manager and the PCP or specialty provider continues to coordinate the member's care.

Provider Responsibilities

Providers may not restrict a member's access to family planning services or subject a member to any prior authorization process for them. Providers who do not comply are subject to administrative review or disciplinary action.

The family planning provider must obtain informed consent for sterilization. A signed Consent Form (PM-330 (PDF)) must be included with all claims for payment for sterilization.

Coverage

The following information applies only to Exclusively Aligned Enrollment Dual Special Needs Plan (EAE D-SNP) participating physician groups (PPGs) and Medi-Cal PPGs and physicians.

The following family planning services are covered for all members of childbearing age:

- Health education and counseling necessary to make informed choices and understand contraceptive methods.
- Limited history and physical examination.
- Laboratory tests, if medically indicated, to assist with decision-making for contraceptive methods (except cervical cancer screening, such as Pap test, provided by a nonparticipating provider where Health Net has previously covered a cervical cancer screening performed by a participating provider in accordance with current U.S. Preventive Services Task Force (USPSTF) guidelines).
- Diagnosis and treatment of sexually transmitted infections (STIs).
- Screening, testing and counseling of individuals at risk for HIV infection.
- Most methods of sterilization (the member must be at least age 21 at the time consent is obtained), including:
    - Tubal ligation.
    - Vasectomy.
- Same methods of birth control as covered by the Department of Health Care Services (DHCS) for the Medi-Cal fee-for-service (FFS) program, devices and supplies (including Depo-Provera® and Lunelle™). Members may receive up to a 12-month supply dispensed at one time for U.S. Food and Drug Administration (FDA)-approved, self-administered hormonal contraceptives, such as 13 vaginal rings, 52 patches and 18 cycles of oral contraceptives.
    - Oral contraceptives are covered when dispensed from an onsite clinic and billed by any qualified provider. A qualified provider is a provider who is licensed to furnish family planning services within their scope of practice, is an enrolled Medi-Cal provider, and is willing to furnish family planning services to a Medi-Cal enrollee as specified in Title 22, California Code of Regulations, Section 51200. A physician, physician assistant (under the supervision of a physician), certified nurse midwife, nurse practitioner, and pharmacist are authorized to dispense medications. When furnished by a pharmacist self-administered hormonal contraceptives must be dispensed in accordance with a protocol approved by the California State Board of Pharmacy and the Medical Board of California. Pursuant to the California Business and Professions Code (B&P Code), Section 2725.2, if contraceptives are dispensed by a registered nurse (RN), the RN must have completed required training pursuant to B&P Code Section 2725.2(b), and the contraceptives must be billed with evaluation and management (E&M) procedure codes 99201, 99211 or 99212 with modifier TD (used for behavioral health RN) as directed in the DHCS Medi-Cal Provider Manual.
- Office-administered follow-up treatment of complications associated with contraceptive methods issued by a family planning provider (limited to two outpatient visits without prior authorization, when provided by a nonparticipating provider).

- Outpatient office visits to manage minor issues associated with hormonal methods of birth control, not limited to two visits; prior authorization is not required.
- Pregnancy testing and full-options counseling when performed by trained staff under the supervision of a licensed physician.

Coordination With Non-Participating Providers

Health Net encourages the primary care physician (PCP) to coordinate care with non-participating providers to avoid duplication of services. If the PCP previously provided the service the non-participating provider is now providing, the non-participating provider is not paid (unless they have documented attempts to contact the member's PCP for medical information).

When a member requests that medical records be forwarded to a non-participating provider, it is the PCP's responsibility to comply. The PCP must obtain a completed signed consent form from the member for records to be transferred to the non-participating provider.

If the member needs medically necessary follow-up care, the non-participating provider must obtain a signed consent from the member to notify the member's PCP. Health Net's Health Services staff are available to assist non-participating providers if any concerns about timely provision of services and referrals arise.

Member Education

Health Net provides new members the following information on family planning services through the Evidence of Coverage (EOC) :

- The member's option to receive family planning services from any qualified participating provider (in- or out-of-network), without referral or prior authorization of coverage
- A complete list of the services offered and descriptions of limitations on the family planning services members may seek from non-participating providers
- The member's right to timely services
- Notification that members must provide informed consent for sterilization
- That confidentiality of medical information and personal data of all members is maintained through strict adherence to applicable state and federal requirements
- The member's right to confidentiality when receiving socially sensitive services, including the availability of services for minors without parental consent
- The positive effect of coordinated care on health outcomes

Hearing/Hearing Aids

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

Health Net plans cover hearing tests provided by a member's physician, audiologist or other qualified provider in accordance with Hearing Aid CAP FAQ and Medi-Cal guidelines (DOC). Hearing aids, including molds, supplies, inserts, and an initial set of batteries, are also covered.

Replacement of a hearing aid is covered if:

- Hearing loss is such that the member's current hearing aid is not able to correct it
- Hearing aid is lost, stolen, or broken and cannot be fixed (and was not the member's fault).

For adults ages 21 and older, Medi-Cal does not include:

- Replacement hearing aid batteries

Health Net contracts with Connect Hearing, Inc., Sonus and Hearing Healthcare Providers (HHP) to provide hearing aid services. Providers should refer members with a prescription, to one of these contracting providers. Once the contracting provider receives a prescription from the treating provider, the contracting provider verifies the member's eligibility and administers benefits in accordance with Medi-Cal guidelines (DOC). For additional information on hearing aid services, refer to the Department of Health Care Services (DHCS) Medi-Cal Provider Manual.

HIV Testing and Counseling

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

Participating providers and non-participating providers may provide confidential HIV testing, counseling and follow-up services for Medi-Cal members, without authorization. Providers must provide information about HIV testing, treatment options and additional testing needed, and advise members of their right to decline testing. If a member declines HIV testing, the provider must document this information in their medical records.

When a member requests confidential HIV testing, counseling or follow-up services, the provider or staff person with authority and license to do so, must administer pre-test counseling services, obtain a complete history and physical (if indicated), and order the requisite lab work. The provider must follow the Centers for Disease Control and Prevention (CDC) guidelines for pre- and post-testing counseling.

Medi-Cal members may also obtain confidential or anonymous HIV testing and counseling services from a local health department (LHD), community-based organization testing site, or a non-participating family planning provider. The member's primary care physician must perform follow-up services. Members who are age 12 years and older may get HIV/AIDs preventive, testing and treatment services without parent's or guardian's permission.

Reimbursement Policy

Providers rendering confidential HIV testing and counseling services are reimbursed at the allowable Medi-Cal fee-for-service (FFS) rate established by the Department of Health Care Services (DHCS), unless a specific rate is included in the provider's contract.

Participating providers are required to coordinate all follow-up services with the member's primary care physician (PCP). Referrals must be obtained from the PCP and authorization for services requiring prior authorization must be obtained. If a participating provider treats a member for follow-up HIV services without the PPGs approval, payment of claims for the services may be denied.

Claims for reimbursement are processed within 45 business days of receipt. Providers are notified in writing of any contested claim in suspense longer than 45 business days.

Release of Confidential Information

The custodian of records is responsible for controlling the release of records related to HIV testing to any third party not involved in the member's care.

If a copy of the member's medical record is requested, the custodian of records must review the record and remove the confidential consent form or the HIV test results, along with any other portion of the record that contains documentation of the HIV test being ordered or the HIV test results (for example, history, physical, consultations, and progress notes). If the HIV test or HIV test results are mentioned anywhere in the medical record, the information is protected. If necessary, the custodian must explain that the protected portion of the record requires special written authorization from the member. The custodian of records must not identify in any way that the record is confidential because of the HIV or AIDS test. It must state that disclosure of it is protected under state law and requires special authorization from the member. After removing all confidential material, the record may be released to the requestor.

Requests by a member for access to medical records containing HIV test result information should be processed according to established guidelines. Prior to providing a member access to the medical record, verify with the provider that the member has been previously informed of the test results. The provider must disclose the results of an HIV test to the subject of the test in a confidential manner. Disclosure must be in person only and not by telephone.

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

Home Health Care Services

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

The following are additional components of home health care:

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

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

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

Service Providers

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

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

Homebound Determination

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

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

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

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

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

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

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

- Members who have had a caesarean section and were discharged from the hospital within 96 hours after delivery are eligible for one home health care visit at the attending physician's request.

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

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

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

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

Exclusions and Limitations

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

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

Authorization Guidelines

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

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

- mental status of member
- types of services and equipment required (including frequency, duration, dressings, injections, and treatments)
- frequency of visits

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

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

Physician Certification

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

Physician Recertification

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

Ongoing Care

Participating providers initiate home health care services as follows:

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

Hospice Care

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

Medi-Cal members who qualify for and elect hospice care services remain enrolled with Health Net while receiving these services. To avoid problems caused by late referrals, participating physician groups' (PPGs') written policies and procedures must clarify how members may access hospice care services in a timely manner, preferably within 24 hours of the request. The only requirement for the initiation of outpatient hospice services is a physician's certification that a member has a terminal illness and the member elected hospice care services. Medi-Cal members ages 21 and above may not have palliative care at the same time as hospice care.

For additional information, see below.

Certification of Terminal Illness

Health Net follows state of California regulations on certification that states a member whose prognosis indicates a life expectancy of six months or less is considered terminally ill. The physician certification must contain the qualifying clause, "the individual's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course." Neither Health Net nor its delegated participating physician groups (PPGs) may deny hospice care to a Medi-Cal member certified as terminally ill. Each certification period needs to be authorized and consists of two 90-day periods followed by an unlimited number of 60-day periods. The hospice provider is required to obtain written certification of terminal illness for each hospice benefit period.

California Children's Services Eligible Services for Life-Limiting Conditions

Hospice care options for children do not fit the traditional adult hospice model. Effective January 1, 2019, pediatric palliative care is authorized and managed by the health plan through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. This applies to members who meet the eligibility criteria.

Policy guidelines and directions for authorization of medically necessary services (PDF) related to a CCS life-limiting condition for children who have elected hospice is available on the DHCS website.

Health Net and its delegated participating physician groups (PPGs) work with CCS to help with continuity of medical care. This includes keeping the current relationship between patient and provider. If elected, hospice care for children with terminal diseases requires working closely with Health Net, the PPG, the local CCS program, and other caregivers. Hospice counseling, including grief, bereavement and spiritual services, may be needed during this transition.

Concurrent Hospice, Palliative and Curative Care for Children

A member under age 21 may be eligible for palliative care and hospice services concurrently with curative care under the Patient Protection and Affordable Care Act (ACA) Section 2302 as detailed in CMS Letter #10-018. Information regarding the concurrent care policy is available in Policy Letter (PL) 11-004, titled "The Implementation of Section 2302 of the Affordable Care Act, titled "Concurrent Care for Children"; APL 13-014; and the appropriate California Children's Services (CCS) Numbered Letter (NL), including any future iterations of these letters.

Palliative care CCS NL 16-1218 (PDF) provides additional palliative care information on the DHCS website.

Note: Palliative care services may be authorized by CCS if they are part of a plan of care of a CCS special care center (SCC). CCS is financially responsible for the palliative care services and not the medical plan.

Description of Hospice Care Services

Upon the Medi-Cal member's election of hospice care services, Health Net and its delegated participating physician groups (PPGs) must ensure provision of, and payment for, hospice care services (listed below) provided by a hospice provider.

Hospice care services include, but are not limited to, the following:

- Nursing services provided by a registered nurse, licensed practical nurse or licensed vocational nurse
- Physical therapy, occupational therapy or speech therapy
- Medical social services under the direction of a physician
- Home health aide and homemaker services
- Medical and surgical supplies, and durable medical equipment (DME)
- Prescribed medications (some drugs may be available through Medi-Cal Rx).
- Family counseling related to the member's terminal condition
- Bereavement services
- Educational services
- Pastoral services
- Dietician services
- Continuous nursing services may be provided for 24 hours to achieve palliation or management of acute medical symptoms. The care must be required due to periods of crisis and only as necessary to maintain the terminally ill member at home. Care provided requires a minimum of eight hours of nursing care within a 24-hour period commencing at midnight a minimum of 51 percent of which time must be provided by a licensed nurse. Nursing services include either homemaker or home health aide services. The eight hours of care do not need to be continuous within the 24-hour period
- Inpatient respite care, short-term care provided to the member only when necessary to relieve the family or other caregivers. Respite care may be on an intermittent, non-routine or occasional basis for up to five consecutive days at a time in a hospital, skilled nursing or hospice facility. Prior authorization is required for inpatient admission
- Short-term inpatient care for pain control or symptom management in a hospital, skilled nursing or hospice facility. Prior authorization is required for inpatient admission

Physician Services

Physician services include general supervisory services of the hospice medical director and participation in establishing the member's plan of care, supervision of care and services, periodic review and updating plan of care, and establishing governing policies by the physician of the hospice interdisciplinary team. Other physician services not related to hospice services are covered separately.

Provision of Hospice Care Services by Interdisciplinary Group

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

Due to the highly specialized services provided by hospice providers, federal law mandates the hospice provider designate an interdisciplinary group to plan, provide and supervise the care and services offered by the hospice provider. A written plan of care must be established by the attending physician, the medical director or designated physician, and the interdisciplinary hospice group prior to providing care. The plan of care is then reviewed and updated as specified in the plan of care by the attending physician, medical director or designated physician and interdisciplinary hospice group.

Health Net and its delegated PPG or primary care physician (PCP) coordinate the care between Health Net, the member's PPG and hospice care providers, and allow for the interdisciplinary hospice group to manage the Medi-Cal member's care.

Election Statement

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

- Identification of the hospice agency that will provide the care
- A statement describing the hospice care program and requirements
- Member's acknowledgment of full understanding that hospice care given as it relates to the member's terminal illness is palliative, and certain specified Medi-Cal benefits are waived by the election. Members under age 21 who voluntary elect hospice care do not constitute a waiver
- Effective date
- Signature of member or guardian
- A statement explaining the member's right to revoke hospice services at any time

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

Face-to-Face Encounters for Continued Hospice Eligibility

The following information applies to participating physician groups (PPGs) and ancillary providers only.

Hospice physicians or hospice nurse practitioners (NPs) must have a face-to-face encounter with every hospice patient to determine continued hospice eligibility. To satisfy this requirement, the following criteria must be met:

1. The face-to-face encounter must occur no more than 30 calendar days prior to the start of the third benefit period and no more than 30 calendar days prior to every subsequent benefit period thereafter.
2. The hospice physician or NP who conducts the face-to-face encounter must attest in writing to it. The attestation must be on a separate and distinct section of, or addendum to, the recertification form, be clearly titled and include the rendering physician's or NP's signature and date of face-to-face encounter. When an NP conducts the face-to-face encounter, the attestation must state the clinical findings were provided to the certifying physician for use in determining whether the patient continues to have a life expectancy of six months or less, if the illness runs its normal course.

In cases where a hospice newly admits a patient in the third or later benefit period, exceptional circumstances may prevent a face-to-face encounter prior to the start of the benefit period (as described in criteria 1). For example, if the patient is an emergency admission on a weekend, it may be impossible for a hospice physician or NP to see the patient until the following Monday, or the hospice may be unaware that the member is in the third benefit period. In such documented cases, a face-to-face encounter within two days after admission is considered timely. If the patient dies within two days of admission without a face-to-face encounter, a face-to-face encounter can be deemed as completed.

The hospice must retain the certification statements and have them available for Health Net's audit purposes.

Prior Authorization

California Code of Regulations (CCR), Title 22, Section 51349 describes four levels of hospice care, which are routine home care, continuous home care, respite care, and inpatient care. Only general inpatient care (HCPCS code Z7106[1]) is subject to prior authorization (PDF). Providers must submit the following to request prior authorization:

- Certification of physician orders for general inpatient care
- Justification for this level of care

Health Net does not require prior authorization for:

- Routine home care (HCPCS code Z7100)
- Continuous home care requiring a minimum of eight hours of care per 24-hour period (HCPCS code Z7102)
- Respite care provided on an intermittent, non-routine and occasional basis for up to five consecutive days at a time (HCPCS code Z7104)
- Physician services (HCPCS code Z7108). Health Net and its delegated participating physician groups (PPGs) reimburse this code as limited to one visit per day, per patient
    - Consulting/special physician services (HCPCS code Z7108) may be billed only for physician services to manage symptoms that cannot be remedied by the patient's attending physician because of one of the following:
        - Immediate need
        - The attending physician does not have the required special skills

Hospice providers must notify the Health Net Hospital Notification Department and the member's participating physician group (PPG) or primary care physician (PCP) on the next business day when a member is admitted for inpatient care after normal business hours.

Hospice Care Rates

For more information on hospice care rates, refer to the Department of Health Care Services (DHCS) website at www.dhcs.ca.gov/services/medi-cal/Pages/Hospice.aspx.

Long-Term Care Residents

Hospice services are covered and are not categorized as long-term care (LTC) services regardless of the member's expected or actual length of stay in a nursing facility (NF) while also receiving hospice care. Section 1905(o)(1)(A) of the Social Security Act (SSA) allows for the provision of hospice care while an individual is a resident of a skilled nursing facility (SNF) or intermediate care facility (ICF).

Health Net and its PPGs should not require authorization for room and board as described in Code of Federal Regulations (CFR), Title 42, Section 418.112 and Section 1902(a)(13)(B) of the SSA.

In accordance with the Centers for Medicare and Medicaid Services (CMS), the hospice provider reimburses the NF for the room and board at the rate negotiated between the hospice and SNF. Payment for the room and board component must be equal to at least 95 percent of the reimbursement the NF/SNF would have been reimbursed by fee-for-service (FFS) Medi-Cal or Health Net less the member's share of cost, if applicable. Payments by a hospice provider to a nursing home for room and board are not to exceed what would have been received directly from FFS Medi-Cal or Health Net if the member had not been enrolled in a hospice. [1] HCPCS codes were taken from the Centers for Medicare and Medicaid Services (CMS) HCPCS website.

Revocation of Hospice Election

Members that elect hospice may revoke or modify their decision at any time during an election period. To revoke the election of hospice care, the member or the member's authorized representative must file a signed statement with the hospice revoking the individual election for the remainder of the election period. The effective date may not be retroactive. At any time after revocation, the member may execute a new election, which starts the 90-day/90-day/unlimited 60-day certification periods of care. A member or their representative may change the designation of a hospice provider once per benefit period. The member's change from one designated hospice to another is not considered a revocation of the hospice election.

Special Consideration in Hospice Election

Non-Participating Hospice

If a Medi-Cal member wishes to elect a hospice provider that is not contracting with Health Net or the delegated participating physician group (PPG), the PPG must consider each member's case individually. The PPG has the option to immediately initiate a contract (one-time or ongoing) with the chosen hospice provider or refer the patient to a participating hospice for hospice care. In some cases, members receiving hospice at the time they become Health Net Medi-Cal members may not be able to change their hospice provider due to limitations on the number of times the member can change a hospice provider during an election period. Health Net or the PPG may also determine that such a change is disruptive to the member's care or is not in their best interest. PPGs must consider a one-time or ongoing contract with the established hospice provider until the new benefit period, or until the end of hospice services.

Home Setting

Hospice care services may be initiated or continued in a home or clinical setting. Health Net and its delegated PPGs remain responsible for the provision of, and payment for, all fee-for-service (FFS) Medi-Cal-covered services not related to the terminal illness, including those of the member's primary care physician (PCP).

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.

Transitioning to Hospice Services

Health Net emphasizes the importance of timely recognition of a member's eligibility for hospice care services and their election of these services.

Once a member has elected hospice care services, participating providers and case management staff work closely with hospice providers to facilitate the transfer of member services from those directed towards cure and/or prolongation of life to those directed towards palliation. Ongoing care coordination ensures that services necessary to diagnose, treat and follow-up on conditions not related to the terminal illness continue or are initiated as necessary (Code of Federal Regulations (CFR), Title 42, CFR, Section 438.208).

Utilization Review

Neither Health Net nor delegated participating physician groups (PPGs) may restrict access to hospice care services (Code of Federal Regulations (CFR), Title 42, Section 438.210(a)). The Medi-Cal fee-for-service (FFS) program does not require prior authorization of hospice services except for inpatient admissions; therefore, Health Net and PPGs only require prior authorization for inpatient admission.

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:

- Administration of Immunizations
- Immunization Schedule

Administration of Immunizations

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

Primary care physicians (PCPs) are responsible for immunizing members and maintaining all immunization information in the member's medical record. Local health departments (LHDs) may also immunize Health Net Medi-Cal members.

The Department of Health Care Services (DHCS) requires participating providers to document each member's need for Advisory Committee on Immunization Practices (ACIP)-recommended immunizations as part of all regular health visits and to report the administration of immunizations within 14 days.

PCPs must be available to administer immunizations during office hours. The PCP is responsible for updating the state-supplied "yellow card" (PM 298) immunization record or other immunization record and giving a copy to the patient or parent/guardian. Providers who administer vaccines must submit patient vaccination records to local health departments and appropriate immunization registries within the specified timelines. Providers must enroll in and use California Immunization Registry (CAIR) to report and track patient immunization records online.

At each visit, the PCP should inquire whether the patient has received immunizations from another provider. The PCP should also educate members regarding their responsibility to inform the PCP if they receive immunizations elsewhere (such as from an LHD or non-participating provider). This information is necessary for documentation and the member's safety.

Vaccines for Children Program

Refer to the Centers for Disease Control and Prevention (CDC) website for Vaccines for Children (VFC) program and other forms for Medi-Cal-eligible members. Providers are required to enroll in the program in order to participate. This federally funded program furnishes free vaccines in bulk to enrolled providers. All Medi-Cal-eligible children under age 19 may receive VFC vaccines.

To participate in the VFC program, providers must complete these forms:

- Provider Enrollment Form
- Provider Profile Form
- VFC Program Vaccine Order Form

Promoting Immunization and Access to Care

The Health Net Medi-Cal Facility Site Review (FSR) Compliance Department provides educational materials that physicians can use to promote immunization services and access to care. Materials available include pediatric and adult immunization checklists, a basic screening questionnaire for contraindications to child and

teem immunizations, a health screening schedule, a member immunization chart, and reproducible member educational materials.

Refer to the CDC immunization schedule guidelines below. If there are less restrictive immunization criteria outlined by Health Net than what is published by the Advisory Committee on Immunization Practices (ACIP), immunizations should be provided according to the less restrictive criteria:

- The adult immunization schedule (PDF).
- The children and adolescents immunization schedule (PDF).

The Health Net FSR Compliance nurses also promote the use of the CDC Vaccine Information Statements (VIS). Distribution of VIS is required when a member receives an immunization. Distribution of VIS and the VIS publication date must be documented in the member's medical record. Refer to the CDC website for VIS and other immunization resources.

Member Outreach Education

Health Net's member outreach and health education efforts concentrate on informing members about the importance of immunizations, immunization schedules, and the need to preserve immunization records. Members receive information in their new member packet, annual immunization reminder postcards, and brochures that are available through the Health Net member website and Health Education Department toll-free information line.

Immunization Schedule

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

Following are immunization schedule recommendations.

Childhood Immunization Schedule Recommendation

The Recommended Childhood and Adolescent Immunization Schedule is approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP) and available on the Centers for Disease Control and Prevention website.

Documentation Requirements

At each non-emergency primary care visit with members less than 21 years of age, the member (if an emancipated minor), or the parent(s) or guardian of the member, must be advised of the vaccinations due and available immediately, if the member has not received vaccinations in accordance with ACIP standards. Documentation must be entered in the member's medical record which must indicate the receipt of

vaccinations or proof of prior vaccination in accordance with ACIP standards. If vaccinations that could be given at the time of the visit are refused, documentation must be entered in the member's medical record which must indicate the vaccinations were advised, and the member's (if an emancipated minor), or the parent(s) or guardian of the member's voluntary refusal of these vaccinations. If vaccinations cannot be given at the time of the visit, then it is required that the medical record must demonstrate that the member was informed how to obtain necessary vaccinations or scheduled for a future appointment for vaccinations.

Medi-Cal Routine Vaccinations for Adults

The following information applies only to participating physician groups (PPGs) and physicians.

Medi-Cal adult members may obtain routine vaccinations that are not subject to prior authorization (PA) from their participating provider or participating pharmacy. The Medi-Cal Rx Contract Drug List for applicable utilization restrictions about age or quantity. The Contract Drug List can be found on the Medi-Cal Rx website.

The financial responsibility for adult immunizations is the same for in-network or self-referral to out-of-network providers. When the Medi-Cal member of a capitated participating physician group (PPG) obtains a vaccine from a participating pharmacy, the cost of the immunization is deducted from the PPG's monthly capitation amount in the same manner as other injectable medications that are the PPG's responsibility. PPGs remain responsible for adult immunizations.

Documentation requirements

At each non-emergency primary care encounter the member must be advised of the vaccinations due and available, if the member has not received vaccinations in accordance with ACIP standards. Documentation must be entered in the member's medical record which indicates the receipt of vaccinations or proof of prior vaccination in accordance with ACIP standards. If vaccinations that could be given at the time of the visit are refused, documentation must be entered in the member's medical record which must indicate the vaccinations were advised, and the member's voluntary refusal of these vaccinations. If vaccinations cannot be given at the time of the visit, then it is required that the medical record must demonstrate that the member was informed how to obtain necessary vaccinations or scheduled for a future appointment for vaccinations,

Local Health Department

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

In accordance with the Department of Health Care Services (DHCS) guidelines, Health Net reimburses local health departments (LHDs) for certain immunizations given without prior authorization. The LHD is responsible for verifying the member's immunization status, as it is not reimbursed for immunizations provided when the member's immunizations are current. LHDs must submit a copy of the member's immunization record with their claim form. On request, Health Net assists LHDs with obtaining the member's immunization history and forwards a copy of the member's immunization record to the member's PCP for inclusion in the member's medical record.

If the member receives an immunization from the LHD and complications occur, the member must contact their PCP for care as with any other medical problem.

Public Health Coordination

Health Net's public programs administrators work with local health departments (LHDs) to facilitate the exchange of data and information.

Reimbursement for Ages 19 and Older

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

For immunizations of members ages 19 and older, Health Net reimburses contracting fee-for-service (FFS) providers at the Medi-Cal FFS rate, which includes an allowance for the vaccine and its administration.

Incontinence Medical Supplies

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

Incontinence medical supplies are covered when prescribed by licensed, in-network providers within their scope of practice for the treatment of members who are incontinent. Health Net contracts with J&B Medical Supply Company, Inc. and Byram to provide these supplies. Incontinence medical supplies include disposable diapers, protective underwear (pull-on products), underpads, belted undergarments, shields, liners, pants and pad systems, pads, and reusable underwear.

Incontinence medical supplies are covered for use only when the member's incontinence is caused by chronic pathologic conditions. When incontinence is a short-term problem or when there is no underlying pathologic condition causing it, incontinence supplies are not covered.

Providers must document the following in the member's medical record to support the need for prescribed incontinence medical supplies:

- Diagnosis for the medical condition and diagnosis causing incontinence.
- Diagnosis for the type of incontinence for which supplies are required.
- Product name and description.
- Anticipated frequency of replacing the supplies.
- Quantity.

Incontinence supplies are limited to the items listed above up to $165 per month. Incontinence creams and washes are not subject to the $165 per month limit and are available for members ages 21 and older.

For more information about incontinence medical supply coverage, refer to the Department of Health Care Services (DHCS) Medi-Cal Provider Manual.

Health Net does not provide benefits for incontinence supplies for Medi-Cal members younger than age five. Benefits are provided only if the incontinence is due to a chronic physical or mental condition, including cerebral palsy and developmental delay, at an age when the child would normally be expected to achieve continence. Incontinence creams and wash products are covered under Medi-Cal.

Initial Health Appointment

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

This section contains general information on the requirements for initial health appointment.

Requirements

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

All Medi-Cal members ages 18 months and older must have an initial health appointment (IHA), which includes an age-appropriate history and physical examination, within 120 calendar days after their date of enrollment. For Medi-Cal Members less than 18 months of age, the IHA must be completed within 120 calendar days following the date of Enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) Bright Futures for ages 2 years and younger, whichever is sooner.

The member may be seen initially during a visit for episodic care. Regardless of the reason for the initial visit, the provider should conduct the IHA at the first health care contact and document the assessment in the medical record. The IHA must be completed by a provider in the primary health setting.

An IHA at a minimum must include: a history of the member's physical and mental health, an identification of risks, an assessment of need for preventive screens or services and health education, a physical examination, and the diagnosis and plan for treatment of any diseases, unless the member's primary care physician (PCP) determines that the member's Medical Record contains complete information, updated within the previous 12 months, consistent with the assessment requirements.

The IHA must be conducted in a culturally and linguistically appropriate manner for all members, including those with disabilities, and it must be documented in the member’s medical record.

IHA Guidelines

For members under age 21, the IHA and ongoing assessments must follow the current AAP Recommendations for Preventive Pediatric Health Care (PDF). The IHA must provide, or arrange for provision of, all immunizations necessary to ensure that the member is up to date with the Recommended Childhood Immunization Schedule (PDF) based on joint recommendations of the Advisory Committee on Immunization

Practices (ACIP), Adverse Childhood Experiences (ACEs) screening, and any required age-specific screenings including developmental screenings. Providers must also ensure that members receive all screening, preventive and Medically Necessary diagnostic and treatment services required under the EPSDT benefit, as described by DHCS in the EPSDT Provider Information.

For members ages 21 and older, the initial appointment includes, but is not limited to, an evaluation and timely provision of applicable preventive services provided in accordance with the United States Preventive Services Taskforce (USPSTF) grade A and B recommendations.

IHA Documentation and Reporting

For all providers, a member eligibility report is available through Health Net Membership Accounting at the primary care physician's (PCP's) request to allow providers to reach out to their new members and ensure completion of all appropriate preventive care services and the IHA within 120 calendar days. Providers may log on to Health Net's provider portal to access the online IHA reports located under Provider Reports.

Health Net reviews monthly claims and encounter data of initial health appointments rendered by participating providers. These encounters are cross-checked against member enrollment data. A member eligibility report is available at the PCP's or participating physician group's (PPG's) request on a monthly basis to provide an aid for IHA compliance.

In all cases, the PCP must document all member contacts, including scheduling of the appointment or the member's refusal to schedule an appointment, in the member's medical record.

Childhood Blood Lead Screening

Providers must follow guidelines issued by the Department of Public Health's California Childhood Lead Poisoning Prevention Branch (CLPPB) Health and the California Childhood Lead Poisoning Prevention Branch (CLPPB)-issued guidelines on childhood blood lead screening, which includes CDC Recommendations for Post-Arrival Lead Screening of Refugees, of the Department of Public Health and also:

- Provide oral or written anticipatory guidance to the parents or guardians of a child that includes information that children can be harmed by exposure to lead. The guidance must be provided at each periodic health assessment for ages 6-72 months.
- Perform blood lead level (BLL) testing on all children as follows:
    - At ages 12 months and 24 months.
    - When the provider performing the periodic health assessment becomes aware that a child age 12-24 months has no documented evidence of a BLL test taken at age 12 months or thereafter.
    - When the provider becomes aware that a child age 24-72 months has no documented evidence of BLL test results taken at age 24 months or thereafter.
    - Whenever the provider becomes aware that a child age 12-72 months has had a change in circumstances that places the child at increased risk of lead poisoning, in the provider's professional judgement.
    - When requested by the parent or guardian.
- The health care provider is not required to perform BLL testing in the following cases. The reasons for not screening must be documented in the child's medical record.
    - The parent or guardian refuses consent for the screening. Providers must obtain a signed statement of voluntary refusal by the parent or guardian, or document reasons for not obtaining the signed statement (i.e. parent refused or is unable to sign, assessment done via telehealth, etc.).

- If in the professional judgement of the provider, the risk of screening poses a greater risk to the child's health than the risk of lead poisoning.

Blood lead level screening must be reported.

- Encounter or claims data is used to track the administration of blood level screenings. Providers must ensure that encounters are identified using the appropriate CPT codes for blood level screenings.
- Laboratories and health care providers performing blood lead analysis on specimens are to electronically report all results to CLPPB, with specified patient demographics, ordering physician and analysis data on each test performed. Information on how to report results to CLPPB can be found at CLPPB website.

Coordination by Health Net

Health Net sends new members a welcome packet that includes an initial health appointment (IHA) notification, provider directory, Evidence of Coverage (EOC), preventive care services, and other important plan information. Instructions are included for new members to schedule appointments with their primary care physicians (PCPs). Health Net contacts new Medi-Cal members by telephone after mailing the new member packet to communicate the importance of scheduling an IHA and to share other relevant information about members using their benefits. If the IHA has not occurred within 45 days of enrollment, Health Net conducts a third member contact via phone. If a member, or the parent or guardian of a child member, refuses to have the IHA performed, it must be documented in the member's medical record.

Providers may contact the Health Net Education Department for more information.

PCP Coordination

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

Health Net sends new members a welcome packet that includes an initial health appointment (IHA) notification and information on how to schedule appointments with their primary care physicians (PCPs). The IHA notification instructs new members to schedule appointments with their PCP for their IHA.

PCPs must document all member contacts, including the scheduling of the IHA appointment or the member's refusal of an appointment in their medical record.

During the initial and subsequent health assessments, PCPs must inform members, parents or guardians of the need for and importance of periodic health assessments and reinforce the member's understanding of the need for routine preventive, well-child screening services at each medical encounter. PCPs are encouraged to schedule the next visit at the conclusion of the member visit. PCPs are also encouraged to use an appointment reminder system. If PCPs identify a medical condition during the IHA, diagnosis and treatment must begin with 60 calendar days. Justification for any delays beyond 60 calendar days must be documented in the member's medical record. If an appointment is scheduled, but missed or broken, PCPs must follow the procedure for missed or broken appointments.

Injectables

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

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

Select any subject below:

Overview

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

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

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

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

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

- Chemo adjunct
- Growth hormones
- HIV/AIDS
- Infertility medications

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

- Chemotherapy and chemo adjunct injectable medications must be associated with a cancer diagnosis using ICD-10 codes between C00.0-C79.9, C7A.00-C7B.8, C80.0-C96.9, D00.0-D09.9. If the appropriate codes are not used, these injectables default to the primary category
- HIV/AIDS must be associated with a HIV or AIDS diagnosis. If the diagnosis is not HIV or AIDS, these injectable medications default to the DOFR therapeutic category
- Home health infusion must be administered in the home by a nurse or physician. If it is not, this injectable medication defaults to the DOFR primary category
- Immunosuppressants for transplants must be associated with an organ transplant. If they are not, these injectable medications default to the DOFR primary category

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

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

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

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

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

Hemophilia

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

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

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

Chemotherapy

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

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

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

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

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

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

Prior Authorization

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

There are three options for submitting a prior authorization form:

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

When certain designated injectables are requested by a participating provider or physician group (PPG) that participates in a shared-risk arrangement, or when the financial risk belongs to Health Net, prior authorization must be obtained through Pharmacy Services. This requirement also applies to PPGs with delegated utilization management (UM). The only injectable medications that require prior authorization are self-injectable medications and a few specific injectable medications.

Some injectables (i.e., self-injectables) are excluded from Health Net's coverage responsibilities when used in the treatment of Medi-Cal members enrolled in carve-out programs, such as Medi-Cal Rx, California Children's Services (CCS) or the HIV/AIDS waiver program. Other injectables are excluded when a Medi-Cal member has a waiver program-eligible condition for which the member is disenrolled from Health Net (for example, most major organ transplants for adult members). For additional information regarding injectable medications, refer to the Health Net Injectable Medication HCPCS/DOFR Crosswalk (PDF) table.

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

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

Chemotherapy Off-Label Use

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

Food and Drug Administration (FDA)-approved chemotherapy medications used for off-label malignancies or indications are covered if they are listed in the Health Net Injectable Protocol Guidelines, or if evidence is presented that the medication is used in treatment for a particular neoplasm under a professionally recognized standard of care, such as an official medication compendium (for example, AHFS Drug Information), or in the bulletin published by the Association of Community Cancer Centers.

Home Infusion

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

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

- Total parenteral nutrition (TPN)

- Intravenous antibiotic and antiviral therapies
- Aerosolized therapy
- Pain management
- Chelation therapy
- Inotropic therapy
- IVIG/IGIV immunoglobins
- Hydration therapy
- Steroid therapy
- Remicade
- Chemotherapy

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

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

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

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

Self-Injectable Medications

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

Self-administered medications, as determined by Health Net, include, but are not limited to, medications cited by the Food and Drug Administration (FDA) as a self-injectable, orally, or topically administered medications and specifically packaged by the manufacturer to be administered by the member in an outpatient environment or at home. Self-injectable medications can be administered subcutaneously or intramuscularly with a syringe and needle. The administration routes must be proven safe and effective when self-injected by the member.

Prior Authorization for these self-administered medications can be obtained by faxing a request to Medi-Cal Rx at 800-869-4325 or by using CoverMyMeds®.

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.

Therapeutic Injections and Other Injectable Substances

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

EPO and HMO

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

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

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

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

Medi-Cal

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

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

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

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

Long-Term Care

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

This section contains general member benefit information on long-term care services and problem resolution. Unless specified in title, information provided applies to all counties listed above.

Identification

The two primary methods of identifying hospitalized Medi-Cal members who may require long-term care (LTC) are:

- Physician identification - The member's primary care physician (PCP) or specialist makes a diagnosis that requires services in an LTC facility. The physician or the physician's representative then contacts the Health Net's Utilization Management (UM) Department (or participating physician group (PPG), if UM responsibilities have been delegated to the PPG) to request prior authorization for admission
- Care management concurrent review - Health Net or the subcontractor's concurrent review nurses review daily census reports that identify members who may need LTC services following discharge

Other means of identifying a candidate for LTC services are reviewing retroactive claims for LTC services or through social workers, discharge planners and other health care providers involved in the member's care.

Additional communication requirements for appropriate and timely concurrent review, claims submission and claims adjudication include:

- Hand-off communications - Upon authorizing LTC services, Health Net and the PPG communicate about the member's LTC admission
- Level of care communications - Health Net and the PPG communicate regarding changes in the member's level of care or transition from Medicare-based skilled nursing services to Medi-Cal-based LTC benefits

Long-Term Care

Medi-Cal members in need of long-term care (LTC) facility services should be placed in facilities providing the level of care commensurate with their medical needs.

- Skilled nursing facility (SNF) for short and long-term care
- Intermediate care facility (ICF)
- Adult subacute care facility
- Pediatric subacute care facility

Turnaround times are as follows:

- Authorization 72 hours

- Placement requirements five business days for Los Angeles and Sacramento Counties, seven business days for San Joaquin, Stanislaus, 14 business days for all other counties.

Hospice services are not considered LTC services. When hospice services are provided in an LTC facility, the member's eligibility under the Medi-Cal managed care is not affected regardless of the member's expected or actual length of stay in the nursing facility.

Special Treatment Program Services

Special treatment program services in nursing facilities are covered under Medi-Cal and rendered to members who:

- Have chronic psychiatric impairment and whose adaptive functioning is moderately impaired
- Have conditions that are responsive to special treatment program services and prohibitive to placement in a skilled nursing facility
- Require a therapeutic program of services designed, staffed and implemented by a special treatment program unit for the purpose of meeting the special needs of this identified population group
- Are disabled mentally or physically and such disability is expected to be prolonged

Coordination of Care

The primary care physician (PCP) continues to provide care during the transition to long-term chronic care, and coordinates with the LTC attending physician to ensure continuity of care. This includes forwarding all pertinent records to the new PCP when identified and available to consult.

Long-Term Care for Permanently Institutionalized

Medi-Cal members who reside in a long-term care (LTC) facility beyond the month of admission plus one month, are deemed permanently institutionalized. These members are reassigned from their participating physician groups (PPGs) to Health Net for utilization management upon Health Net's evaluation that the member is deemed permanently institutionalized and qualifies for reassignment. PPGs are responsible for LTC members until they are no longer listed on their monthly eligibility reports.

Health Net must authorize long-term care (LTC) services when a member has a medical condition that requires LTC. LTC includes both skilled nursing care and non-skilled custodial care, specific to out-of-home protective living arrangements with 24-hour supervised or observation care on an ongoing intermittent basis to abate deterioration.

LTC is care provided in a skilled nursing facility (SNF), intermediate care facility or subacute care facility. Additionally, it is an inpatient care level for members who meet medical necessity at the following care levels as defined in the Manual of Criteria for Medi-Cal Authorization:

1. A skilled nursing facility admission for members accessing Medi-Cal nursing facility Level A or B benefit level.
2. An intermediate care facility admission for members accessing Medi-Cal nursing facility Level A benefits.
3. A subacute care facility admission for members accessing Medi-Cal covered subacute care services.

Members in need of LTC services are placed in facilities providing the level of care commensurate with their medical needs.

Criteria for Long-Term Care

To qualify for long-term care (LTC), which includes nursing facility and custodial care, a member must have a medical condition that requires an out-of-home protective living arrangements with 24-hour supervision and skilled nursing care or observation on an ongoing intermittent basis to abate deterioration. LTC services emphasize care aimed at preventing or delaying acute episodes of physical or mental illness and encourage each member's independence to the extent of the member's ability. The following factors are considered in determining appropriate placement for LTC:

- The complexity of the member's medical problem is such that the member requires skilled nursing care or observation on an ongoing intermittent basis and 24-hour supervision to meet the member's health needs.
- Medications may be mainly supportive or stabilizing, but still require professional nurse observation for response and effect on an intermittent basis. Members on daily, injectable medications or frequent doses of pro re nata (PRN) narcotics may not qualify.
- Diet may be special, but the member needs little or no feeding assistance.
- The member may require minor assistance or supervision in personal care, such as in bathing or dressing.
- The member may need encouragement in restorative measures for increasing and strengthening functional capacity to work toward greater independence.
- The member may have some degree of vision, hearing or sensory loss.
- The member may have some limitation in movement, but must be ambulatory with or without an assistive device, such as a cane, walker, crutches, prosthesis, or wheelchair.
- The member may need some supervision or assistance in transferring to a wheelchair, but must be able to ambulate the chair independently.
- The member may have occasional urine incontinence; however, a member who has bowel incontinence or complete urine incontinence may qualify for intermediate care service when the member has been taught and is capable of self-care.
- The member may exhibit some mild confusion or depression; however, the member's behavior must be stabilized to such an extent that it poses no threat to self or others.

One of the criteria Health Net uses to determine medical necessity is the Department of Health Care Services (DHCS) Manual of Criteria for Medi-Cal Authorization (PDF).

Coordination of Care

The PCP continues to provide care during the transition to LTC, and coordinates with the LTC attending physician to ensure continuity of care. This includes forwarding all pertinent records to the new PCP when identified and available to consult. For coordination of benefit questions, providers may contact the Health Net Public Programs Department.

Additional communication requirements for appropriate and timely concurrent review, claims submission and claims adjudication include:

- Hand-off communications - Upon authorizing LTC services, Health Net and the participating physician group (PPG) communicate about the member's LTC admission.
- Level of care communications - Health Net and the PPG communicate regarding the member's level of care or transition from Medicare-based skilled nursing services to Medi-Cal-based LTC benefits.

Referrals and Authorizations

Providers must supply both the completed Health Net Long-Term Care Authorization Notification Form Medi-Cal (PDF), Long-Term Care Authorization Notification Form - Community Health Plan of Imperial Valley (PDF), Long-Term Care Authorization Notification Form - CalViva Health (PDF), as well as any supporting clinical information, such as the Pre-Admission Screening and Resident Review (PASRR), Minimum Data Set (MDS) or approved Treatment Authorization Request (TAR), as applicable, to the Health Net Long-Term Care Intake Line by fax. Health Net continues to honor any currently active TAR approved authorizations.

For new admission authorization/notification requests, once a decision is made, Health Net notifies the provider by phone or fax. Other ancillary services may require prior authorization and are not included in the nursing facility room rate. Providers must obtain prior authorization prior to providing such services.

Providers may contact the Health Net Long-Term Care Intake Line with all questions regarding LTC referrals and authorizations, or to check the status of a request.

Claims and Payment

Most non-dual and dual LTC members in all counties (including those with a Share of Cost) are required to enroll in a Medi-Cal Managed Care Plan, including Fresno, Kings and Madera counties. Providers may refer to the Cal Duals for enrollment charts and timelines, including enrollment data by county to confirm transitioned dates. Additionally, providers must verify eligibility to ensure claims are appropriately directed and may submit claims directly to the Health Net Medi-Cal Claims Department, as outlined in the Division of Financial Responsibility (DOFR).

Member Selection Criteria - Los Angeles County Only

Long-term care (LTC) coverage eligibility is based on intensity of medical services required and severity of illness. Each member is evaluated based on primary care physician (PCP) diagnosis and treatment recommendations, facility heath care team assessments, Medi-Cal regulations, including the Department of Health Care Services (DHCS) Manual of Criteria for Medi-Cal Authorization, and the Minimum Data Set (MDS). The MDS is a standardized, primary health status screening and assessment tool that forms the foundation of the comprehensive assessment of all nursing facility residents in LTC facilities.

If the provider's Medi-Cal contract is through Molina Healthcare, providers should contact Molina for a copy of its LTC member selection criteria. Specific policies can be accessed by contacting the participating physician group (PPG) administrator. Where there are conflicts between established Health Net medical policy and DHCS policies and guidelines, Health Net defers to DHCS requirements.

Member Selection Criteria - All other counties

Long-term care (LTC) coverage eligibility is based on intensity of member services required and severity of illness. Each member is evaluated based on primary care physician (PCP) diagnosis and treatment recommendations, facility health care team assessments, Medi-Cal regulations, including the Department of Health Care Services (DHCS) Manual of Criteria for Medi-Cal Authorization, and the Minimum Data Set (MDS).

The MDS is a standardized, primary screening and assessment tool of health status that forms the foundation of the comprehensive assessment of all nursing facility residents in long term care facilities.

Criteria for Adult Subacute Care Program

Adult subacute level of care refers to very intensive, licensed, skilled nursing care provided to members who have fragile medical condition. To qualify for the adult subacute program, the member must require at least four hours of direct skilled nursing care per day and at least one of the following:

- Tracheostomy care with continuous mechanical ventilation for at least 50 percent of the day
- Tracheostomy care with suctioning and room air mist or oxygen as needed, and one of the six treatment procedures listed below; or
- Administration of any three of the six following treatment procedures:
    - total parenteral nutrition
    - inpatient physical, occupational or speech therapy at least two hours per day, five days per week
    - tube feeding (nasogastric or gastrostomy)
    - inhalation therapy treatments every shift and a minimum of four times per 24-hour period
    - intravenous (IV) therapy involving one of the following:
        - continuous administration of a therapeutic agent
        - hydration
        - frequent intermittent IV medication administration via a peripheral or central line (heparin lock)
    - wound debridement, packing and medicated irrigation with or without whirlpool treatment

One of the criteria Health Net uses to determine medical necessity is the Department of Health Care Services (DHCS) Manual of Criteria for Medi-Cal Authorization (PDF).

Criteria for Coverage of Skilled Nursing Facility Care

To qualify for coverage of skilled nursing facility (SNF) care, the member must no longer need acute hospital care, but requires skilled nursing or skilled rehabilitation services daily. The member's overall condition must be evaluated for purposes of admission to a SNF.

Criteria for coverage of skilled nursing services are as follows:

- Intravenous, intramuscular or subcutaneous injections and intravenous feeding.
- Administration of new medications requiring initial observations by skilled staff.
- Levin tube and gastrostomy feedings.
- Nasopharyngeal and tracheostomy aspiration.
- Insertion, sterile irrigation and replacement of catheters.
- Application of dressings involving prescription medications and aseptic techniques.
- Treatment of extensive decubitus ulcers or other widespread skin disorder.
- Heat treatments that have been specifically ordered by a physician as part of active treatment and require observation by skilled staff to evaluate the member's response.
- Initial phases of a regimen involving administration of medical gases.
- Rehabilitation nursing procedures, including related teaching and adaptive aspects of nursing, that are part of active treatment (for example, institution and supervision of bowel and bladder training programs).

- Colostomy and ileostomy care for new colostomies and ileostomies or for debilitated members.

Criteria for coverage of skilled rehabilitation services are as follows:

- Services concurrent with management of a member care plan, including tests and measurements of range of motion, strength, balance, coordination, endurance, functional ability, activities of daily living, perceptual deficits, speech and language, or hearing disorders.
- Therapeutic exercises or activities that, because of the type of exercises employed or the condition of the member, must be performed by or under the supervision of a qualified physical therapist or occupational therapist to ensure the safety of the member and the effectiveness of the treatment.
- Gait evaluation and training furnished to restore function to a member whose ability to walk has been impaired by neurological, muscular or skeletal abnormality.
- Range of motion exercises that are part of active treatment of a disease that has resulted in a loss of, or restriction of, mobility.
- Maintenance therapy, when the specialized knowledge and judgment of a physical therapist is required to design and establish a maintenance program based on an initial evaluation and periodic reassessment of the member's needs.
- Ultrasound, short-wave and microwave therapy treatment by a physical therapist.
- Hot packs, hydrocollator, infrared treatments, paraffin baths, and whirlpool in cases where the member's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications and the skills, knowledge and judgment of a physical therapist are required.
- Services of a speech pathologist or audiologist when necessary for the restoration of speech or hearing.

Additional requirements for skilled nursing services and/or skilled rehabilitation services:

- The service must be so inherently complex that it can only be safely and effectively performed by, or under the supervision of, professional or technical staff.
- A condition that does not ordinarily require skilled services may require them because of special medical complications.
- The restoration potential of a member is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a member may need skilled services to prevent further deterioration or preserve current capabilities.
- Criteria for "daily" means with the following frequency:
    - Skilled nursing services or skilled rehabilitation services must be needed and provided seven days a week.
    - As an exception, if skilled rehabilitation services are not available seven days a week, those services must be needed and provided at least five days a week.
    - A break of one or two days in the furnishing of rehabilitation services does not preclude coverage if discharge would not be practical for the one or two days during which therapy is suspended (for example, the physician has postponed therapy sessions because the member exhibited extreme fatigue).
- The primary care physician (PCP) and hospital discharge planner determine that the member requires short-term nursing facility care for post-surgical, rehabilitative, or therapy services designed to cure the member's condition rather than just relieve the condition. In making a practical matter determination, consideration must be given to the member's condition and to the availability of more economical, alternative facilities and services:
    - Member's condition - Inpatient care would be required as a practical matter if transporting the member to and from the nearest facility that furnishes the required daily skilled services would be an excessive physical hardship.

- Economy and efficiency - Even if the member's condition does not preclude transportation, inpatient care might be more efficient and less costly if, for instance, the only alternative is daily transportation by ambulance.

One of the criteria Health Net uses to determine medical necessity is the Department of Health Care Services (DHCS) Manual of Criteria for Medi-Cal Authorization (PDF).

Criteria for Pediatric Subacute Care Program

To qualify for the pediatric subacute care program, the member must be under age 21 and need one of the following:

- Tracheostomy care with dependence on mechanical ventilation for a minimum of six hours each day
- Tracheostomy care requiring suctioning at least every six hours, room air mist or oxygen as needed, and dependence on one of the four (2-5) treatment procedures listed below
- Total parenteral nutrition or other intravenous nutritional support and one of the five treatment procedures listed below
- Skilled nursing care in the administration of any three of the five treatment procedures listed below

Treatment Criteria for Pediatric Subacute Care

1. Intermittent suctioning at least every eight hours and room air mist or oxygen as need.
2. Continuous intravenous therapy, including administration of therapeutic agents necessary for hydration or of intravenous pharmaceuticals, or intravenous pharmaceutical administration of more than one agent via a peripheral or central line without continuous infusion.
3. Peritoneal dialysis treatment requiring at least four exchanges every 24 hours.
4. Tube feeding via nasogastric or gastrostomy tube.
5. Other medical technologies required continuously, which, in the opinion of the attending physician and Medi-Cal consultant, require the services of a professional nurse.

Additional Criteria

- The intensity of medical/skilled nursing care required by the member is such that the continuous availability of a registered nurse in the pediatric subacute unit is medically necessary to meet the member's health care needs and not be any less than the nursing staff ratios required.
- The member's medical condition must have stabilized so that the immediate services of an acute care hospital, including daily physician visits, are not medically necessary.
- The intensity of medical/skilled nursing care required by the member is such that, in the absence of a facility providing pediatric subacute care services, the only other medically necessary inpatient care appropriate to meet the member's health care needs under the Medi-Cal program is in an acute care licensed hospital bed.

One of the criteria Health Net uses to determine medical necessity is the Department of Health Care Services (DHCS) Manual of Criteria for Medi-Cal Authorization (PDF).

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:

Coverage Explanation

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

Members may see any qualified participating Health Net provider within their participating physician group (PPG), including their primary care physician (PCP), obstetrician or gynecologist (OB/GYN), or certified nurse midwife (CNM) and certified nurse practitioner (CNP) for prenatal care. PPGs or PCPs and specialists are prohibited from requiring a referral or prior authorization for basic prenatal care. If there are no CNMs or CNPs in the PPG network, access to non-contracting CNMs or CNPs is a benefit.

All pregnant members must have access to Comprehensive Perinatal Services Program (CPSP) services, which integrate health education, nutrition and psychosocial services with obstetrical care. CPSP support services providers are required to use the Department of Health Care Services (DHCS)-approved assessment tools. Health Net has developed assessment tools approved by DHCS that are included in this manual. The multidisciplinary approach to delivering perinatal care in the CPSP framework is based on the recognition that providing these services from conception through 60 days following delivery improves pregnancy outcomes.

The provision of CPSP services to pregnant members is the responsibility of all California Department of Public Health (CDPH)-certified CPSP providers who contract with Health Net, a subcontracting health plan or PPG.

Health Net-participating PPGs must maintain and reimburse a network of obstetric and community providers who are CPSP-certified in order to promote access to CPSP and improve birth outcomes for their patients. PPGs may not redirect CPSP services away from participating CPSP-certified providers who are in good standing with the state and local county CPSP program. CPSP-certified providers must be allowed to provide services to Health Net Medi-Cal members. Health Net and CDPH attempt to have all obstetricians providing care to Medi-Cal members become CPSP-certified to allow CPSP services to be provided during routine obstetric prenatal and postpartum visits.

Refer to Doula section of the provider operations manual for additional information.

Billing

Individual participating providers who are not certified by the California Department of Public Health (CDPH) for the Comprehensive Perinatal Services Program (CPSP) are reimbursed for maternity services with a global professional fee, which includes all professional services normally provided for routine perinatal care. CPSP providers should bill each service separately, using the DHCS designated "Z" codes.

Compliance and Quality Improvement

Compliance with Health Net's perinatal standards of care is monitored by the Health Net State Health Programs Quality Improvement Department.

Comprehensive Risk Assessment and Individualized Care Plan

Comprehensive Perinatal Services Program (CPSP) providers should complete a comprehensive risk assessment and individualized care plan (ICP) if the obstetric care provider is not providing the full scope of CPSP support services.

The comprehensive risk assessment includes information from the medical-obstetric assessment combined with a health education, nutrition and psychosocial assessment. The assessment is designed to evaluate the member's health behaviors, knowledge base, medical conditions, and psychosocial situation. The assessment is conducted by the provider or trained paraprofessional (comprehensive perinatal health worker). The ICP is developed by the provider in consultation with the member. The provider is responsible for making referrals to alleviate identified risks, with priority given to the most severe. This assessment must be administered at the initial prenatal visit, once each trimester thereafter, and at the postpartum visit.

Identified risks, interventions and referrals comprise the ICP. The ICP includes a statement of the risks identified and the interventions taken to address the risks in priority order, the identification of the persons responsible for carrying out the proposed interventions, the evaluation or outcome of the actions taken by the provider or member, and any updates. The provider must retain a copy of the ICP in the member's medical record.

For all members participating in CPSP, risk reassessment occurs during each trimester and the postpartum period. The ICP is revised as indicated.

Health Net makes available the following CPSP assessment tools and resources:

- Initial and Trimester Assessment (PDF)
- Postpartum Assessment and Individualized Care Plan (PDF)
- Dual Provider Agreement (PDF)
- Perinatal Nutrition Assessment (PDF)
- HIV Information Documentation form (PDF)
- Domestic Violence Danger Assessment form (PDF)

Educating Providers on Perinatal Services

Information regarding perinatal services and community information sources is available from the Health Net Medi-Cal Facility Site Review (FSR) Compliance Department and the Health Net Health Education Department.

Member Rights

Prior to the administration of any assessment, medication, procedure, or treatment, the member must be informed of potential risks that may affect them or their unborn child during pregnancy, labor, birth, or postpartum, and the alternative therapies available to them. The member has a right to consent to or refuse administration of any assessment, medication, procedure, test, or treatment.

The member has the right to:

- Be treated with dignity and respect
- Have their privacy and confidentiality maintained
- Review their medical treatment record with their physician
- Be provided explanations about tests, and clinic and office procedures
- Have their questions answered about procedures and care
- Participate in planning and decisions about their management during pregnancy, labor and delivery, and the postpartum period

Notification and Early Entry into Care

Upon the discovery that a member is pregnant, all participating providers (including primary care physicians (PCPs), obstetric care providers, midwives, and family planning clinics) are required to notify the care manager of their affiliated participating physician group (PPG). Direct network providers must notify the Health Net Medi-Cal Health Services Department. Primary care physicians only should complete the Confirmation of Pregnancy Form (Medi-Cal, CalViva Health, Community Health Plan of Imperial Valley) for the pregnant member and fax it to the number at the top of the form.

The Pregnancy Outcome Notification Report provides Health Net with the information needed to meet the Department of Health Care Services (DHCS) reporting requirements. Completed forms must be faxed to the Health Net Medi-Cal Health Services Department .

Pregnancy Care Management

The initial prenatal examination must occur within two weeks (for Medi-Cal facility site review purposes, within seven calendar days) of the initial referral or request for pregnancy-related services. The obstetric provider is expected to provide care for members using standards consistent with current American Congress of Obstetricians and Gynecologists (ACOG) recommendations and within accepted Health Net guidelines.

ACOG's guidelines for Perinatal Care (PDF) recommends the following examination schedule for a woman with an uncomplicated pregnancy:

- Every four weeks for the first 28 weeks
- Every two to three weeks until 36 weeks gestation
- Weekly from 36 weeks gestation until delivery
- Postpartum, four to eight weeks after delivery

Women with medical or obstetric problems may require closer surveillance. The interval between visits is determined by the obstetric provider according to the nature and severity of the problems.

Recommended intervals for routine tests for individual members during pregnancy are as follows:

- Initial visit (as early as possible):
    - Hemoglobin or hematocrit measurement
    - Urinalysis, including microscopic examination and infection screening
    - Blood group and Rh type determinations
    - Antibody screening
    - Rubella antibody titer measurement
    - Syphilis screening (Venereal Disease Research Laboratory (VDRL) test and rapid plasma reagin (RPR) test)
    - Cervical cytology
    - Hepatitis B virus screening
    - HIV education, counseling and voluntary testing according to the California Perinatal HIV Testing Project guidelines
    - Tuberculosis testing
    - Chlamydia testing
    - Gonorrhea testing
    - Blood pressure
    - Complete medical and obstetrical history, including genetic risk assessment and review of systems
    - Complete physical examination
    - Orientation to Comprehensive Perinatal Services Program (CPSP)
    - Prescription and dispensing of 300-day supply of vitamin and mineral supplements as needed
    - Counseling related to:
        - Danger signs and what to do in an emergency
        - Seat belt safety
        - Teratogens
        - Smoking, alcohol and substance use
    - Breastfeeding promotion
    - Referral to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) program
    - Referral to Department of Health Care Services (DHCS)-certified genetic services (if needed)
    - Comprehensive nutrition, psychosocial and health education risk assessment (ideally at initial visit, but within four weeks of initial visit)
    - Development of an individualized care plan (ICP)
- 8 to 18 weeks:
    - Ultrasound (if indicated)
    - Amniocentesis (if indicated)
    - Chorionic villus sampling (if indicated, between 9 and 12 weeks only)
- 10 to 21 weeks:
    - Cell-free fetal DNA (cfDNA) screening (recommended from 10 weeks 0 days though 21 weeks 0 days, but can be ordered on or after 10 weeks 0 days through term), to screen for

fetal autosomal trisomies (trisomy 21, trisomy 18, and trisomy 13) and sex chromosome aneuploidy (X, XXY, XYY, XXX)

- 15 to 21 weeks
  - Maternal serum alpha-fetoprotein
- By 27 weeks:
  - Reassessment of nutrition, psychosocial and health education needs (revise ICP as needed)
- 26 to 28 weeks:
  - Diabetes screening
  - Repeat hemoglobin or hematocrit (if indicated)
- 28 weeks:
  - Repeat antibody test for unsensitized Rh-negative members
  - Prophylactic administration of Rho (D) immune globulin (if indicated)
- 32 to 36 weeks:
  - Ultrasound (if indicated)
  - Repeat testing for sexually transmitted infections (STIs), including bacterial vaginosis (if indicated)
  - Repeat hemoglobin or hematocrit, if indicated
  - Family planning counseling and plan
  - Offer HIV test again if previously refused or continued high-risk health behaviors
- By 39 weeks:
  - Reassessment of nutrition, psychosocial and health education needs (revise ICP if needed)
  - Inquiry related to member's plan for pediatric services. Provide information about preventive and well-child screening exams and importance of well-baby visits
- Every prenatal visit:
  - Urine check for glucose and protein
  - After quickening, report of fetal movement
  - Blood pressure, weight, uterine size, fetal heart rate, edema, Leopold's maneuvers
  - Interval history
  - Opportunity for questions
  - Continual risk assessment and revision of the ICP and referral (if needed)
- Postpartum care visits 7 to 84 days after delivery, and additional postpartum care as needed until 365 days after delivery):
  - Physical exam to include:
    - Breast examination
    - Recto-vaginal evaluation
    - Bimanual examination of the uterus and adnexa
    - Weight and blood pressure
    - Abdominal examination
  - Interval history and adaptation to newborn
  - Discussion of normal symptoms and warning of postpartum depression
    - Family adaptation
  - Immunization status (especially rubella for non-immune women)
  - Breastfeeding inquiries
  - Counseling regarding future health and pregnancies (for example, gestational diabetes, vaginal birth after cesarean, genetic anomalies, and hypertension)
  - Laboratory data as indicated (for example, hgb if anemic on discharge from hospital)
  - Family planning counseling and prescription
  - Preventive and well-child screening exams and well-child care needs inquiry and referral
  - Reassessment of nutrition, psychosocial and health education needs (revise or close ICP as needed)

- Send copy of the ICP to the member's primary care physician (PCP)

For information on provider responsibility and pregnancy program, refer to Maternal Mental Health Screening Requirement.

Pregnancy Packet for Medi-Cal Members

When Health Net is notified that a Medi-Cal member is pregnant, the member is offered, with their consent, a pregnancy packet from the Health Net Health Education Department. The packet includes educational materials on various subjects, including breastfeeding, nutrition, exercise, perinatal check-ups, safety, and alcohol and substance misuse. It contains a booklet about having a healthy pregnancy, breastfeeding and caring for a newborn. It also contains information about Health Net's toll-free Breastfeeding and Nutrition Support Line (BNSL), information about postpartum care and information about how to get health insurance coverage after the baby is delivered. The packet is available in English and Spanish and provides member with additional resources on:

- Helping members find a ride to and from their doctor’s appointments, labs or the hospital
- Providing breastfeeding support and resources
- Helping members obtain a breast pump at no cost to them
- Assisting members if they are experiencing the baby blues (feeling sad, overwhelmed, “down” or thinking about harming themselves or others)
- Providing methods to help members quit smoking, alcohol or drugs
- Pregnant members may also contact the Health Education Department at 800-804-6074 to request the Infant Nutrition Benefit Guide (INBG).

Pregnant members are identified through primary care physician (PCP) or obstetric care provider submission of assessment reports, authorizations, inpatient admissions, Comprehensive Perinatal Services Program (CPSP) reports, and member contact with the Health Net Medi-Cal Member Services Department (Health Net or CalViva), the Health Net Medi-Cal Health Services Department or the Health Net Health Education Department.

At-Risk Pregnancy Conditions

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

Obstetric care providers are required to use a comprehensive risk assessment tool for all pregnant members that is comparable to the American College of Obstetricians and Gynecologists’ (ACOGs’) and Comprehensive Perinatal Services Program (CPSP) and maintain the results of the assessment in the member’s medical record. This assessment tool must be administered at the initial prenatal visit, once each trimester, and at the postpartum visit. Providers are responsible to refer pregnant members to freestanding birthing centers, certified nurse midwives, licensed midwives and inform them of doula coverage as appropriate. For members with high-risk pregnancy indicators, providers must refer them to perinatal specialists, coordinating other medically necessary services, and making referrals to social services and community support agencies at any time during the pregnancy when high-risk indicators are identified.

The Medical Management Department is available to help coordinate services. The obstetric care provider supervises the member's individualized care plan (ICP) to ensure that risks are addressed by priority and that actions taken can be expected to ameliorate the conditions identified. This responsibility exists notwithstanding that the services may take place outside the provider's practice.

Health Education Risk Factors

The following is a list of some of the risk factors, derived from the history or physical examination of the member, that may increase pregnancy risks and necessitate further evaluation, consultation or referral:

- Substance use
- HIV risk status
- Noncompliance with medical advice
- Failed appointments
- Age less than 17 or greater than 35
- Late initiation of prenatal care
- Primagravida or grand multipara
- Previous pregnancy problems
- Nutritional status indicators
- Occupational risk
- Diabetes
- Hypertension/pregnancy-induced hypertension
- Cardiovascular problems
- Hepatitis
- Tuberculosis
- Sexually transmitted infections (STI) history
- Uterine problems
- Kidney problems
- Pulmonary disease
- Epilepsy
- Hematologic disorders
- Preterm labor
- Eating disorders
- Mental disabilities
- Physical disabilities
- Inability to read or low reading level
- Language barriers
- Low educational level
- Low motivation
- Negative attitude about pregnancy
- Little or no prior experience with Western medicine/ health care
- Lack of social support structures
- Inability to reach decisions/comprehension difficulties
- Extreme anxiety or emotional problems
- Transportation challenges
- Family problems/abuse
- Economic/housing needs
- Informed consent needs
- Other children not linked to well-child care resources

- Lack of knowledge related to management of common pregnancy and postpartum-related conditions/discomforts

Nutritional Disorders and Nutritional Risk Factors

The following is a list of some of the nutritional risk factors, derived from the history or physical examination of the member, that may increase pregnancy risks and necessitate further evaluation, consultation or referral:

- Inadequate (less than two pounds per month after first trimester) or excessive (more than eight pounds per month) weight gain
- Eating disorders
- Tobacco, alcohol, drug, and caffeine use
- Hematocrit less than 27 percent
- Hemoglobin less than 9 percent
- MCV less than 83 or greater than 95 cu ml
- Abnormal three-hour glucose tolerance test
- Presence of glucose, ketones or protein in urine
- Pica
- No cold food storage or cooking facilities
- Less than three years since onset of menses
- High parity (five or more previous deliveries at greater than 20 weeks gestation)
- Excessive use of nutrient supplements
- Chronic use of laxatives, antacids or other over-the-counter medications known to affect nutritional status
- Use of herbal remedies known or suspected to cause toxic side effects

Obstetric and Genetic Problems

The following is a list of some of the factors, derived from the history or physical examination of the member, that may increase pregnancy risks and necessitate further evaluation, consultation or referral:

- Poor obstetric history
- Maternal age under 17 or over 35
- Previous congenital anomalies
- Multiple gestation
- Isoimmunization
- Intrauterine growth retardation
- Third-trimester bleeding
- Pregnancy-induced hypertension
- Uterine structural anomalies (for example, septum abnormality caused by in utero exposure to diethylstilbestrol)
- Abnormal amniotic fluid volume
- Fetal cardiac arrhythmias
- Prematurity
- Breech or transverse lie (intrapartum)
- Rupture of membranes for a period of time longer than 24 hours
- Chorioamnionitis
- Inadequate pregnancy interval

Psychosocial Problems

The following is a list of some of the factors, derived from the history or physical examination of the member, that may increase pregnancy risks and necessitate further evaluation, consultation or referral:

- Inadequate housing
- Domestic violence
- Absence of adequate psychosocial support
- Cognitive deficits
- Transportation needs
- Excessive worries and fears
- Previous pregnancy loss
- Severe emotional problems
- Eating disorders
- History of depression, suicidality, psychosis, or hospitalization
- Pregnancy complicated by detection of fetal anomaly
- Extreme difficulty or resistance to compliance with medical recommendations or restrictions
- Postpartum depression

Comprehensive Perinatal Services Program (CPSP)

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

Providers are required to refer members to Department of Health Care Services (DHCS)-certified Comprehensive Perinatal Services Program (CPSP) providers to ensure that all pregnant women have access to care in accordance with DHCS requirements. The required services include:

- Client orientation
- Obstetrical services
- Nutrition, psychosocial and health education support services initial assessments
- Formal reassessments offered each subsequent trimester and in the postpartum period
- Development of individualized care plans (ICPs) that include planned actions as indicated by the assessments and objectives for each of the four categories, with revision at least each subsequent trimester and postpartum
- Case coordination
- Vitamin and mineral supplementation
- Referral to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- Provision of, or referral for, dental, genetic, family planning, and preventive, well-child screening care exams and services

California Department of Public Health (CDPH)-certified CPSP providers who contract to provide CPSP support services for non-certified providers are responsible for providing all support services and assessments, ICPs,

reassessments, interventions, and case coordination information to pregnant members enrolled in CPSP upon referral from the identified obstetric provider.

The division of responsibilities between obstetric care providers and CDPH-certified CPSP providers for the rendering of CPSP support services is outlined below. Providers in a participating physician group (PPG) should contact their PPG administrator for sources of CPSP support services.

Obstetrical care provider responsibilities:

- Provide for all obstetrical care, including antepartum, intrapartum and postpartum care
- Prescribe prenatal vitamins and indicated medications
- Refer all pregnant Medi-Cal members to a CPSP support services provider
- Provide a copy of all antepartum exams, labor and delivery experience, and postpartum exam to a CPSP support services provider to be included in CPSP chart
- Include copies of all assessments, reassessments and interventions by CPSP support services provider in the medical chart

Responsibilities of the CPSP support services provider:

- Provide support services assessment, an ICP, reassessments, interventions, and case coordination information to pregnant members enrolled in CPSP pursuant to a referral
- Bill for all CPSP services, including case coordination bonus if called for by contract
- Provide copy of assessments, reassessments and intervention documentation to an obstetric provider for inclusion in the obstetric medical record each trimester and more frequently if needed
- Include copies of obstetric exams, labor and delivery experience, and postpartum exam in CPSP chart as received from the obstetric provider

The ICP must comply with the requirements described in the Comprehensive Risk Assessment and Individualized Care Plan discussion.

The Health Net Medi-Cal Health Services Department is available to coordinate care with other case management agencies to ensure that services are available to the member and to avoid duplication.

CDPH-Certified CPSP Providers

The Health Net public programs administrators verify the status of participating providers with the California Department of Public Health (CDPH) before they begin providing health care. Comprehensive Perinatal Services Program (CPSP) certification is verified annually.

Contracting CDPH-certified CPSP providers are responsible for providing CPSP services to pregnant members and for complying with CPSP requirements. CDPH-certified CPSP providers are also responsible for complying with Health Net policies, procedures and standards, including:

- Use of assessment and documentation tools (CPSP assessment tools, individualized care plans (ICPs) and protocols are available at no cost to participating providers)
- Submission of encounter and outcomes data (PDF)

Health care workers who perform CPSP support services assessments and interventions must meet Medi-Cal standards for comprehensive perinatal providers. More information about these requirements may be found in the CPSP Provider Handbook.

Health plan-approved policies, procedures and standards are available from the Health Net Public Program Department.

CPSP Provider Requirements

The provision of Comprehensive Perinatal Services Program (CPSP) services to pregnant members is the responsibility of all California Department of Public Health (CDPH)-certified CPSP providers who participate with Health Net.

All CDPH-certified CPSP providers must have access to Health Net's CPSP protocols and the CPSP Enhancement Steps to Take materials. These materials contain information helpful to staff members in assessing, planning actions (for common pregnancy conditions and discomforts, not for high-risk situations) and referral of pregnant members.

Intrapartum Care

Pregnant members are assigned a facility for delivery. The obstetric provider forwards a copy of the member's prenatal care records in accordance with the facility's procedures.

Women with high-risk pregnancies must be directed to facilities with advanced obstetrics and California Children's Services (CCS)-designated neonatal care units. Care for CCS-eligible newborns is carved out of Health Net's coverage.

The following conditions require specialized care and may require member referral or transport:

- Intermediate, community or regional neonatal intensive care unit (NICU) designation recommended:
  - Premature rupture of membranes, 32 to 34 weeks gestation
  - Premature labor greater than 32 weeks and less than 36 weeks gestation
  - Twins or triplets at 34 to 38 weeks gestation
  - Hydrops fetalis
- Community or regional NICU designation recommended:
  - Intrauterine growth retardation
  - Premature rupture of membranes less than 32 weeks gestation, unknown dates with estimated fetal weight 2,000 grams
  - Premature labor less than 32 weeks gestation and unknown dates with estimated fetal weight 2,000 grams
  - Trauma requiring intensive care or surgical correction or requiring a procedure that may result in the onset of premature labor
  - Acute abdominal emergencies
  - Preeclampsia, eclampsia or other hypertensive complication
  - Third-trimester bleeding
  - Multiple gestation less than 34 weeks gestation and all pregnancies where there are more than three fetuses
- Medical complications:
  - Infections
  - Heart disease
  - Diabetes mellitus
  - Thyrotoxicosis

- Renal disease with deteriorating function or increased hypertension
- Hepatic disease
- Drug overdose

- Fetal conditions:
  - Anomalies that may require surgery
  - Congenital anomalies requiring specialized newborn care
  - Erythroblastosis requiring intrauterine transfusion
- Neonatal conditions where transport may be indicated:
  - Gestation less than 32 weeks or weight less than 1,500 grams
  - Persistent respiratory stress
  - Seizures refractory to usual treatment
  - Congenital malformations requiring special diagnostic procedures or surgical care
  - Sequelae of hypoxia persisting beyond two hours, with evidence of multisystem involvement
  - Cardiac disorders that require special diagnostic procedures or surgery
  - Sepsis

Monitoring and Oversight

Health Net assesses and tracks all participating providers' ability to deliver Comprehensive Perinatal Services Program (CPSP) services required by Medi-Cal. Health Net monitors compliance and provision of obstetrical services according to the American Congress of Obstetrics and Gynecology (ACOG) guidelines for Prenatal and Perinatal Health (PDF).

All compliance monitoring and oversight activities are undertaken with the goal of helping the obstetrical provider comply with the standards.

Non-CDPH-Certified Obstetric Care Providers

A non-California Department of Public Health (CDPH)-certified provider must comply with Health Net policies, procedures and standards, including:

- Use of assessment and documentation tools (Comprehensive Perinatal Services Program (CPSP) assessment tools, individualized care plans (ICPs) and protocols are available at no cost to participating providers)
- Submission of encounter and outcomes data (PDF)
- Establishment of a formal agreement with a CDPH-certified CPSP provider for provision of CPSP support services for Medi-Cal members

The Health Net public health program administrator is available to provide information about:

- Memorandum of understanding (MOU) or formal agreement language requirements
- Coordination activities requirements
- CPSP program information and technical assistance in collaboration with local public health departments' CPSP coordinators

Lactation Education and Support Services

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

Lactation education and support services are considered medically necessary for those members who would like to breastfeed, but for whom the standard education and support services have not proven sufficient to secure sustained, effective breastfeeding.

Lactation education and support services may be provided by the following:

- A lactation educator-counselor
- An International Board-Certified Lactation Consultant (IBCLC)

Providers participating through participating physician groups (PPGs) must follow the PPGs' processes.

Billing for Lactation Education and Support Services

Persons with lactation educator-counselor or IBCLC certifications are not recognized by the state of California as designated professionals who can be assigned a Medi-Cal provider number or bill Medi-Cal for services directly. A Medi-Cal provider, however, can bill for lactation support services under their Medi-Cal number if the services are rendered by a community perinatal health worker (CPHW), medical assistant (MA), registered nurse (RN), nurse practitioner (NP), or physician assistant (PA) who has one of these certifications. If the provider does not have a person on staff with a lactation certification, the provider may contract with a lactation consultant and reimburse that individual as a subcontracting employee.

Referral for Lactation Education and Support Services through CPSP Providers

Comprehensive Perinatal Services Program (CPSP)-certified providers can provide breastfeeding education, support and referrals in the antepartum and postpartum period to members.

Referral for Lactation Education and Support Services by Non-CPSP Providers

Health Net directly contracting (fee-for-service (FFS)) Medi-Cal participating providers who are not CPSP certified can provide lactation services if a staff member is a lactation educator-counselor or IBCLC and bill using appropriate ICD-10 or CPT codes. Providers may refer a member to lactation services for infants up to age one.

Without a formal arrangement with a participating physician or facility, the lactation consultant is considered a non-participating provider and must contact Health Net prior to rendering service to confirm authorization and receive billing instructions.

Lactation Durable Medical Equipment

Lactation durable medical equipment (DME) includes breast pumps, breast shells and nipple shields. These items help establish and sustain milk supply when nursing at the breast is difficult or not possible, and help eliminate breastfeeding difficulties.

A mother or baby may need lactation DME for one or more of the following reasons:

- Mother and infant are separated due to hospitalization
- Infant is unable to nurse (for example, latch or suck issues, post-operative, tube feedings)
- Mother has a physical condition requiring mechanical lactation assistance
- Mother is exclusively breastfeeding and is preparing to return to work or school
- Mother experiences nipple or breast pain
- Infant experiences latch-on difficulties
- Mother has flat or inverted nipples
- Mother has low milk supply
- Infant experiences slow weight gain
- Mother is breastfeeding a premature infant
- Mother is breastfeeding twins or triplets
- Mother is providing relactation or adoptive breastfeeding
- Infant has a neurological deficit or physical disability

Health Net Medi-Cal members may obtain the following types of breast pumps:

- Manual breast pump
- Personal-use electric breast pump and kit
- Hospital-grade electric breast pump and kit - rentals only (prior authorization required)

Prescriptions for lactation DME must be written by a licensed provider, including a physician, physician assistant, nurse practitioner, or certified nurse midwife.

Providers participating through participating physician groups (PPGs) must follow the PPGs' processes.

Breastfeeding Promotion Toolkit

Health Net has developed a Promoting and Supporting Breastfeeding in Your Practice toolkit for providers. The toolkit contains information about using the World Health Organization growth charts, clinical protocols for breastfeeding and resources for provider offices, including online continuing medical education units and breastfeeding apps for smartphones. Also included in the toolkit is a checklist to ensure medical offices are breastfeeding-friendly and a poster that supports breastfeeding and can be placed anywhere in the office. Providers may request a toolkit by contacting Health Net Provider Services (Medi-Cal).

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.

Pregnancy Termination

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

Certain different rules of confidential treatment, coverage and selection of providers apply to the sensitive services of family planning services, sexually transmitted disease (STD) treatment, abortion (pregnancy termination), and human immunodeficiency virus (HIV) testing as follows:

Abortion (pregnancy termination) services do not require prior authorization of coverage by the health plan. The primary care physician, their physician group, or the Health Net Medi-Cal Member Services Department , Community Health Plan of Imperial Valley Member Services Department or CalViva Health Medi-Cal Member Services Department (for Fresno, Kings and Madera counties) can help identify an appropriate provider.

PPG Financial Responsibility

Abortions performed by participating and non-participating providers are the financial responsibility of the capitated participating physician group (PPG). PPG financial responsibility for non-participating providers is limited to the Medi-Cal fee-for-service (FFS) rate.

Pregnancy Termination Services

An abortion is classified as a sensitive service. Medi-Cal members may obtain an abortion from any qualified provider, in or out of plan, without obtaining a referral or prior authorization (unless the abortion is performed during an inpatient hospitalization). Members may also receive mifepristone (RU-486) in accordance with the Food and Drug Administration (FDA)-approved treatment regimen and other mandated requirements.

A Medi-Cal member seeking an abortion may self-refer or request a referral from her primary care physician (PCP). If asked for a referral, PCPs may direct members to an abortion provider within their participating physician group (PPG) but may not indicate in any manner that the member cannot seek services elsewhere. A qualified provider of abortion services is the member's PCP, an OB/GYN, certified nurse midwife, nurse practitioner, physician assistant, family planning clinic, or a federally qualified health center (FQHC).

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:

- Covered Services

Covered Services

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

Medi-Cal members have the right to receive covered nurse midwife services from any Medi-Cal freestanding birth centers (FBCs) and to services provided by certified nurse midwives (CNMs) and licensed midwives (LMs) without referral or prior authorization.

Services provided by Medi-Cal participating FBCs, CNMs and LMs are a covered benefit. However, services or treatments that are specifically excluded from Medi-Cal coverage are not covered.

Certified Nurse Midwives and Licensed Midwives

The Department of Health Care Services (DHCS) authorizes CNMs and LMs as providers of all services permitted within the scope of the practitioner's license. Both are authorized under state law to provide prenatal, intrapartum and postpartum care. This includes family planning care for the mother and immediate care for the newborn.

The table below outlines the differences between these two provider types and conditions under which they can provide care.

Midwife type	Licensing	Services
CNM	Licensed as a **registered nurse** and certified as a nurse midwife by the *California Board of Registered Nursing.*	Permitted to "attend cases of normal childbirth"
LM	Licensed as a **midwife** by the Medical Board of California.	Permitted to "attend cases of normal pregnancy and childbirth, as defined" and must adhere to a detailed set of restrictions and requirements when a patient's condition deviates from the legal definition of normal.

Freestanding Birth Centers

Federal law mandates coverage of freestanding birth centers (FBCs), also referred to as alternative birthing centers (ABCs), services and requires separate payments to providers administering prenatal labor and delivery or postpartum care. FBCs or ABCs are specialty clinics authorized to bill Medi-Cal for Comprehensive Perinatal Services Program (CPSP), obstetrical and delivery services. These centers must be accredited and certified with either the Commission for the Accreditation of Birthing Centers (CABC) or CPSP to provide prenatal labor and delivery, or postpartum care and other ambulatory services that are included in the plan coverage.

Primary care physicians (PCPs) may help members in obtaining FBC, ABC, CNM, and LM services by accessing the American College of Nurse Midwives' Find a Midwife website at www.midwife.org, and entering the member's geographic information. Members who do not have Internet access, or need translation services or other assistance, may call the Health Net Medi-Cal Member Services Department , Community Health Plan

of Imperial Valley Member Services Department or CalViva Health Medi-Cal Member Services Department (for Fresno, Kings and Madera counties).

PCP and Care Management Responsibilities

Participating providers are required to inform Medi-Cal members of their right to obtain covered services from an out-of-network, non-participating certified nurse midwife (CNM) if one is not available in the network.

It is the primary care physician's (PCP's) responsibility to forward the member's medical records to the CNM within 30 days after receiving the member's request.

Health Net's Health Services staff is available to assist CNMs or PCPs if they have any concerns about members' care, including provision of timely services and referrals.

Obesity

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

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

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

Coverage

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

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

Resources

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

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

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

The following information does not apply to Medi-Cal

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

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

Podiatry

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

If determined to be medically necessary by the member's participating physician group (PPG) or Health Net, podiatry services are covered for Medi-Cal members. Podiatry services are:

- Limited to medical and surgical services necessary to treat disorders of the feet, ankles or tendons that insert into the foot; that are secondary to or complicated by chronic medical conditions; or that significantly impair the member's ability to walk
- Subject to prior authorization for in-office testing and surgical procedures for members under age 21. Office visit limitations do not apply
- Limited to a maximum of two services, among other services, such as chiropractic, speech therapy and occupational therapy, in any one calendar month unless authorization for additional services is obtained

Routine nail trimming is not covered, and emergency services do not require prior authorization. Medically necessary podiatry services for Medi-Cal members who are hospitalized or in a nursing facility are covered and require prior authorization.

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:

Overview

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

Preventive care aims to prevent or reduce disease risk factors and promote early detection of disease or precursor states. Medical services and supplies required for preventive care are to be provided to all members as directed by the primary care physician (PCP) or designee.

Preventive care service guidelines include:

- Routine pediatric and adult examinations and health screenings, newborn hospital visits, counseling anticipatory guidance, developmental and behavioral assessment, screening diagnostic tests, and laboratory services
- Routine pediatric immunizations recommended jointly by the American Academy of Pediatrics (AAP), the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP), and the American Academy of Family Physicians (AAFP)
- Routine adult immunizations recommended by ACIP

Health Net PCPs should consult the Guide to Clinical Preventive Services, a report of the U.S. Preventive Services Task Force (USPSTF), as the minimum acceptable standard for adult health services. Current USPSTF guidelines can be found on the Agency for Healthcare Research and Quality (AHRQ) website.

Covered CPT Codes

Most preventive services are covered by the following CPT codes:

- 99381-99384 (physical examination for new patients under age 18).
- 99203-99205 (physical examination for new patients ages 18 and over).
- 99391-99394 (physical examination for established patients under age 18).
- 99203-99205 (physical examination for established patients ages 18 and over).

PCP Responsibilities

The primary care physician (PCP) is responsible for:

- Providing an initial health appointment (IHA), which includes an age-appropriate history and physical examination within 120 calendar days after the member's date of enrollment.
- Completing ongoing health assessments as indicated in the periodicity table. Adult and senior assessments are completed every three to five years.
- Notifying members of periodic or clinically indicated appointments.
- Documenting assessment findings, treatment, recommendations, and follow-up in the member's medical record.
- Providing follow-up care, laboratory evaluation and specialty care if a medical condition warranting further care is found at the time of routine assessment.
- Coordinating care with specialists, including providing adequate clinical information to specialists to whom a member was referred for additional services.
- Making appointments for required assessments.
- Documenting missed or broken appointments in the member's medical record and following up with the member according to the procedure for missed or broken appointments.

Click To Edit

Preventive Services Guidelines

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

The preventive services listed in the following tables are not necessary at every periodic visit (except in accordance with the American Academy of Pediatrics (AAP) guidelines). The services may be performed during visits for other reasons (for example, illness visits or chronic disease check-ups). This list does not include reviews of body systems and history relevant to lifestyle in a routine physical, as they are assumed to be covered during the physical.

- A & B Recommendations – U.S. Preventive Services Task Force
- Preventive health services – HealthCare.gov
- Women's Preventive Services Guidelines – Health Resources & Services Administration

Refer to the AAP website for:

- Recommendations for preventive pediatric health care (PDF).

Refer to the CDC website for:

- Adult immunization schedule (PDF).
- Children and adolescents immunization schedule (PDF).

Additional information on preventive service guidelines for pregnant members is provided under Benefits > Maternity > Pregnancy Care Management.

Preventive and Screening Services Under Age 21

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

Some preventive and screening services previously provided by the Child Health and Disability Prevention (CHDP) program will continue to be provided by the Managed Care Plan (MCP). Health Net provides preventive, well-child screening services to children and youth under age 21.These services encompass the requirements of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/Medi-Cal for Kids & Teens program, and aim to prevent childhood disability by screening children during critical times of growth and development and making referrals necessary to improving their health.

Preventive and screening services must be provided in accordance with the most recent AAP Recommendations for Preventive Pediatric Health Care (PDF), and the Recommended Childhood Immunization Schedule (PDF) based on joint recommendations of the Advisory Committee on Immunization Practices (ACIP).

For more information, select any subject below:

- Certification for School entry
- Appointment and Referrals
- Coordination of Care
- Coordination of Services with School-Based Programs
- Examinations
- Follow-up for Missed Appointments
- Obtaining Consent
- Billing for Services
- Provider Certification Requirements

Certification for School Entry

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

California law requires that children entering first grade must provide their schools with a certificate documenting that they have had a preventive, well-child screening exam or a waiver of the exam signed by the parent or guardian. The exam may be done up to 18 months prior to, or within 90 days after, entrance into first grade. Providers must give the parent or guardian of a child entering kindergarten or first grade a certificate documenting that the child has received the health exam. A child may be certified without a preventive, well-child screening exam if the child has received a physical exam and ongoing comprehensive medical care from that physician during the 18-month period prior to, or within 90 days following, entrance into the first grade. Health Net and local schools urge parents to get their child's health assessment on entry into kindergarten. If a health assessment is refused by the parent or guardian, the parent or guardian must submit a waiver to the school.

The Advisory Committee on Immunization Practices (ACIP) has formally adopted an exception to their recommendation for MMR vaccination, now allowing administration of the MMR to children up to four days prior to their first birthday. California state laws regarding school entry, however, preclude this exception for children in California. Children in California who receive the MMR immunization prior to their first birthday are required to be reimmunized prior to entrance into first grade.

Refer to the samples of the Report of Examination for School Entry PM 171A in English (PDF) and Spanish (PDF).

Appointments and Referrals

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

Medi-Cal members requesting an appointment with their primary care physician (PCP) must be scheduled for an appointment within 10 business days if the child is behind schedule for a preventive, well-child screening exam. If the PCP cannot provide the needed services within 10 business days, the PCP may refer the member to another participating provider, out-of-network well-child screening services provider, local health department, or school-based well-child screening services program. A PCP referring a member to an out-of-network provider must furnish a complete referral.

If an external source (for example, school, member or out-of-network provider) contacts the Health Net Medi-Cal Member Services Department Community Health Plan of Imperial Valley Member Services Department or CalViva Health Medi-Cal Member Services Department (for Fresno, Kings and Madera counties), a representative makes contact with the member's PCP to determine whether the member is in need of current preventive, well-child screening services and to provide assistance with appointment scheduling as needed.

Coordination of Care

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

The primary care physician (PCP) is responsible for supervision of physician extenders, providing ongoing care and coordination of all services the member receives. The provider must verify any suspected serious medical condition (for example, heart murmur, scoliosis and developmental problems). If needed services fall outside the PCP's scope of practice, referrals must be made and treatment initiated within 60 days after the health assessment appointment at which the condition was identified. The Health Net Medi-Cal Health Services Department is available to provide coordination, if indicated by the member's condition and requested by the PCP.

Physician extenders may not be barriers to a request to see a physician. Any member being cared for by a physician extender must be given an appointment with the PCP without having to work through the physician extender.

Health Net's public program administrator specialists receive information from the Health Net Medi-Cal Member Services Department regarding members who have disenrolled. If a member disenrolls, services are stopped.

If members in need of transportation assistance do not meet the criteria for non-emergency transportation, the PCP refers the member to Public Programs for assistance with transportation.

Coordination of Services with School-Based Programs

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

Health Net's policy on routine preventive, well-child screening services to children under age 21 is that they are provided principally by the member's primary care physician (PCP) for the following reasons:

- Services are the PCP's basic responsibility.
- All members have an assigned PCP who can provide these services.
- Provision of these services by the member's PCP provides for better continuity of care.

Recognizing the significance for improving both public and personal health outcomes and indicators, as well as health care access for school age Health Net members, Health Net has entered into contracts and agreements to provide and coordinate health care services where school-based clinics operate under the auspices of a Health Net participating physician group (PPG). Members who are identified at school sites as being in need of preventive and screening services receive these services from the participating school-based clinics within the required state and federal time frames. Health Net follows up and documents that preventive and screening services are provided to members. Health Net's participating school-based clinics and PCPs provide health assessments in accordance with the most recent American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care (PDF) for preventive health services.

All Health Net PPG-linked school-based clinics and PCPs must comply with the provisions of EPSTD/Medi-Cal for Kids & Teens. When a request is made for preventive and screening services by a member, the member's parent or guardian, an appointment must be made for the member to be examined within 14 days from the request if the child is deficient for EPSDT/Medi-Cal for Kids & Teens services. PCPs and PPG-linked school-based clinics must provide health assessments in accordance with the AAP Recommendations for Preventive Pediatric Health Care.

All members who are identified at school sites as being in need of preventive and screening services are to receive these services from their PCPs within the required state and federal time limits. If the member's PCP is unable to provide the needed exam within 14 days of the request when the exam is overdue, the PCP may refer the member to another Health Net provider, out-of-network provider, local health department, or PPG-linked school-based clinic.

Health Net's public programs administrators work with the PPG-linked school-based clinics to coordinate preventive and screening services to Medi-Cal members. School-based providers are required to:

- Coordinate with the child's PCP for identified follow-up care. The PCP's name and telephone number are listed on the child's Health Net member identification (ID) card.
- Notify the PCP of all needed services identified during the examination.

Examinations

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

Preventive, well-child screening exams must include:

- A complete health and development history, including mental health development (risk assessment)
- A head-to-toe unclothed physical examination, including assessment of physical growth
- A vision screening
- A hearing screening
- Identify dental health, screening of fluoride supplementation and applied varnish, as appropriate
- Nutritional assessment and counseling
- Laboratory tests appropriate to age and sex, including tests for anemia, diabetes and urinary tract infections
- Tuberculosis screening/testing, as indicated
- Testing for sickle cell trait, when appropriate
- Lead screening/testing, as appropriate
- Immunizations, if needed
- Additional tests or exams, if needed
- Health education and anticipatory guidance appropriate to the person's age and health status
- Weight assessment by BMI percentage and counseling intervention, as appropriate
- Counseling for physical activity

The primary care physician (PCP) must provide the member and the member's parent or guardian with a copy of the member's examination results and an explanation of results in terms of needed diagnosis and treatment.

All children with dental problems must be referred directly to a dentist for care. All members ages three and older must be referred annually for preventive dental care to a dentist that accepts Denti-Cal, regardless of whether a dental problem exists. Providers or members may contact Denti-Cal for a list of three Denti-Cal providers within the requester's ZIP code. Providers may also call their affiliated health plan's provider inquiry units for directions on dental referrals and dental networks.

Follow-Up for Missed Appointments

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

No-show appointments must be followed up with a telephone call/text/email or a letter from the provider's office to the member's parent or guardian to schedule another appointment (this includes the member's failure to follow-up on a referral to a specialist). Place a copy of the letter and documentation of any follow-up attempts in the member's medical record. After two no-shows, primary care physician (PCPs) should contact Health Net's public programs administrator, or their participating physician group (PPG) if contracting through a PPG, which then contacts Health Net's public program administrator or subcontractor.

Obtaining Consent

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

Providers must obtain the voluntary written consent of the member or the member's parent or legal guardian before performing a preventive, well-child screening exam. Consent is also required for any release of medical information. The program has a standard consent form (PM 211 in English (PDF) and Spanish (PDF)) available to providers who do not have their own consent form for release of information.

If the member or member's parent or legal guardian refuses to have the exam or any portion of it performed, this information must be documented in the member's medical record.

Billing for CHDP Services

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

Billing for Services

For fee-for-service (FFS) physicians, preventive and screening services for children and youth under age 21 years are billed on a CMS-1500 form using appropriate CPT/HCPCS codes. The XX indicator "3" must be also entered in the box 24H (EPSDT/family planning) of the CMS-1500 to indicate that the visit was for preventive and screening services.

For capitated providers, preventive and screening services for children and youth under age 21 must be submitted on an encounter to the participating physician group (PPG) for each visit.

Note that health assessment services are included in payment for the office visit and are not separately payable.

Provider Certification Requirements

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

Providers of pediatric primary care services must be enrolled in the Medi-Cal program. Medi-Cal enrollment is offered at no charge to providers by the Department of Health Care Services (DHCS) Provider Enrollment

Division (PED). Non- Medi-Cal-enrolled providers may obtain enrollment information by contacting DHCS or, go to the DHCS Provider Application and Validation for Enrollment.

Due to the CHDP transition, physicians and other providers enrolled and active in the Child Health and Disability Program (CHDP) Gateway on June 30, 2024, are automatically enrolled in the Children's Presumptive Eligibility (CPE). Additional information about the transition can be found on the CHDP Program Transition website.

Physicians and other providers not active in CHDP as of June 30, 2024, must complete steps to meet eligibility requirements to become enrolled as a Medi-Cal provider and then a CPE provider. After enrolling in Medi-Cal and receiving approval, providers can take the training on the Medi-Cal Learning Portal to participate in CPE as of July 1, 2024.

Primary Care

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

The following services, including ancillary services, are available to members for the prevention, diagnosis and treatment of illness or injury.

Visits for the following services are covered as medically necessary:

- Routine adult and pediatric examinations
- Specialist consultations
- Injections and allergy tests and treatments
- Physician services in or out of the hospital

American Indian Health Service

All eligible American Indians have the right to medical services from Indian Health Care Provider (IHCP) facilities. Members do not need a referral from their primary care physician (PCP) to obtain care at these facilities. AIHP providers can operate as PCPs for American Indian members and provide referrals directly to network providers. AIHP services are covered by Health Net Medi-Cal plans and only apply to American Indian members. Members have the right to disenroll from the plan at any time, without cause.

Emergency Services

The following information about coverage for emergency services is from the Member Handbook.

Emergency services are health services needed to evaluate or stabilize an emergency medical condition. An emergency medical condition can involve one or more of the following symptoms:

- Difficulty in breathing
- Seizures (convulsions)
- Unusual or excessive bleeding

- Unconsciousness
- Severe pain
- Possible ingestion of poison, or medicine overdose
- Suspected broken bones

If a medical emergency occurs, members should be directed to go to the nearest emergency room for care or call 911. Members are encouraged to use the 911 emergency response system as appropriate. Members are required to notify their primary care physician (PCP) as soon as they are able. Emergency services are available 24 hours a day, seven days a week.

Emergency services are covered under this health plan when they are provided in the United States. No services are covered outside of the United States, except for emergency services requiring hospitalization in Canada or Mexico.

Extended Care in Skilled Nursing Facility

Long-term care coverage is a managed health care benefit. Services provided when medically necessary include, but are not limited to, the following:

- Room and board
- Physician and nursing services
- Medication administration

Home Health Care

The following home health care services are covered when medically necessary, referred by the member's primary care physician (PCP), and not covered under a carve-out or waiver program:

- Part-time skilled nursing services
- Visits by a registered nurse (RN)
- Diagnostic and treatment services, which can reasonably be provided in the home, including nursing care
- Rehabilitation, physical, occupational, or other therapies (may require prior authorization)

Family Planning

Members do not need a referral or prior authorization to receive the family planning services listed below. Members may also see a provider who is not a Health Net participating physician without obtaining a referral or prior authorization from their primary care physician (PCP). Members may see licensed California providers who are practicing in another county from their county of residence.

A full range of family planning services is covered for members of child-bearing age that enable them to determine the number and spacing of their children. These services include all methods of birth control approved by the U.S. Food and Drug Administration (FDA), including:

- Contraceptive pills, including emergency contraceptives.
    - Members may receive up to a 12-month supply dispensed at one time for FDA-approved, self-administered hormonal contraceptives, such as 12 vaginal rings, 36 patches and 13 cycles of oral contraceptives, when dispensed from an onsite clinic and billed by any

qualified provider. A qualified provider is a provider who is licensed to furnish family planning services within their scope of practice, is an enrolled Medi-Cal provider, and is willing to furnish family planning services to a Medi-Cal enrollee as specified in Title 22, California Code of Regulations, Section 51200. A physician, physician assistant (under the supervision of a physician), certified nurse midwife, nurse practitioner, and pharmacist are authorized to dispense medications. Pursuant to the California Business and Professions Code (B P Code), Section 2725.2, if contraceptives are dispensed by a registered nurse (RN), the RN must have completed required training pursuant to B P Code Section 2725.2(b), and the contraceptives must be billed with evaluation and management (E M) procedure codes 99201, 99211 or 99212 with modifier TD (used for behavioral health RN) as directed in the DHCS Medi-Cal Provider Manual.

- Contraceptive devices (intrauterine device (IUD), Depo-Provera and diaphragm).
- Vasectomy and tubal ligation.
- Pregnancy testing and counseling.

Maternity Care

Members may choose any Health Net participating provider or certified nurse midwife within their participating physician group (PPG) for maternity care services. Members do not need to be referred by their PCPs, but may ask their PCPs to recommend a maternity care provider. Covered professional maternity care services include:

- Prenatal services.
- Postpartum services.
- Nutrition assessment and information.
- Health education assessment and information.
- Psychosocial assessment.

The following hospital services are covered:

- Semi-private accommodations, including all hospital services for mother and child.
- Hospital services for at least 48 hours following vaginal delivery, or at least 96 hours following a delivery by cesarean section. The coverage for the inpatient hospital stay may be less if the decision to discharge the mother and her newborn is made by the treating physician in consultation with the mother.
    - 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 is admitted.
- Newborn coverage is limited to the month of birth and the following month if the child does not enroll in the plan.

Federally Qualified Health Centers

Federally qualified health center (FQHC) services must be made available to all Medi-Cal beneficiaries, including those enrolled in managed care plans. A Medi-Cal member who seeks care from an FQHC must choose a primary care physician (PCP) at an FQHC that contracts with Health Net. This does not apply to services that do not require prior authorization from Health Net or the member's PCP, such as emergency services, family planning services, nurse midwife services, sexually transmitted infection (STI) treatment, and confidential HIV testing and counseling services.

Health Net does not cover FQHC services if:

- The member receives services in an FQHC that is a participating provider with Health Net, but is not the FQHC that was chosen by the member or was assigned to the member as the primary care location
- The member receives services in an FQHC that is not a participating provider with Health Net

Inpatient Hospital Services

The following are covered when medically necessary:

- Room and board in a semi-private room, or if medically necessary, in a private room
- Surgical procedures
- Anesthesia
- Laboratory and X-ray, including radiation therapy
- Use of operating room, special cardiac care units, intensive care, recovery room
- All other medically necessary hospital services, including medications and nursing services

Laboratory and Prescribed Services and Supplies

The following are covered for diagnosis and treatment and may be subject to prior authorization requirements. Direct network physicians can refer to the Prior Authorization list (CalViva Health):

- Laboratory tests
- X-ray procedures
- Other medically necessary tests, such as electrocardiograms (EKGs) and electroencephalograms (EEGs)
- Prostheses (for example, artificial arms and legs)
- Prosthetics and orthotic devices (subject to utilization controls)
- Orthopedic and conventional shoes when provided by a prosthetic and orthotic supplier when at least one of the shoes is attached to a prosthesis or brace
- Eyeglasses (subject to utilization controls)
- Medical supplies when prescribed by a licensed practitioner
- Durable medical equipment (DME) (for example, wheelchairs and crutches)
- Blood and blood plasma
- Hospice services for terminally ill members
- Audiology services and hearing aids for hearing disorders
- Podiatry services
- Speech, physical and occupational therapy when the services meet the requirements of Title 22, California Code of Regulations

Medications (Medi-Cal Rx)

The Medi-Cal Rx Contract Drug List (CDL) is the list of covered drugs that the Medi-Cal Rx program covers. The Medi-Cal Rx CDL applies to drugs that members can receive at retail pharmacies. To learn about the Medi-Cal Rx program, visit the Medi-Cal Rx website

The following medications are covered by Health Net:

- Medications administered while the member is hospitalized or in an emergency room
- Medications administered in a provider's office or infusion center billed through the medical benefit
- Home infusion or other medication-related services billed through the medical benefit

The following medications are covered by the Medi-Cal Rx program:

- Self-administered and provider-administered medications listed on the Medi-Cal Rx Contract Drug List (CDL) and billed through a pharmacy claim
- Self-administered and provider-administered medications not listed on the Medi-Cal Rx CDL billed through a pharmacy claim (prior authorization may be required)
- Medications prescribed by a psychiatrist that are on the Medi-Cal Rx CDL and filled at a participating Medi-Cal Rx Pharmacy
- A 72-hour supply of a covered medication in a medical emergency.

Principal Exclusions and Limitations

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

General Exclusions and Limitations

The following are the general exclusions and limitations for the Health Net or Medi-Cal fee-for-service(FFS) program:

- Covered services are limited to those services and supplies covered under the Medi-Cal FFS program that are described in Health Net's agreement with the Department of Health Care Services (DHCS) as being Health Net's coverage responsibility. In the event the California legislature passes a law to eliminate or reduce a service that was covered under the Medi-Cal FFS program, or the DHCS amends its Medi-Cal agreement with Health Net to eliminate or reduce a service that was covered under the agreement, benefits under this health plan are similarly eliminated or reduced upon the effective date of the change
- In order for services to be covered, they must be provided by a participating provider and coordinated by the member's primary care physician (PCP). The following services do not require a referral or pre-approval: emergency services, family planning services, nurse midwife services, sexually transmitted infection (STI) treatment, confidential HIV testing, and counseling services
- Coverage is limited to services that are medically necessary
- Coverage for hospice services is limited to terminally ill members with a life expectancy of six months or less. Coverage is provided in accordance with the hospice benefit and terms and conditions of eligibility and coverage under the Medi-Cal program and is subject to all exclusions and limitations of coverage under this plan
- Newborn coverage is limited to the month of birth and the following month if the child is not enrolled. Members must contact the Health Care Options (HCO) office to enroll the child to ensure continuous coverage
- Children may be entitled to additional services under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Services Program under certain conditions

A maximum of two visits per calendar month for any single combination of categories of services listed below (this limit does not apply to children under age 21):

- Speech therapy
- Occupational therapy
- Acupuncture
- Audiology services
- Chiropractic services
- Podiatry services

Exclusions

The following are not covered by Health Net or the Medi-Cal FFS program:

- Experimental procedures
- Cosmetic surgery (except when required to repair trauma, congenital defects or disease-related disfigurement)
- Personal comfort or convenience items
- Services to reverse surgically induced infertility
- Infertility treatment
- Fertility preservation
- Home modifications
- Vehicle modifications
- Private-duty nurses (except when medically necessary)
- Circumcision for members age 31 days and older (except when medically necessary)
- Custodial care while confined to a facility or home
- Chronic kidney dialysis when a member is eligible for coverage under Medicare
- Vaccines not recommend by the Advisory Committee on Immunization Practices (ACIP) or CDC
- The following vision services:
    - Eyeglasses used for protective, cosmetic, or job-related purposes
    - Eyeglasses prescribed for other than the correction of refractive errors or binocular vision problems
    - Progressive lenses
    - Multifocal contact lenses
    - Vision therapy or visual training

Exceptions Due to Extraordinary Circumstances

Health Net makes all reasonable attempts to provide coverage for services, but is not responsible for:

- Delay or failure to render service due to major disaster or epidemic affecting facilities or staff
- Interruption of services due to war, riot, labor disputes, or destruction of facilities

Failure to provide service when a member has refused a recommended service for personal reasons or when participating physicians believe no professionally acceptable alternative treatment exists.

Determinations of medical necessity of treatment are subject to review by a medical director, who is to consider all opinions and make a final decision about whether the services are covered.

FFS Program

The following are not covered by Health Net, but are covered by and coordinated with the Medi-Cal fee-for-service (FFS)or Medi-Cal Rx program:

- Self-administered oral, topical and injectable medications
- Some medications to treat behavioral health conditions, HIV and AIDS
- Alcohol and medication treatment services
- Outpatient heroin detoxification services
- Dental services and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental dental services for certain beneficiaries
- California Children's Services (CCS) program services
- Waiver program services (Home and Community Based Services (HCBS), AIDS, and Multipurpose Senior Services Program (MSSP))
- Direct observation treatment (DOT) for tuberculosis
- Alpha-fetoprotein (AFP) screening
- Blood coagulation factors
- Home and community-based services
- In-home support services

Support for Disabled Members

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

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

Select any subject below:

- 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.

Transgender Services

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

Medically necessary transgender services for treatment of gender identity disorder (GID) are covered benefits for Medi-Cal beneficiaries, as defined in the Medi-Cal Provider Manual, Part 2, Department of Health Services, All Plan Letter (APL) 20-018, and any superseding letter. Medi-Cal's criteria for medical necessity of transgender services is based on the most current "Standards of Care for Health of Transsexual, Transgender, and Gender Nonconforming People" (SOC) published by the World Professional Association for Transgender Health (WPATH). Additional clinical information is located on the Health Net provider portal under Working with Health Net > Clinical > Medical Policies > Gender Reassignment Surgery.

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

Treatment for GID is a covered Medi-Cal benefit for members, who have the capacity for fully informed consent, and when medical necessity has been demonstrated. Covered benefits include mastectomy, orchiectomy, hysterectomy, salpingo-oophorectomy, ovariectomy, and genital surgery, including placement of testicular prostheses when indicated, as well as other medically necessary reconstructive surgery.

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." (Health and Safety Code, Section 1367.63(c)(1)(B)). 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." (Health and Safety Code, Section 1367.63(d)).

This section clarifies how Health Net administers benefits in accordance with the WPATH, SOC, Version 8. 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 "Statement of Medical Necessity for Electrolysis" (July 15, 2016) 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 electrolysis, 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 electrolysis 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 the prior authorization request.

Members may select available specialists in the diagnosis and treatment of GID from Health Net's network. When network specialists are not available, arrangements must be made to refer members to appropriate out-of-network specialists. To find out which specialist providers contract with Health Net or accept Health Net members and who perform transgender services, contact the PPG or Health Net Provider Services Department.

Direct Network Providers

Direct Network providers must request prior authorization by completing and faxing the Inpatient California Medi-Cal Prior Authorization Form (PDF) or the Outpatient California Medi-Cal Prior Authorization Form (PDF) .

Providers Participating through PPGs

Providers participating through PPGs must contact their PPGs, follow the PPGs' prior authorization process and use the PPGs' forms. PPGs are responsible for authorizing GID services.

Transplants

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

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

Select any subject below:

- Coverage Explanation
- Injectable Transplant Medication
- Responsibility for Inpatient Concurrent Review and Transfer for Transplant Evaluation

Coverage Explanation

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

All Transplants for Members Under Age 21

All transplant services for Medi-Cal members under age 21 are coordinated through California Children's Services (CCS). Health Net is not responsible for payments related to any transplant or post-transplant care, as these services are carved out to the CCS program.

A primary care physician (PCP) or specialist who identifies a member as a potential candidate for transplant services must submit a referral to the appropriate CCS program office and request prior authorization for a pre-transplant evaluation at a CCS-approved facility. If the CCS program office deems the member to be a potential candidate, the transplant physician must submit a Service Authorization Request (SAR) in a timely manner to the appropriate CCS program office and coordinate services with the CCS case manager. If the CCS program determines that the member is not eligible for the CCS program, but the transplant service is medically necessary, Health Net will be responsible for authorizing the transplant service, as appropriate.

Transplants for Members Ages 21 and Over

Subject to prior authorization, all transplants, as well as all pre- and post-operative transplant-related costs, not limited to evaluation, hospitalization, transportation, and drugs that are not covered by Medi-Cal Rx, are covered under the Health Net Medi-Cal contracts. There is *no* PPG delegation for Medi-Cal transplants.

Health Net covers the cost of medically necessary, non-experimental and non-investigative organ and stem cell transplants at a Medi-Cal approved, Center of Excellence (COE) transplant program which operates within a hospital setting.

Health Net must provide prior authorization for requests for transplant services on an expedited, 72-hour basis, or less if the member's condition requires it or if the organ or bone marrow the member will receive is at risk of being unusable due to any delay in obtaining prior authorization or delay in obtaining the organ or bone marrow.

Referral Process for Solid Organ Transplant and Bone Marrow Transplant (BMT) – Both Allogenic Stem Cell and Autologous Stem Cell

A PCP, specialist or participating physician group (PPG) who identifies a member as a potential candidate for transplant services must provide applicable medical records to a Medi-Cal approved, Health Net Transplant Performance Center (Center) for transplant evaluation.

The Center must submit a prior authorization request for the evaluation to the Centene Centralized Transplant Unit (CTU) through the provider portal, or via fax directly to the CTU at 833-769-1141. On receipt of a request for an evaluation, the CTU contacts the Center to request any necessary medical records to complete the clinical review. Once complete medical records are received, a review is performed to establish medical necessity. If approved, the Center is notified and provided an authorization number for the evaluation.

Once a member has completed an evaluation and is approved by the Center for transplant, the Center must submit a prior authorization request for listing to the Centene CTU through the provider portal, or via fax directly to the CTU at 833-769-1141. On receipt of a request for a listing, the CTU contacts the provider to request any necessary medical records to complete the clinical review. Once complete medical records are received, a review is performed to establish medical necessity. If approved, the Center is notified and provided an authorization number.

CAR-T cell therapy, corneal transplant, tissue transplant, pancreatic islet cell auto-transplant after pancreatectomy, or parathyroid auto-transplant after thyroidectomy requests must be submitted directly to Health Net. The CTU reviews all solid organ and stem cell transplants including human leukocyte antigen (HLA) typing for stem cell, donor search and stem cell harvest and collection.

Refer to the Prescription Drug Program topic for additional information about coverage for immunosuppressive medications following a Medi-Cal approved transplant.

Injectable Transplant Medication

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

An injectable transplant medication is an injectable immunosuppressive used specifically during the course of transplantation to prevent organ rejection. Refer to the Health Net Injectable Medication HCPCS/DOFR Crosswalk (PDF) table for a list of injectable transplant medications.

Responsibility for Inpatient Concurrent Review and Transfer for Transplant Evaluation

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

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

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

Vision

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

This section provides general member benefit information for vision services.

Select any subject below:

- Overview

Overview

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

The following vision services are covered under Medi-Cal plans:

- Routine eye examination and refraction every two years (service date to service date).

- Annual diabetic retinal eye examinations by an ophthalmologist or optometrist for members who have been diagnosed with diabetes.
- Second eye examination with refraction within two years is covered only when the criteria for replacement lenses and the following criteria are met:
  - The member is unable to return to or obtain the prescription from the previous provider.
  - The examination is necessary to determine a change in vision.
- Medically necessary eye exams by ophthalmologists or optometrists for acute or urgent care.
- Medically necessary contact lenses. Contact lens testing and contact lenses may be covered if the use of eyeglasses is not possible due to eye disease or condition (such as missing an ear). Medical conditions that qualify for special contact lenses include, but are not limited to, aniridia, aphakia, and keratoconus. Adults ages 21 and older are covered for bandage contacts only when medically necessary; other ophthalmological materials are not covered.

Frames and Lenses

- Optical lenses and frames are covered every two years (service date to service date).

Polycarbonate Lenses

- Polycarbonate lenses are covered for:
- Visual impairment in one or both eyes where the optimal correction is equal to or less than 0.30 decimal or 20/60 Snellen or equivalent at specified distances.
- Either visual field is limited to 10 degrees or less from the point of fixation in any direction.

Note: Optical lenses are made by California Prison Industry Authority (CALPIA) optical laboratories and provided without cost through the optometrist's or ophthalmologist's office participating with Centene Vision Services for those identified above.

Frame Replacement and Repair

- Replacement within two years of initial coverage is limited to the same model whenever feasible.
- Replacement frames within two years are not covered if an existing frame can be made suitable for continued use by the following:
  - Adjustment
  - Repair of broken frame
  - Replacement of broken frame part

Replacement Lenses*

Replacement is covered when:

- The power is changed at least 0.50 diopters in any corresponding meridian.
- The cylinder axis is changed 20 degrees or greater for cylinder power of 0.50 - 0.62 diopters, 15 degrees or greater for cylinder power of 0.75 - 0.87 diopters, 10 degrees or greater for cylinder

power of 1.00 - 1.87 diopters, or 5 degrees or greater for cylinder power of 2.00 diopters or greater. Change in axis of cylinder power of 0.12 - 0.37 diopters, as the sole reason for change, is not covered.
- The prismatic differential correction is changed at least 0.75 prism diopters in the vertical meridian or at least 1.5 prism diopters in the horizontal meridian.
- The previous lens is lost, stolen, broken or marred to a degree significantly interfering with vision or eye safety.
- A different frame size or shape is necessary due to patient growth, metal allergy or other justifiable medical reasons.

- *Replacement lenses should be ordered directly through the CALPIA optical laboratories.

Low Vision Examinations and Aids

- Low vision examinations and aids (including the fitting) are covered if:

- The best corrected visual acuity is 20/60 or worse in the better eye, or there is a field restriction of either eye to 10 degrees or less from the fixation point.
- The condition causing subnormal vision is chronic and cannot be relieved by medical or surgical means.
- The physical and mental condition of the recipient is such that there is a reasonable expectation that the aid will be used to enhance the everyday function of the recipient.
- The aid prescribed or provided is the least costly type that will meet the needs of the recipient.

Contact Centene Vision Services to refer members or arrange visits. Centene Vision Services optometrists or ophthalmologists arrange orders and dispense lenses and frames, if indicated.

For River City Medical Group (RCMG) members, contact RCMG. For Molina Healthcare members, contact March Vision Care.

Routine Eye Examinations

The primary care physician (PCP) is the primary screener for ocular abnormalities requiring referral for a comprehensive eye examination. Comprehensive eye examinations performed by an optometrist or ophthalmologist are covered for all Medi-Cal members.

Providers should refer to the Health Net Provider Directory for a list of participating optometrists and ophthalmologists. Providers may contact the Health Net Medi-Cal Provider Services Center, CalViva Health Medi-Cal Provider Services Center (for Fresno, Kings and Madera counties) or Community Health Plan of Imperial Valley Provider Services Center to obtain the most current directory.

All children should undergo an evaluation to detect eye and vision abnormalities during the first few months of life and again at about age three. Children between ages four and six should have a comprehensive eye examination in addition to the screening performed by the PCP. Children with prescription eyewear or contact lenses should have an eye examination annually.

Referrals to ophthalmologists or optometrists for non-routine eye problems should be directed and coordinated by the PCP or PPG. Children with one or more of the following should have a comprehensive eye evaluation by an ophthalmologist:

- Abnormalities detected in the screening evaluation
- Signs or symptoms of eye problems
- History of eye problems
- Multiple health problems, systemic disease or use of medications that are known to be associated with eye disease and vision abnormalities
- Family history of conditions that cause, or are associated with, eye or vision problems
- Health and developmental problems that make screening by the PCP difficult or inaccurate

Obtaining an Eye Exam (Los Angeles County Only)

Health Net and Molina Healthcare each contract with a specific panel of optometric providers. These providers are listed in the provider directory. Providers may contact the Health Net Medi-Cal Member Services Department to obtain the most recent provider directory.

Non-routine visits, such as evaluation of apparent or potential ocular abnormalities are coordinated through the primary care physician (PCP).

In some cases, the participating physician group (PPG) may contract with a panel of vision providers. Members must direct questions about the vision network to their PPG for Medi-Cal member referral purposes.

Obtaining an Eye Exam (All Other Counties)

Members may self-refer to obtain annual routine vision services from a participating optical provider. Members should refer to the Health Net provider directory for participating optometrists. Members may contact the Health Net Medi-Cal Member Services Department, CalViva Health Medi-Cal Member Services Department (for Fresno, Kings and Madera counties) or Community Health Plan of Imperial Valley Member Services Department to obtain the most recent provider directory.

Filling Lens Prescriptions and Fitting

Filling Lens Prescriptions

The participating optical provider sends the lens prescription and frame order to the California Prison Industry Authority (CALPIA) laboratory for production.

The PIA laboratory manufactures the lenses, inserts them into the frames, and returns them to the dispensing provider.

In instances when members require lenses that are not available through PIA, Health Net will cover the cost of fabrication and dispensing of lenses by another laboratory.

Fittings

Once the glasses are received in the optical provider's office, the participating optical provider ensures that each member receives an appointment for an eyeglass fitting and adjustment.

Contracting Optical Providers

Members of all ages have additional benefits for lenses and frames provided by the California Prison Industry Authority (CALPIA) every two years.

Additionally, medical eye exams (to monitor diabetes, hypertension and other medical conditions) are available as medically necessary, generally on an annual basis or as indicated by the primary care physician (PCP) or treating specialty ophthalmologist.

Health Net contracts with Centene Vision Services (to provide vision benefits to Health Net Medi-Cal members; however, River City Medical Group (RCMG) members must contact RCMG and Health Net members assigned to Molina Healthcare must contact March Vision Care.

Exclusions

The following are not covered:

- Eyeglasses used primarily for protective, cosmetic, occupational, or vocational purposes
- Eyeglasses prescribed for reasons other than the correction of refractive errors or binocularity anomalies
- Progressive lenses
- Orthoptic and/or pleoptic training
- Prescription eyeglasses for alternative use by a person who has and is able to wear contact lenses
- Upgraded frames or non-standard lenses, unless when meeting medical necessity.
- Prosthetics (may be covered by the health plan/medical group).
- Surgical professional services normally performed by an ophthalmologist (may be covered by the health plan/medical group).
- Multifocal contact lenses

X-Ray and Laboratory Services

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

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

Select any subject below:

- In-Office Laboratory Services
- Laboratory Services

In-Office Laboratory Services

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

Coverage for laboratory and radiology services for Health Net's Medi-Cal plan mirrors that of the Department of Health Care Services (DHCS) fee-for-service (FFS) Medi-Cal program. Additionally, in accordance with the correct coding initiative and the Centers for Medicare and Medicaid Services (CMS), there are certain restrictions in place to ensure professional interpretation and billing are performed by specialists trained in the interpretation of radiology tests.

In-office laboratory services are only covered for certain STAT and sensitive services, when medically necessary and ordered by a Health Net provider. Supplies needed to stock the laboratory or perform the test, such as needles, syringes, slides, reagents, bandages, and labels, are included in the reimbursement for the laboratory test. Collection of venous blood by venipuncture and handling or conveyance of specimen for transfer to a laboratory are not benefits of the Medi-Cal program.

Surgical pathology is not within the scope of this policy. Laboratory tests for the evaluation and treatment of infertility are not covered under the Medi-Cal program. Tests required for the performance of family planning services or abortion are not subject to prior authorization requirements and can be provided at any facility, by any willing provider, whether in- or out-of-network.

Laboratory Services

Provider Type: Physicians

Quest Diagnostics® and LabCorp® are Health Net's preferred providers are Health Net's preferred provider for laboratory services for the following lines of business:

- Point of Service (POS)
- PPO
- EPO
- Fee-for-service (FFS):
    - HMO
    - Medicare Advantage (MA)
    - Medi-Cal

  Quest Diagnostics is the world's leading provider of diagnostic testing, information and services, and offers:

- Convenient access to testing services with over 400 Quest Diagnostics Patient Service Center (PSC) locations in California, in addition to an online PSC locator and appointment scheduling function to minimize wait times.
- Access to more than 3,000 clinical, esoteric and anatomic pathology tests performed at one of Quest Diagnostics' testing facilities.

- Industry-leading standards of quality, integrity and clinical excellence, providing the greatest level of consistency and security for providers' practices.
- Consultation services with more than 800 physician and clinical specialists for rare or difficult test results.
- 24-hour-a-day, seven-day-a-week access to electronic laboratory orders and results, and other office solutions through Care360® Labs & Meds.
- Electronic prescription capability to order and renew prescriptions.
- Patient-friendly reports that help easily explain test results.

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.

Tracers

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

A tracer is a request for Health Net to research the status of a previously submitted claim that, according to the provider's records, has not been processed. If the claim has been processed (paid or denied), it should not be marked as a tracer. If the provider is disputing the payment amount or denial of a claim, it must be submitted as a provider dispute (refer to the Overview discussion in the Provider Appeals and Dispute Resolution section under the Appeals and Dispute Resolution topic for more information).

Identify a claim that is a tracer by writing or stamping "TRACER" prominently in a blank area of the claim form.

Tracers for Medi-Cal claims must be submitted within 12 months after the date of service and must include all necessary supporting documentation, such as other carrier payment information, chart notes and referral information. Tracers that are received after 12 months are denied for exceeding the timely filing deadline, unless providers can show proof (through such means as explanation of coverage or benefits, or correspondence) that the claim was received by Health Net and subsequently followed up in a timely manner by the provider.

Providers should include documentation with each tracer claim, showing the previous dates that the provider has submitted the claim and explain if the provider sent the claim to any addresses other that the designated Health Net Medi-Cal Claims address.

Participating providers may not balance-bill members at any time, including while tracer claims are under consideration.

Accessing Claims on the New Health Net Portal

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

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

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

Adjustments

Provider Type: Physicians | Ancillary

If a participating provider believes that a claim was processed inaccurately and wants to request an adjustment, the claim may be resubmitted to Health Net requesting reconsideration of the claim by following the provider dispute resolution process.

Balance Billing

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

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.

Participating providers may bill a member for non-covered services when the member is notified in advance that the services to be provided are not covered and the member, nonetheless, requests in writing that the services be rendered.

A participating provider who exhibits a pattern and practice of billing members for covered services will be contacted by Health Net and is subject to disciplinary action in accordance with California state and federal law and Health Net’s Provider Participation Agreement.

For more information, select any subject below:

- 15-Day Letters
- Fee Prohibitions
- Missed Appointments

15-Day Letters

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

A “15-day letter” is a formal written request for settlement of an unpaid claim. The applicable capitated provider is given 15 working days of an unpaid claim for capitated services rendered to a member. This is regardless of when the services were rendered (no time limitations).

The request for a 15-day letter is initiated when a Health Net member or provider has not been able to resolve a claim/ payment with the capitated Facility or the Participating Provider Group (PPG) for covered benefits. The servicing provider that is requesting the 15-day letter is required and responsible for providing all supporting documentation, including proof of timely filing when submitting claims with overdue payment for dates of service.

The plan advises its capitated providers to respond within 15 working days of the date listed on the 15-day letter about the disposition of the claim(s) so the plan may inform their member and servicing provider of the resolution. Any payment to the servicing provider must include a corresponding Explanation of Benefits (EOB) from the payee at risk.

If the capitated Facility or the Participating Provider Group (PPG) fails to respond to the 15-day letter or if the claim is not resolved satisfactorily within the time frame specified, the plan pays the claim and deducts the payment from the capitated provider's capitation check the following month.

Capitated providers are asked to produce a corrective action plan if the volume of 15-day letters exceeds the number permitted by the plan for more than three months. Capitated providers may be sanctioned if the volume of 15-day letters continues to exceed 0.2 percent of its enrollment by line of business. Sanctions may include freezing new enrollment and may ultimately result in termination of the capitation contract. Capitated providers are also advised by the Health Plan to check their capitation payments monthly for any capitation deductions to ensure that each 15-day letter(s) was received in the appropriate location or department for processing.

Fee Prohibitions

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

Providers are prohibited from charging Medi-Cal members for the completion of any form that is required by, or is necessary for the administration of, the Medi-Cal benefit. This includes, but is not limited to, CMS 1500 and UB-04 claim forms, health education behavioral assessment tools (HEBAT), health histories, patient consent forms, and medical record transfer forms.

The prohibition also extends to the completion of any form related to services covered under the Medi-Cal program. This may include sports physical forms for school athletics, physical exam forms for employment, school or preschool enrollment forms, tuberculosis (TB) testing, and health insurance forms. A provider may not charge a member for completion of a form that certifies that a Medi-Cal-covered service was rendered or documents the findings of the covered service. For example, a provider is reasonably expected to complete a physical release form for a child entering a school athletic program, provided that the child is eligible for the service at the time of request. The provider is expected to complete the release form at no charge, qualifying

the release with the date of the covered exam. The prohibition does not apply to the completion of forms and services that are not covered under the Medi-Cal program, in a case where the collection of payments is permitted under a contractual or legal entitlement. Providers also retain the right to charge reasonable fees for copying portions of or complete medical records for a member's use (does not apply if the provider is transferring records to another provider).

All medical services are covered under the Medi-Cal program, including urgent, emergent and preventive services, in addition to screenings, exams or treatments provided off-cycle from the usual periodicity schedule for the provision of pediatric preventive health care services. Preventive, well-child exams and services providers can use the tracking mechanism on the periodicity schedule for the provision of pediatric preventive health care services and as a reminder for when to deliver recommended services. For medically necessary interperiodic health assessments (MNIHAs), complete health assessments may be performed before the next regularly scheduled physical examination when the following situations exist:

- There is a need for a sports or camp physical examination
- The individual is in foster care or out-of-home placement
- There is a need for a school or preschool entrance examination
- There is a need for providing additional anticipatory guidance to the individual or the parent or legal guardian
- There is a history of perinatal problems
- There is evidence of significant developmental disability

Missed Appointments

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

Health Net providers are prohibited from charging a Health Net Medi-Cal member for a missed appointment. Medi-Cal managed care members are not share-of-cost beneficiaries and are not subject to copayments or deductibles for office visits, so they cannot be held accountable for these charges in the event of a missed appointment.

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:

- Additions and Exceptions
- Claims Receipt Acknowledgement
- Claims Submission Requirements
- Clinical Information Submission
- CMS-1500 Billing Instructions
- Community-Based Adult Services Claims Submission

- National Drug Codes for Medi-Cal Claims
- Trauma Services
- UB-04 Billing Instructions

Additions and Exceptions

Provider Type: Hospitals

Outpatient Claims

The following are additions or exceptions to commercial billing rules. Facilities are required to follow these guidelines for Medi-Cal billing:

- Bill type is desired (a delay in claims payment will result if not provided)
- Revenue codes are required
- CPT and HCPCS codes are required
- Place of Service code (box 50 on the UB-04 form) is required if the bill type field is left blank
- Complete condition code if services are preventive, well-child screening services or family planning related
- Use A1 if services are preventive, well-child screening services
- Use A3 if services are family planning-sterilization related
- Use A4 if services are family planning-other related

Inpatient Claims

The following are additions or exceptions to commercial billing rules. Facilities are required to follow these guidelines for Medi-Cal billing:

- Revenue code is required
- Bill type is required
- Place of Service code (box 50) is required if the bill type field is left blank
- Type of Admission code (box 19) is required
- Source of Admission code (box 20) is required
- Complete condition code field if services are preventive, well-child screening or family planning related
- Use CPT codes and not ICD-10 codes in boxes 80 and 81

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 Requirements

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

Health Net encourages providers to submit claims electronically. Paper submissions are subject to the same edits as electronic and web submissions.

All paper claims sent to the claims office must first pass specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected or denied. Claims missing the necessary requirements are not considered clean claims and will be returned to providers with a written notice describing the reason for return. Nonstandard forms include any that have been downloaded from the Internet or photocopied, which do not have the same measurements, margins, and colors as commercially available printed forms.

Refer to un-clean claims for more information.

Acceptable Forms

For paper claims, Health Net only accepts the Centers for Medicare & Medicaid Services (CMS) most current:

- CMS-1500 form - complete in accordance with the guidelines in the National Uniform Claim Committee (NUCC) 1500 Claim Form Reference Instruction Manual, updated each July.
- CMS-1450 (UB-04) form - complete in accordance to UB-04 Data Specifications Manual, updated each July.

Other claim form types will be upfront rejected and returned to the provider. Providers should adhere to the claims submission requirements below to ensure that submitted claims have all required information, which results in timely claims processing.

Electronic Claims

For fastest delivery and processing, claims can be submitted electronically using the HIPAA 5010 standard 837I (005010X223A2) and 837P (005010X222A1) transaction. Each claim submitted must include all mandatory elements and situational elements, where applicable. Secondary COB claims can be sent electronically with all appropriate other payer information and paid amounts.

Paper Claims

Paper claim forms must be typed in black ink with either 10 or 12 point Times New Roman font, and on the required original red and white version to ensure clean acceptance and processing. Claims submitted on black and white, handwritten or nonstandard forms will be rejected and a letter will be sent to the provider indicating the reason for rejection. To reduce document handling time, providers must not use highlights, italics, bold text, or staples for multiple page submissions. Copies of the form cannot be used for submission of claims, since a copy may not accurately replicate the scale and optical character recognition (OCR) color of the form.

Health Net only accepts claim forms printed in Flint OCR Red, J6983 (or exact match) ink and does not supply claim forms to providers. Providers should purchase these forms from a supplier of their choice.

Professional Claims

Providers billing for professional services and medical suppliers must complete the CMS-1500 (02/12) form. The form must be completed in accordance with the guidelines in the National Uniform Claim Committee (NUCC) 1500 Claim Form Reference Instruction Manual Version 5.0 7/17 at www.nucc.org. Paper claims follow the same editing logic as electronic claims and will be rejected with a letter sent to the provider indicating the reason for rejection if non-compliant.

Institutional Claims

Providers billing for institutional services must complete the CMS-1450 (UB-04) form. The form must be completed in accordance with the National Uniform Billing Committee (NUBC) Official UB-04 Data Specifications Manual 2018 at www.nubc.org. Paper claims follow the same editing logic as electronic claims and will be rejected with a letter sent to the provider indicating the reason for rejection if non-compliant.

Medicare Billing Instructions

Medicare CMS-1500 and completion and coding instructions, are available on the CMS website at www.cms.gov.

Mandatory Items for Claims Submission

Refer to CMS-1500 Billing instructions or UB-04 Billing Instructions as applicable for complete description and required or conditional fields.

Reference guide for commonly submitted items

Form Fields	Electronic	CMS-1500	UB-04
Billing provider tax ID	Loop 2010AA REF segment with TJ qualifier	Box 25	Box 5
Billing provider name, address and NPI	Loop NM109 with XX qualifier	Box 33	Box 1
Subscriber (name, address, DOB, sex, and member ID required)	2000B and 2010BA	Subscriber box 1a, 4, 7, 11	Box 58 and 60
Provider taxonomy		Box 33B and Box 24	Box 57
Patient (name, address, DOB, sex, relationship to subscriber, status, and member ID)	2000C and 2010CA	Patient box 2, 3, 5, 6, 8	Box 8, 9, 10, 11
Principal diagnosis and additional diagnoses	Loop 2300 HI segment qualifier BK (ICD9) or ABK (ICD10)	Box 21	Box 66
Diagnosis pointers (up to 4)	Loop 2410 SV107	Box 24E (A-L)	N/A
Referring provider with NPI	Loop 2300 NM1 with DN qualifier	Box 17	N/A
Attending provider with NPI	Loop 2300 NM1with DN qualifier	N/A	Box 76

Form Fields	Electronic	CMS-1500	UB-04
Rendering provider	Loop 2300 NM1 with 82 qualifier (if differs from billing provider)	NPI in Box 24J	N/A
Service facility information	Loop 2310C or 2310E NM1 with 77 qualifier (if differs from billing provider)	Box 32	N/A
Procedure code	Loop 2400 SV segment	Box 24D	Box 44 if applicable
NDC code	Loop 2410 LIN segment with N4 qualifier. Must include mandatory CTP segment.	Box 24D shaded	Box 43
UPN	Loop 2410 LIN segment with appropriate UP, UK, UN qualifier. Must include mandatory CTP segment.	Box 24D shaded	Box 43
Value codes (for accommodation codes, share of cost, etc.)	Loop 2300 HI segment with qualifier BE	N/A	Box 39, 40, 41
Condition codes	Loop 2300 HI segment with qualifier BG	N/A	Box 18-28
COB-other subscriber or third party liability	Loop 2320, 2330A and 2330 B	Box 9, if applicable (requires paper EOB from other payer), 10, 11	Box 50-62 (requires paper EOB from other payer)

Form Fields	Electronic	CMS-1500	UB-04
Claim DOS	Loop 2400 DTP segment with 472 qualifier	Box 24A	Box 45 for outpatient when required
Claim statement date	Loop 2300 with 434 qualifier	N/A	Box 6 from and through

Claims Rejection Reasons and Resolutions

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

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
01	Member's DOB is missing or invalid	Enter the member's 8-digit date of birth (MM/DD/YYYY)	CMS-1500 box 3 UB-04 box 10	Section 2 [1]Non-standard submission or equivalent
02	Incomplete or invalid member information	Enter the member's Health Plan member identification (ID) for Commercial and Medicare or Client Identification Number (CIN) for Medi-Cal. Social Security number (SSN) should not be used. Check eligibility online, electronically, or refer to the member's current ID card to determine ID numbers	CMS-1500 box 1a UB-04 box 60	Section 2 [1]Non-standard submission or equivalent

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
06	Missing/invalid tax ID	Include complete 9-character tax identification number (TIN)	CMS-1500 box 25 UB-04 box 5	Section 1a [1]Non-standard submission or equivalent
17	Diagnosis indicator is missing POA indicator is not valid DRG code is not valid	Ensure 9/0 (“9” for ICD-9 or “0” for ICD-10) appears in field 66 for all claims. Ensure present on admission (POA) indicators are valid when billed. Ensure a valid DRG code is used in field 71. POA valid values are: Y – Diagnosis was present at time of inpatient admission. N – Diagnosis was not present at time of inpatient admission. Leave blank if cannot be determined	UB-04 box 66-70 UB-04 box 71	Section 3 [1]Non-standard submission or equivalent
75	The claim(s) submitted has missing, illegible or invalid value	When box 24 is completed, then box 24G must be	CMS-1500 box 24D and 24G	N/A

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
	for anesthesia minutes	completed as well		
76	Original claim number and frequency code required	When submitting a corrected claim, for UB-04 box 64 and CMS-1500 box 22, you must reference the original claim. Claim numbers can be found on your Remittance Advice (RA)/ Explanation of Payment (EOP) or check claims status online. Do not include punctuation, words or special characters before or after the claim number. Submission ID from a reject letter is not a valid claim number. If not using frequency codes 7 or 8 leave boxes 64 and 22 blank. Submit contested claims to Medi-Cal Provider Contested Claims.	CMS-1500 box 22 UB-04 box 4 and 64	Section 4 [1]Non-standard submission or equivalent
77	Type of bill or place of service invalid or missing	Enter the appropriate type of bill (TOB) code as specified by	UB-04 box 4	N/A

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
		the NUBC UB-04 Uniform Billing Manual minus the leading “0” (zero). A leading “0” is not needed. Digits should be reflected as follows: 1st digit – Indicating the type of facility 2nd digit – Indicating the type of care 3rd digit – Indicating the bill sequence (frequency code)		
87	One or more of the REV codes submitted is invalid or missing	Include complete 4-digit revenue code	UB-04 box 42	N/A
92	Missing or invalid NPI	Enter provider’s 10-character National Provider Identifier (NPI) ID	CMS-1500 box 24J and 33A UB-04 box 56	Section 1b [1]Non-standard submission or equivalent
A5	NDC or UPIN information missing/invalid	Providers must bill the UPIN qualifier, number, quantity, and type or National Drug Code (NDC) qualifier, number, quantity, and unit/basis of measure. If any	CMS-1500 box 24D UB-04 box 43	N/A

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
		of these elements are missing, the claim will reject		
A7	Invalid/missing ambulance point of pick- up ZIP Code	When box 24 D is completed, include the pickup/drop off address in attachments	CMS-1500 box 24 or box 32. Medicare claims require a point of pickup (POP) ZIP in box 23 in addition to the addresses in 24 shaded area or box 32	N/A
A9	Provider name and address required at all levels	Include complete provider billing address including city, state and ZIP Code	CMS-1500 box 33 UB-04 box 1	Section 1a [1]Non-standard submission or equivalent
AK	Original claim number sent when the claim is not an adjustment	When submitting an initial claim, leave CMS 1500 box 22 and UB-04 box 64 blank. Any values entered in these boxes will cause a claim to reject.	CMS-1500 box 22 UB-04 box 64	Section 4 [1]Non-standard submission or equivalent
C8	Valid POA required for all DX fields	Do not include the POA of 1. The valid values for this field are Y or N or blank. (for description	UB-04 box 67–67Q and 72A–72C	N/A

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
		see Reject code 17)		
B7	Review NUCC guidelines for proper billing of the CMS-1500 versions (08/05) and (02/12). Claims will be rejected if data is not submitted and/or formatted appropriately	Only CMS-1500 02/12 version is accepted	N/A	N/A
C6	Other Insurance fields 9, 9a, 9d, and 11d are missing appropriate data	If the member has other health insurance, box 9, 9a and 9d must be populated, and box 11d must be marked as yes. If this is not provided, the claim will be rejected	CMS-1500 box 9, 9a, 9d and 11d	N/A
AV	Patient's reason for visit should not be used when claim does not involve outpatient visits	Include patient reason for visit for bill type 013x, 078x, and 085x (outpatient) when Type of Admission/Visit (Box 14) is 1 (emergency), 2 (urgent) or 5 (trauma) and revenue code 045x, 0516 or 0762 are reported.	UB-04 box 70a, b, c	N/A

Reject code	Reject reason	Requirements	CMS-1500 or UB-04	ECM and Community Supports Invoice Claim Form
		Otherwise, do not populate		
HP	ICD-10 is mandated for this date of service	Submit with the ICD indicator of 9/0 on both UB-04 and CMS-1500 claim forms according to the 5010 Guidelines requirement to bill this information. (for description see Reject code 17)	CMS-1500 box 21 UB-04 box 66	N/A
RE	Black/white, handwriting or nonstandard format	Use proper CMS-1500 or UB-04 form typed in black ink in 10 or 12 point Times New Roman font	N/A	N/A

[1]This is not a standard claim form like the CMS-1500 or the UB-04 claim forms; used to bill ECM and Community Supports services only.

Clinical Information Submission

Provider Type: Physicians | Participating Physician Groups (PPG)

Health Net routinely requires Medicare employer groups to include clinical information at the time of claim submission as follows:

- Evaluation and Management Services (E&M) - There are general principles of medical record documentation that are applicable to all types of medical and surgical services in all settings. While E&M services vary in several ways, such as the nature and amount of physician work required, the following general principles help ensure that medical record documentation for all E&M services is

appropriate. The diagnosis and treatment codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

The documentation of each patient encounter should include the following:

- Reason for the encounter and relevant history, physical examination findings, and any prior and additional diagnostic test results.
- Assessment, clinical impression or diagnosis.
- Medical plan of care.
- Date and legible identity of the observer.
- Any additional relevant information.

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill higher level of evaluation and management service when a lower level of service is warranted.

Health Net reserves the right to request clinical records before or after claim payment to identify possible fraudulent or abusive billing practices, as well as any other inappropriate billing practice not consistent or compliant with the American Medical Association (AMA) CPT codes or guidelines, provided there is evidence such an investigation is warranted.

CMS-1500 Billing Instructions

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

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

Field number	Field description	Instruction or comments	Required, conditional or not required
1	Insurance program identification	Check only the type of health coverage applicable to the claim. This field indicated the payer to whom the claim is being field. Enter "X" in the box noted "Other"	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
1a	Insured identification (ID) number	The nine-digit identification number on the member's ID card	Required
2	Patient's name (Last name, first name, middle initial)	Enter the patient's name as it appears on the member's ID. card. Do not use nicknames	Required
3	Patient's birth date and sex	Enter the patient's eight-digit date of birth (MM/DD/YYYY), and mark the appropriate box to indicate the patient's sex/gender. M= Male or F= Female	Required
4	Insured's name	Enter the subscriber's name as it appears on the member's ID card	Conditional - Needed if different than patient
5	Patient's address (number, street, city, state, ZIP code) Telephone number (include area code)	Enter the patient's complete address and telephone number, including area code on the appropriate line. 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,	Conditional

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

Field number	Field description	Instruction or comments	Required, conditional or not required
		enter the city and state. Third line - Enter the ZIP code and telephone number. When entering a nine-digit zip code (ZIP + 4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number such as (803)5551414. Note: Patient's telephone does not exist in the electronic 837 Professional 4010A1	
8	Reserved for NUCC	N/A	Not required
9	Other insured's name (last name, first name, middle initial)	Refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan. Enter the complete name of the insured	Conditional refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan
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

Field number	Field description	Instruction or comments	Required, conditional or not required
9c	Reserved for NUCC	N/A	Not required
9d	Insurance plan name or program name	REQUIRED if field 9 is completed. Enter the other insured's (name of person listed in field 9) insurance plan or program name	Conditional REQUIRED if field 9 is completed
10 a, b, c	Is patient's condition related to:	Enter a Yes or No for each category/line (a, b and c). Do not enter a Yes and No in the same category/line. When marked Yes, primary insurance information must then be shown in box 11	Required
10d	Claims codes (designated by NUCC)	When reporting more than one code, enter three blank spaces and then the next code	Conditional
11	Insured policy or FECA number	REQUIRED when other insurance is available. Enter the policy, group, or FECA number of the other 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	Conditional

Field number	Field description	Instruction or comments	Required, conditional or not required
		insured. Only one box can be marked. If gender is unknown, leave blank	
11b	Other claims ID (Designated by NUCC)	The following qualifier and accompanying identifier has been designated for use: Y4 Property Casualty Claim Number For worker's compensation of property and casualty: Required if known. Enter the claim number assigned by the payer	Conditional
11c	Insurance plan name or program number	Enter name of the insurance health plan or program	Conditional
11d	Is there another health benefit plan	Mark Yes or No. If Yes, complete field's 9a-d and 11c	Required
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	Conditional - Enter "Signature on File," "SOF," or the actual legal signature

Field number	Field description	Instruction or comments	Required, conditional or not required
		to process and/or adjudicate the claim	
13	Insured's or authorized person's signature	Obtain signature if appropriate.	Not required
14	Date of current: Illness (First symptom) or Injury (Accident) or Pregnancy (LMP)	Enter the six-digit (MM/DD/YY) or eight-digit (MM/DD/YYYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported. 431 Onset of Current Symptoms or Illness 484 Last Menstrual Period	Conditional
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

Field number	Field description	Instruction or comments	Required, conditional or not required
16	Dates patient unable to work in current occupation	Enter the six-digit (MM/DD/YY) or eight-digit (MM/DD/YYYY)	Conditional
17	Name of referring physician or other source	Enter the name of the referring physician or professional (first name, middle initial, last name, and credentials)	Conditional - Enter the name of the referring physician or professional (first name, middle initial, last name, and credentials)
17a	ID number of referring physician	Required if field 17 is completed. Use ZZ qualifier for Taxonomy code	Conditional REQUIRED if field 17 is completed
17b	NPI number of referring physician	Required if field 17 is completed. If unable to obtain referring NPI, servicing NPI may be used	Conditional REQUIRED if field 17 is completed. If unable to obtain referring NPI, servicing NPI may be used
18	Hospitalization on dates related to current services		Conditional
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	Enter the codes to identify the patient's diagnosis and/or condition. List no more	Required - Include the ICD indicator

Field number	Field description	Instruction or comments	Required, conditional or not required
	form allows up to 12 diagnoses, and ICD indicator	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	
22	Resubmission code / original REF	For resubmissions or adjustments, enter the original claim number of the original claim. New form - for resubmissions only: - Replacement of Prior Claim - Void/Cancel Prior Claim	Conditional - For resubmissions or adjustments, enter the original claim number of the original claim
23	Prior authorization number or CLIA number	Enter the authorization or referral number. Refer to the provider operations manual for information on services requiring referral and/or prior authorization. CLIA number for CLIA waived or CLIA certified laboratory services	If authorization, then conditional If CLIA, then required If both, submit the CLIA number Enter the authorization or referral number. Refer to the provider operations manual for information on services requiring referral and/or prior authorization.

Field number	Field description	Instruction or comments	Required, conditional or not required
			CLIA number for CLIA waived or CLIA certified laboratory services
24 A-G Shaded	Supplemental information	The shaded top portion of each service claim line is used to report supplemental information for: • NDC • Narrative description of unspecified codes • Contract rate • For detailed instructions and qualifiers refer to Appendix IV of this guide	Conditional - The shaded top portion of each service claim line is used to report supplemental information for: NDC Narrative description of unspecified codes Contract rate
24A Unshaded	Dates of service	Enter the date the service listed in field 24D was performed (MM/DD/YYYY). If there is only one date, enter that date in the "From" field. The "To" field may be left blank or populated with the "From" date. If identical services (identical CPT/HCPC code(s)) were performed, each date must be entered on a separate line	Required

Field number	Field description	Instruction or comments	Required, conditional or not 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 modifiers may be entered per claim line. Codes entered must be valid for date of service. Missing or invalid codes will be denied for payment. Only the first modifier entered is used for pricing the claim. Failure to use modifiers in the correct position or combination with the procedure code, or invalid use of modifiers, will result in a rejected, denied, or incorrectly paid claim	Required - Ensure NDC or UPIN is included if applicable

Field number	Field description	Instruction or comments	Required, conditional or not required
24 E Unshaded	Diagnosis code	In 24E, enter the diagnosis code reference letter (pointer) as shown in box 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. ICD-10-CM diagnosis codes must be entered in box 21 only. Do not enter them in 24E. Do not use commas between the diagnosis pointer numbers. Diagnosis Codes must be valid ICD-10 codes for the date of service, or the claim will be rejected/denied	Required
24 F Unshaded	Charges	Enter the charge amount for the claim line item service billed. 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	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line	
24 G Unshaded	Days or units	Enter quantity (days, visits, units). If only one service provided, enter a numeric value of one	Required
24 H Shaded	EPSDT (Family Planning)	Leave blank or enter "Y" if the services were performed as a result of an EPSDT referral	Conditional - Leave blank or enter "Y" if the services were performed as a result of an Early and Periodic Screening, Diagnostic and Treatment (EPSDT) referral
24 H Unshaded	EPSDT (Family Planning)	Enter the appropriate qualifier for EPSDT visit	Conditional - Enter the appropriate qualifier for EPSDT visit
24 I Shaded	ID qualifier	Use ZZ qualifier for taxonomy. Use 1D qualifier for ID, if an atypical provider	Required
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	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		Atypical providers: Enter the provider ID number.	
24 J Unshaded	NPI provider ID	Typical providers ONLY: Enter the 10-character NPI of the provider who rendered services. If the provider is billing as a member of a group, the rendering individual provider's 10-character NPI may be entered. Enter the billing NPI if services are not provided by an individual (such as DME, independent lab, home health, RHC/FQHC general medical exam)	Required
25	Federal Tax ID number SSN/EIN	Enter the provider or supplier nine-digit federal tax ID number, and mark the box labeled EIN	Required
26	Patient's account NO	Enter the provider's billing account number	Conditional - Enter the provider's billing account number
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	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

Field number	Field description	Instruction or comments	Required, conditional or not required
		the back of the CMS-1500 (02-12) claim form for the section pertaining to payments	provider accepts assignment
28	Total charge	Enter the total charges for all claim line items billed - claim lines 24F. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to the right of the vertical line.	Required
29	Amount paid	REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to	Conditional REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing

Field number	Field description	Instruction or comments	Required, conditional or not required
		the right of the vertical line	
30	Balance due	REQUIRED when field 29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payer). Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to the right of the vertical line	Conditional REQUIRED when field 29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payer)
31	Signature of physician or supplier including degrees or credentials	If there is a signature waiver on file, you may stamp, print, or computer-generate the signature; otherwise, the practitioner or practitioner's authorized 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

Field number	Field description	Instruction or comments	Required, conditional or not 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 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	Conditional REQUIRED if the location where services were rendered is different from the billing address listed in field 33
32a	NPI - Services rendered	Typical providers ONLY: REQUIRED if the location where services were	Conditional Typical providers ONLY: REQUIRED if the location where

Field number	Field description	Instruction or comments	Required, conditional or not required
		rendered is different from the billing address listed in field 33. Enter the 10-character NPI of the facility where services were rendered.	services were rendered is different from the billing address listed in field 33.
32b	Other provider ID	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Typical providers: Enter the 2-character qualifier ZZ followed by the taxonomy code (no spaces). Atypical providers: Enter the 2-character qualifier 1D (no spaces)	Conditional REQUIRED if the location where services were rendered is different from the billing address listed in field 33
33	Billing provider INFO & PH#	Enter the billing provider's complete name, address (include the ZIP + 4 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	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		address (for example, 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line - In the designated block, enter the city and state. Fourth line- Enter the ZIP code and telephone number. When entering a nine-digit ZIP code (ZIP + 4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e., (555)555-5555). NOTE: The nine digit ZIP code (ZIP + 4 code) is a requirement for paper and EDI claim submission	
33a	Group billing NPI	Typical providers ONLY: REQUIRED if the location where services were rendered is different from the billing 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.	Required

Field number	Field description	Instruction or comments	Required, conditional or not required
		Typical providers: Enter the provider taxonomy code. Use ZZ qualifier. Atypical providers: Enter the provider ID number	

Community-Based Adult Services Claims Submission

Ancillary

Community-Based Adult Services (CBAS) centers must submit claims for program services on a UB-04 (CMS-1450) form to ensure prompt, accurate claims processing.

CBAS centers can submit claims electronically using Health Net's payer identification (ID) number 95567. CBAS centers may use the clearinghouse of their choice. They may also submit paper claims to the Health Net Medi-Cal Claims Department.

National Drug Codes for Medi-Cal Claims

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

In accordance with Department of Health Care Services (DHCS) requirements, providers must submit claims with a valid National Drug Code (NDC) in conjunction with the customary HCPCS Level I, II or III codes, when appropriate, on claims submitted for medication reimbursement. Claims received without the appropriate NDC and HCPCS codes are contested. For Medi-Cal claims, both the CMS-1500 and UB-04 claim forms require valid NDC information.

When the health plan receives a Medi-Cal claim with both an NDC and a HCPCS code, the health plan applies line-level claim edits to determine:

- Is the NDC valid?
- Is the HCPCS code valid?
- Is the NDC/HCPCS code combination valid?

If the response to any of the above questions indicates an invalid code or invalid code combination, the health plan will contest the claim to ask for corrected billing.

NDC Billing Requirements: Medication Billed Separate from Service

Providers are required to use a valid NDC when a medication is billed separate from a service. The following chart outlines the NDC requirements:

Type of Claim	NDC
Medicare/Medi-Cal crossover	Not required.
Fee-for-service Medi-Cal as primary	Required when the medication is billed independent of the service.
Medi-Cal as secondary (other health coverage)	Required when the medication is billed independent of the service.
California Children's Services (CCS)	Required when the medication is billed independent of the service.
Genetically Handicapped Persons Program (GHPP)	Required when the medication is billed independent of the service.
Presumptive eligibility	Required when the medication is billed independent of the service.
Cancer Detection Program: Every Woman Counts (CDP: EWC)	Required when the medication is billed independent of the service.

Compound Medications

Compound medications dispensed in an outpatient hospital environment are not exempt from the NDC billing requirement. Each medication dispensed should be entered on a separate line of the CMS-1500 or UB-04 claim form using the appropriate NDC and HCPCS Level I, II or III codes. Only the claim lines for the physician-administered medication is contested if the NDC information is missing or invalid. All other claim lines are processed accordingly.

Description of Medications with HCPCS Level III Codes

In addition to NDC billing requirements, providers are required to describe medications used with a HCPCS Level III code, such as Z7610 (miscellaneous supplies), or a procedure code, such as 90779 (therapeutic injection), in the Reserved for Local Use field (Box 19) on the CMS-1500 claim form, or the Remarks field (Box 80) on the UB-04 claim form. Any medications administered or dispensed for such codes still require a description and valid NDC information on these forms.

Family PACT providers are exempt from reporting the NDC in conjunction with Z7610.

Trauma Services

Provider Type: Hospitals

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

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

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

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

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

UB-04 Billing Instructions

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

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

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

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

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:

- Shared-Risk Claims
- Anesthesia Procedure Code Modifiers with the Minute Qualifier

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).

Anesthesia Procedure Code Modifiers with the Minute Qualifier

Professional anesthesia capitated encounters billed with specific modifiers must use the minute qualifier, MJ. If you use the unit qualifier, UN, an edit will reject the encounter. The edit applies regardless of the date of service.

This change follows the Health Insurance Portability and Accountability Act (HIPAA) 5010 HIPAA 837 Companion Guide.

Use the MJ qualifier with these modifiers:

- AA
- AD
- QK
- QS
- QX
- QY

- QZ

Modifiers, other than the ones listed above, can process with the UN qualifier and not cause an edit.

If a professional encounter claim is sent with the above listed modifiers and the UN qualifier, the edit display will read: ANESTHESIA QUALIFIER IS INCORRECT. Resend a corrected capitated encounter with the MJ qualifier.

Claims Processing for DSNP in EAE Counties

Provider Type: Participating Physician Groups (PPG)

Participating physician groups that are responsible for claims that are Medicare covered services must forward claims that have Medi-Cal covered services to Health Net within 10 business days for the Plan to process as a secondary claim. The secondary claim requires a copy of the Provider Explanation of Benefits (EOB) or Remittance Advice (RA) from the primary payer. Include the information that the claim was forwarded to the Plan in the EOB or RA. Do not deny the claim without checking both Medicare and Medi-Cal covered services. You can submit the secondary claim to the Plan following Standard Claims Submission requirements. You can also submit a paper claim to the Health Net Medi-Cal Claims Department or the Health Net Medicare Advantage Claims Department.

Telehealth Billing Requirement

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

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

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

For Commercial members:

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

For Medicare members:

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

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

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

Emergency Claims Processing

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

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

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

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

Complete Emergency Claims

A complete emergency claim meets the following definitions:

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

- A claim from a provider is deemed complete when submitted on a completed CMS-1500, or its electronic equivalent, and reasonable relevant information is requested.

Delegation

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

Interest Charged for Late Payment

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

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

Exceptions

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

Fee-For-Service Billing and Submission

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

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

Select any subject below:

- Electronic claims Submission
- FFS Claims Submission

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.

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).

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

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 refund the overpayment amount to the Health Net Overpayment Recovery Department within 60 days, (or the terms of the

Provider Participation Agreement (PPA)) in which the overpayment was identified with a copy of the applicable Remittance Advice (RA) and a cover letter indicating why the amount is being returned. If the RA is not available, provide member name, date of service, payment amount, Health Net member identification (ID) number, provider tax ID number, and provider ID number.

When Health Net determines that an overpayment has occurred, Health Net notifies the provider of services in writing within 365 days of the date of payment on the overpaid claim through a separate notice that includes the following information:

- Member name
- Claim ID number
- Clear explanation of why Health Net believes the claim was overpaid
- The amount of overpayment, including interest and penalties

The 365-day time period does not apply to overpayments caused in whole or in part by fraud or misrepresentation on the part of the provider.

The provider of service has 30 business days to submit a written dispute to Health Net if the provider does not believe an overpayment has occurred. In this case, Health Net treats the claim overpayment issue as a provider dispute.

- Include a copy of the RA that accompanied the overpayment or the refund request letter to expedite Health Net's adjustment of the provider's account. If neither of these documents are available, the following information must be provided: member name, date of service, payment amount, Health Net member ID number, vendor name and number, provider tax ID number, provider number, vendor number and reason for the overpayment refund. If the RA is not available, it may take longer for Health Net to process the overpayment refund.
- Send the overpayment refund and applicable details to the Health Net Overpayment Recovery Department. If a provider is contacted by a third-party overpayment recovery vendor acting on behalf of Health Net, such as HMS, Optum, Rawlings, or GB Collects, the provider should follow the overpayment refund instructions provided by the vendor.

Health Net may recoup uncontested overpayments by offsetting overpayments from payments for a provider's current claims for services if:

- The provider's Provider Participation Agreement (PPA) authorizes it to offset overpayments from payments for current claims for services.
- Otherwise permitted under state laws.

A written notification is sent to the provider of service if an overpayment is recouped through offsets to claim payments. The notification identifies the specific overpayment and the claim ID number.

Hospital Overpayments

If Health Net has incorrectly paid a hospital as the primary rather than as the secondary carrier, attach a copy of the primary carrier's explanation of benefits (EOB) with a copy of Health Net's RA highlighting the incorrect or duplicate payments and include a check for the overpaid amount. Also include a written explanation indicating the reason for the refund (for example, other coverage, duplicate or other circumstances). Send the overpayment refund and applicable details to the Health Net Overpayment Recovery Department.

Reimbursement

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

This section contains general provider reimbursement information.

Select any subject below:

Emergency Claims

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

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

If a claim or portion of a claim is contested on the basis that a payer has not received information reasonably necessary to determine payer liability for the claim, the payer has 45 business days after receipt of this additional information to complete reconsideration of the claim. If reconsideration of the claim (including payment, if appropriate), is not completed within the respective 45 business days after the payer's receipt of the additional information, the payer must pay statutory interest and any other applicable penalties described in California Health and Safety Code section 1371.35(b).

Complete Emergency Claims

A complete emergency claim is defined as follows:

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

- A claim from a provider is deemed complete when submitted on a completed CMS-1500, or its electronic equivalent, and any requested reasonable relevant information has been received

Delegation

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

Interest Charged for Late Payment

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

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

Exceptions

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

Emergency-Based and Post-Stabilization Services

Provider Type: Participating Physician Groups (PPG) | Hospitals

Claims for all emergency and approved post-stabilization acute inpatient services at all nonparticipating hospitals, including public and out-of-state hospitals, are paid using the diagnosis-related group (DRG) pricing payment methodology in accordance with 42 CFR 438.114 and APL 19-008. The All Patient Refined DRGs (APR-DRGs) pricing methodology is used to assign DRGs to claims.

To the extent acute rehabilitation services are provided at nonparticipating hospitals on an emergency or post-stabilization basis, Medi-Cal managed care plans may not pay more than the statewide per diem rate that DHCS is developing.

Health Net pays claims for participating hospitals based on *Provider Participation Agreement* (*PPA*).

Refer to www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx for additional information on DRG.

Health Net's Prestabilization Services Policy

The following defines Health Net's policy on prestabilization services:

1. The first day of all emergency admissions is prestabilization.
2. When a claim is billed with specific revenue codes or bed type and the emergency room stay is greater than one day, the days for which these bed types and services are used are considered prestabilization:
    - Intensive care unit (ICU), coronary care unit (CCU), pediatric ICU, and neonatal ICU (NICU) levels III and IV
    - Certain obstetrics services up to and including the day of delivery

Health Net's Post-Stabilization Services Policy

Any services not defined under the prestabilization services policy section above and claims submitted with subsequent hospital days thereafter are paid according to the most recent APL 13-004, *Rates for Emergency and Post-Stabilization Acute Inpatient Services Provided by Out-Of-Network General Acute Care Hospitals Based on Diagnosis Related Groups* .

Endoscopies Classification Reimbursement

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

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

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

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

Pharmacist Services

Provider Type: Participating Physician Groups (PPG)

Pharmacists may bill for covered services that are within the pharmacist's scope of practice and follow certain conditions for members. Pharmacists must be reimbursed 85% of the Medi-Cal fee schedule for these services under the member's medical benefit.

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

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

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

Federally Qualified Health Centers Alternative Payment Methodology

Provider Type: Participating Physician Groups (PPG)

Federally Qualified Health Centers (FQHCs) participating in the Department of Health care Services (DHCS) Alternative Payment Methodology (APM) can move away from the traditional Prospective Payment System (PPS) to a front-loaded reimbursement method that more closely aligns with evolving practice needs and the effective delivery of health care services. Participating FQHCs:

- Receive monthly payments equivalent to their total projected PPS payment entitlement in the form of an APM per member per month (PMPM) rate.
- Are reimbursed across all assigned members attributable to each managed care plan with whom the participating FQHC has contracted.

This system aims to prioritize high-quality and cost-effective care that is coordinated, team-based, convenient to access and best meets members' needs.

More information about the APM for FQHCs is available from the Department of Health Care Services.

Payment Scenarios for contracted and non-contracted FQHCs with Health Net

If a participating physician group (PPG) has a member who is being treated at an FQHC that is participating in the APM, and the FQHC is:

- **Contracted** with Health Net, the PPG should not make any additional payments to the FQHC as the cost of the service is included in the APM PMPM.
- **Not contracted** with Health Net, the PPG will need to pay the PPS rate for those services.

Targeted Rate Increase

Provider Type: Participating Physician Groups (PPG)

Pursuant to the 2023 Budget Act and AB 118 (Chaptered 42, Statutes of 2023), the Department of Health Care Services (DHCS) is increasing reimbursement rates for contracted providers to no less than 87.5% of the lowest California-specific Medicare allowable for certain Medi-Cal covered physician services.

Eligible providers and services include the following

TRI category	Eligible provider types	Eligible claim forms	Contract status
Primary/ general care	• Physicians • Physician Assistants • Nurse Practitioners • Podiatrists • Certified Nurse Midwives • Licensed Midwives • Doula Providers • Psychologists • Licensed Professional Clinical Counselor • Licensed Clinical Social Workers • Licensed Marriage and Family Therapists	CMS 1500	Contracted Network Provider (Does not include SCA, LOA)
Obstetric	Any/all	CMS 1500 (professional)/UB04 (facility)/nonstandard invoice	Contracted Network Provider (Does not include SCA, LOA)
Non-Specialty Mental	Any/all	CMS 1500 (professional)/UB04	Contracted Network Provider (Does not include SCA, LOA)

Health Services		(facility)/nonstandard invoice	

TRI payment calculation methodology

TRI payment calculation methodology

Step 1: Calculate current contract + Prop 56 Physician Services payment amount	Step 2: Determine the TRI fee schedule amount	Step 3: Pay using the greater amount from steps 1 and 2, and apply final "Lesser of Charges"
Billed $80, contract $40 Lesser of = $40 Prop 56 Physician Services payment = $30 Total = $70	**Greater than** the TRI fee schedule TRI $50	PPG pays the current contracted rate + Prop 56 Physician Services payment Payment = $70
Billed $80, contract $40 Lesser of = $40 Prop 56 Physician Services payment = $30 Total = $70	**Less than** the TRI fee schedule TRI $100	Payment is based on the TRI fee schedule price, but the final "Lesser of" will affect payment. Payment before "Lesser of" = $100 Payment after "Lesser of" = $80

Attestation requirement

Health Net requires PPGs to attest to complying with TRI requirements, including confirmation that rendering providers are paid in accordance with the APL. Health Net will provide an attestation form with PPGs amended contract to be signed by the PPG's finance executive.

Claims Coding Policies

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

This section describes Health Net's claims coding process and policies.

Select any subject below:

Add-On Codes

Provider Type: Physicians

Add-on procedures are commonly carried out in addition to a primary procedure. The codes representing add-on procedures are identified in the American Medical Association (AMA) CPT book with a "+" symbol and are listed in Appendix D of the CPT manual. Add-on codes are always performed in addition to a primary procedure. They should never be reported as standalone codes. An add-on code billed without the accompanying code for the primary procedure may be contested. They are exempt from multiple procedure reduction rules and should not be billed with modifier 51.

Health Net does not require documentation at the time of claim submission; however, if the claim is audited, documentation may be required.

Supporting Sources

- AMA CPT Book

Allergy Services with Evaluation and Management Services

Provider Type: Physicians

Evaluation and management (E&M) services for established member office visits (99211-99215) are considered to be included with allergy testing (95004-95075) and allergy immunotherapy (95115-95199) unless a significant, separately identifiable service was performed. In this case, bill the E&M code with modifier -25. Documentation is not required with the claim but the medical record must support the use of modifier -25.

Health Net does not require documentation at the time of claim submission; however, in the event the claim is audited, documentation may be required.

Supporting Sources

- American Medical Association (AMA) CPT Book
- CMS National Policy

Assistant Surgeons (State Health Programs)

Provider Type: Physicians

Health Net's list of procedures eligible for assistant surgeon reimbursement is based in part on the Centers for Medicare and Medicaid Services (CMS) assistant surgeon policy. Assistant surgeon charges are not allowed for procedures denoted by CMS with indicator "1" or "assistant surgeon may not be paid" on the National Physician Fee Schedule.

Assistant surgeon claims are to be coded with modifier 80 for physicians and modifier AS for non-physicians. Reimbursement is 20 percent of the surgeon's allowable rate of reimbursement.

Health Net does not require documentation at the time of claim submission; however, in the event the claim is audited, documentation may be required.

Supporting Sources

- CMS National Policy

Basic Coding Guidelines

Provider Type: Physicians

Current ICD-10-CM codes, CPT codes, HCPCS codes, and modifiers in effect on the date of service are required on all Health Net claims.

These codes should be used in basic accordance with the publishers' stated guidelines. Three major publications - the American Medical Association's Current Procedural Terminology (CPT-4) code book, the Centers for Medicare and Medicaid Services' (CMS') Healthcare Common Procedural Coding System (HCPCS) code book and the International Classification of Diseases (ICD-10-CM) - represent the basic standard of service code documentation and reference required by Health Net.

Valid ICD-10-CM diagnosis codes are required on all claims. The first diagnosis on the claim form is reserved for the primary diagnosis. Up to four diagnoses may be reported.

Code each diagnosis to the highest level of specificity (4th or 7th digit when available).

Valid AMA CPT-4 and Level II HCPCS procedure codes are required on all claims. A three-month grace period for submitting deleted codes is allowed. After three months, deleted codes are denied.

Procedure codes should be chosen based on the publishers' definitions and be appropriate for the age and gender of the member.

Procedure code modifiers are to be used only when the service meets the definition of the modifier and are to be linked only to procedure codes intended for their use.

If a deleted code and its current replacement code are submitted on the same date of service, the last code submitted is denied as a duplicate.

Health Net does not require documentation at the time of claim submission; however, in the event the claim is audited, documentation may be required.

Supporting Sources

- AMA CPT Book
- CMS National Policy
- HIPAA

Bilateral Procedures

Provider Type: Physicians

Bilateral procedures are procedures that are performed on both sides of the body at the same operative session or on the same date of service. Health Net's list of codes eligible for bilateral reimbursement is based on the Centers for Medicare and Medicaid Services (CMS) list. Health Net also follows CMS payment methodology wherein the allowable rate of reimbursement for bilateral procedures is either 150 percent of the rate that would be allowable if the procedures were only performed on one side of the body or 100 percent of the rate for each side.

To report bilateral procedures for codes that allow 150 percent payment for both sides, use modifier -50 (bilateral procedure) on appropriate codes in the surgical series (10021-69979) and the medicine series (90281-99602).

When billing for these bilateral procedures, the applicable procedure code should be reported on two separate lines, one with the base procedure code, and one with the procedure code and modifier -50.

To report bilateral procedures, for codes that allow 100 percent payment for each side, report the procedure code twice with modifier RT (right) on one line and modifier LT (left) on another line on appropriate codes in the radiology series (70010-79999), and appropriate codes in the medicine series (90281-99602).

Bilateral procedures fall into one of three categories:

- Procedures that may not be reported bilaterally (it is inappropriate to report the following types of procedures with modifier -50 or RT/LT):
  - Procedures that are bilateral in nature
  - Procedures that cannot be performed bilaterally based on anatomy
  - Procedures on parts of the body that have multiple units on both sides (fingers and toes)
  - Procedures specifying unilateral in the code description if there is an existing code for the bilateral procedure
  - Procedures specifying bilateral in the code description
  - Procedures specifying unilateral or bilateral in the code description
- Procedures paid at 150 percent of the allowed amount for both sides*
- Procedures paid at 100 percent of the allowed amount for each side*

* May be subject to reduction by the multiple procedure reduction rule.

Documentation Requirements

Health Net does not require documentation at the time of claim submission; however, if the claim is audited, documentation may be required.

Supporting Sources

- CMS National Policy

Bundled Services and Supplies (State Health Programs)

Provider Type: Physicians

Services and supplies that are covered but considered included in a related service are denied or bundled into the payment for the related service. Health Net follows the Centers for Medicare and Medicaid Services (CMS) bundled services policy with some exceptions.

The following codes are exempt from the CMS bundled services rule. These codes are classified as always bundled by CMS; however, they are not routinely bundled by Health Net. (These codes may be subject to bundling policies outside of the CMS bundled services rule.)

- 36416: Collection of capillary blood
- 99070: Supplies and materials (non-routine only)
- 99100: Anesthesia for extreme age
- 99116: Anesthesia with hypothermia
- 99135: Anesthesia with controlled hypotension
- 99140: Anesthesia complicated by emergency conditions
- 99358: Prolonged physician service; first hour

- 99359: Prolonged physician service; each additional 30 minutes

Health Net considers other services that are not part of the CMS bundled services policy as always included in a more primary procedure.

Health Net does not require documentation at the time of claim submission; however, in the event the claim is audited, documentation may be required.

Supporting Sources

- CMS National Policy

Co-Surgeons (State Health Programs)

Provider Type: Physicians

Health Net's list of procedures eligible for co-surgeon reimbursement is based in part on the Centers for Medicare and Medicaid Services (CMS) co-surgeon policy. Co-surgeon charges are not allowed for procedures denoted by CMS with the following indicators on the National Physician Fee Schedule: Indicator 0 ("co-surgeon not permitted") or indicator 9 (concept does not apply).

According to the American Medical Association (AMA) CPT definition of modifier -62, co-surgeons are two surgeons that work as primary surgeons performing distinct parts of the procedure. They each bring a different skill set to the procedure, so are not merely assisting one another.

Each surgeon must bill the same CPT code with modifier -62. When a claim is received without modifier -62 and there exists a previously processed claim for the same procedure code with modifier -62, Health Net adds modifier -62 to the second claim.

Each surgeon is reimbursed 62 percent of the allowed amount for the procedure, but is not reimbursed when billing as each other's assistant for a procedure. Multiple procedures are subject to the multiple procedure reduction rule.

If a separate surgical assistant is used, he or she must bill the same CPT code as the surgeon and reimbursement is based on 20 percent of the allowable reimbursement rate for the surgeon. Surgeons who perform additional procedures should bill separate codes without modifier -62. These codes are reimbursed at 100 percent of the allowed amount, subject to the multiple procedure reduction rule.

Surgeons may bill as assistants on each other's additional procedures only if they are not billing as primary for their own additional procedure. Surgeons may not bill as primary and assistant for the same member on the same date of service.

Health Net does not require documentation at the time of claim submission; however, in the event the claim is audited, documentation may be required.

Supporting Services

- AMA CPT Book
- CMS National Policy

Global Surgery

Provider Type: Physicians

The global surgical package includes all necessary services normally provided by the surgeon before, during and after the surgical procedure. The global surgical package applies to minor procedures that have a 0 or 10-day post-operative period and major procedures that have a 90-day post-operative period as defined by the Centers for Medicare and Medicaid Services (CMS) Physician Fee Schedule. It also applies to obstetrical procedures that have a 42-day post-operative period.

The global surgical package policy applies to all places of service.

Services Included in the Global Package

The following services are included in the global surgical package and, therefore, are not eligible for separate payment.

- Preoperative evaluation and management (E&M) services that are performed one day prior to major surgery or on the same day as a minor or major procedure
    - Exception: New member visits (CPT codes 99201-99205) on the same day as a minor surgery are not included in the global package
- Intraoperative services that are a usual and necessary part of the surgical procedure
- Anesthesia provided by the surgeon
- Supplies
- All additional medical or surgical services required of the surgeon during the post-operative period because of complications, which do not require additional trips to the operating room
- Post-operative E&M services that are related to the surgery
- Post-operative pain management by the surgeon
- Dressing changes, local incision care, removal of operative packs, removal of cutaneous sutures, staples, lines, wires, tubes, drains, and splints, insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes and change and removal of tracheostomy tubes

Services Not Included in the Global Surgery Package

The following services are not included in the global surgical package and, therefore, are eligible for separate payment.

- E&M service that was significant and separately identifiable from the minor surgical procedure performed on the same day. Modifier -25 should be added to the E&M code
- E&M service performed the day prior to or on the same day of surgery resulting in the decision for a major surgical procedure. Modifier -57 should be added to the E&M code
- E&M services that occur during the post-operative period that are unrelated to the surgery. Modifier -24 should be added to the E&M code
- Critical care when billed for serious injuries or burns
- Services of other physicians not in the same participating physician group (PPG) of the physician that performed the surgery, except where a formal transfer of care occurs
- Diagnostic tests and procedures, including diagnostic radiological procedures
- Clearly distinct surgical procedures during the post-operative period that are not re-operations or treatment for complications. Modifiers -58 (staged procedure) or -79 (unrelated procedure or service performed by a physician during the post-operative period) should be added to the surgical procedure code
- Treatment of post-operative complications that require a trip to the operating room. Modifier -78 should be added to the surgical procedure code
- Immunosuppressive therapy for organ transplants. Modifier -24 should be added to the E&M code

NOTE: An E&M service that was significant and separately identifiable from the minor surgical procedure performed on the same day that falls within a global period of a previous service but is not related to the previous service requires both a modifier -25 and a modifier -24.

Health Net does not require documentation at the time of claim submission; however, in the event the claim is audited, documentation may be required.

Supporting Sources

- CMS National Policy

Incident to Services

Provider Type: Physicians

The Centers for Medicare and Medicaid Services (CMS) defines "incident to" services as those services furnished as an integral, although incidental, part of the physician's personal professional services.

A physician may be reimbursed for "incident to" services performed by auxiliary personnel only when an employer relationship exists between the physician and auxiliary personnel.

When these procedures are performed in an inpatient or outpatient hospital setting, they are denied as "incident to" the physician's service.

Health Net administers the CMS list of procedures that are "incident to" the physician's professional services when performed in a hospital setting.

The following are examples of services on the CMS "incident to" services list:

- Immunizations and therapeutic injections
- Chemotherapy administration
- IV infusion
- Allergy testing and immunotherapy

For a complete list of codes/services, refer to the CMS website at www.cms.gov. The rationale for "incident to" services can be found in Publication 100-4 Medicare Claims Processing, Chapter 12, Section 30.5.

Health Net does not require documentation at the time of claim submission; however, in the event the claim is audited, documentation may be required.

Supporting Sources

- CMS National Policy

Modifier -59

Provider Type: Physicians

The American Medical Association (AMA) CPT definition of modifier -59, distinct procedural service, is as follows: "Under certain circumstances, the provider may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier -59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, 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 participating provider. However, when another already established modifier is appropriate it should be used rather than modifier -59. Only if a more descriptive modifier is not available, and the use of modifier -59 best explains the circumstances, should the modifier -59 be used."

Use modifier -59 with the code that would normally be considered a component of a more comprehensive procedure when the procedures are distinct (as defined by the CPT definition of the modifier set forth above). The medical record must reflect that the modifier is being used appropriately.

Health Net reimburses separately for procedures billed with modifier -59 as permitted by AMA CPT guidelines and national CMS policies such as the Correct Coding Initiative (CCI) edits and the bundled services policy.

The following policy is an exception to this rule. In this case, the service billed with modifier -59 would not qualify for separate reimbursement:

- Pulmonary perfusion imaging is included with myocardial perfusion studies when both are performed at the same time

Claims should be coded with ICD-10-CM codes corresponding to all procedures billed. This serves to further support the distinctness for some types of procedures.

Modifier -59 should not be used if one of the following modifiers is more descriptive than modifier -59.

- E1-E4 (eyelid)
- FA (left thumb)
- F1-F9 (fingers)
- LC (left circumflex coronary artery)
- LD (left anterior descending coronary artery)
- LT (left side)
- RC (right coronary artery)
- RT (right side)
- TA (left great toe)
- T1-T9 (toes)
- 50 (bilateral procedure)
- 58 (staged procedure)
- 78 (return to the operating room)
- 79 (unrelated procedure by different physician during postoperative period)
- 91 (repeat clinical diagnostic laboratory test)
- XE (separate encounter, a service that is distinct because it occurred during a separate encounter)
- XP (separate practitioner, a service that is distinct because it was performed by a different practitioner)
- XS (separate structure, a service that is distinct because it was performed on a separate organ/structure)
- XU (unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service)

Health Net does not require documentation for modifier -59 at the time of claim submission; however, in the event the claim is audited, documentation may be required.

Refer to the National Correct Coding Initiative (NCCI) Edits and Unbundling and Fragmentation policy for more information.

Prepayment Clinical Claims Review

Health Net conducts prepayment clinical claims reviews on all procedures billed with modifier -59. A Health Net registered nurse reviews the information billed on the claim, along with the member's and provider's claims history, to determine whether modifier -59 was used correctly for procedures performed on the date of service. Health Net uses nationally published guidelines from CPT and CMS when determining whether the modifier was used correctly, including the use of claim documentation requirements as listed below:

- The diagnosis codes 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.
- To avoid incorrect denials providers should assign to the claim all applicable diagnosis and procedure codes using all applicable anatomical modifiers designating which areas of the body were treated.

Provider Appeals and Dispute Resolution Requests

In the event the claims documentation is insufficient to support billing modifier -59, Health Net will send the provider denial determination on his or her explanation of payment (EOP). The provider may submit an appeal or reconsideration request according to the guidelines outlined in the provider operations manual under Dispute

Submission. Providers should submit all pertinent medical records for the date of service and procedures billed. Medical records should not be submitted on first-time claims submissions as first-time claim reviews consist only of a review of the information documented on the claim and in the member and provider history. Medical records should only be submitted once the provider receives a denial and wishes to request a reconsideration or appeal.

Supporting Sources

- AMA CPT
- CMS National Policy

Claim Editing

Provider Type: Physicians

Health Net verifies physician and outpatient facility codes using internal and vendor-sourced HIPAA-compliant code editing tools. The software detects, corrects, and documents coding errors on provider claims prior to payment by analyzing CPT, HCPCS, ICD-10, modifier and place of service codes against correct coding guidelines. These principles are aligned with a correct coding “rule.” When the software audits a claim that does not adhere to a coding rule, a recommendation known as an “edit” is applied to the claim.

While code editing software is a useful tool to ensure provider compliance with correct coding, it does not wholly evaluate all clinical patient scenarios. Consequently, Health Net uses clinical validation by a team of experienced nursing and/or coding experts to further identify claims for potential billing errors. Clinical validation allows for consideration of exceptions to correct coding principles and may identify where additional reimbursement is warranted. For example, clinicians review all claims billed with Modifier 25 and Modifier 59 for clinical circumstances which justify separate reimbursement for the service performed.

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. The software may make the following recommendations:

Deny: Code editing rule recommends denial of a service line. The appropriate explanation code is documented on the provider’s explanation of payment along with reconsideration/appeal instructions.

Pend: Code editing rule recommends that the service line pend for clinical review and/or 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 rule 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 and a new line is added to reflect the software’s recommendations. For example, an incorrect CPT code is billed for the member’s age. The software denies the original service line billed by the provider and adds 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.

Claims Editing Software Updates

Claims editing software is updated quarterly to incorporate the most recent medical practices, coding principles, industry standards and annual changes to CPT and CMS guidelines.

Edit Sources

Claims editing software contains a comprehensive set of rules addressing coding inaccuracies such as: unbundling, frequency limitations, 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:

- Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) for professional and facility claims. The NCCI edits include column 1/column 2, medically unlikely edits (MUE), mutually exclusive and outpatient code editor (OCE) edits. These edits were developed by CMS to control incorrect code combination billing contributing to incorrect payments.
- Public domain specialty society guidance (i.e., American College of Surgeons, American College of Radiology, American Academy of Orthopedic Surgeons, etc.).
- CMS Claims Processing Manual CMS Medicaid NCCI Policy Manual State Provider Manuals, Fee Schedules, Periodic Provider Updates (bulletins/transmittals)
- CMS coding resources, such as HCPCS Coding Manual, National Physician Fee Schedule, Provider Benefit Manual, Claims Processing 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)
    - Etc.
    - State-specific policies and procedures for billing professional and facility claims Health Plan policies and provider contract considerations.

Code Editing Software

- **ClaimsXten**
    - ClaimsXten™ is a software application that edits claims for adherence to Centene Corporation policies, reimbursement coverage policies, benefit plans, and industry-standard coding practices based mainly on CMS and AMA guidelines. ClaimsXten facilitates accurate

claim processing for medical and behavioral claims submitted on a CMS 1500 claim form and for certain claims submitted on a UB04 claim form. Code editing within ClaimsXten is based on assumptions about the most common clinical scenarios for services performed by a health care professional for the same patient, and the logic within ClaimsXten is based on a thorough review by doctors of current clinical practices, specialty society guidance, and industry standard coding.

- **Cotiviti**
  - Cotiviti PCI offers claims editing solutions that validate, identify and review claims to comprehensively address Fraud Waste and Abuse, reducing waste and improving payment accuracy. This process detects common errors such as duplicates, improper frequency, the unbundling of services, and inappropriate modifier use.
  - Cotiviti PCI 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 when additional reimbursement is warranted. For example, clinicians review all claims billed with modifiers -25 and -59 for clinical scenarios which justify separate payment for the service billed.

Claims Editing Principles

Unbundling - PTP Practitioner and Hospital Edits

Unbundling refers to two or more procedure codes used to report a service when a single, more comprehensive code should have been used. The less comprehensive code is denied. As part of the National Correct Coding Initiative (NCCI) to prevent inaccurate claims payment, CMS has designated combinations of codes that should not be billed together. CMS developed Procedure to Procedure (PTP), also known as Column I/Column II, edits to detect incorrect claims submitted by providers. The column I procedure code is the most comprehensive code and reimbursement for the column II code is subsumed into the payment for the comprehensive code. The column II code is considered an integral component of the column I code. While these codes should not typically be billed together, there are circumstances when a modifier may be appended to the column II code to identify a significant and separately identifiable or distinct service. When these modifiers are billed, clinical validation will be performed. PTP practitioner edits are applied to claims submitted by physicians, non-physician practitioners and ambulatory surgical centers. PTP hospital edits apply to hospitals, skilled nursing facilities, home health agencies, outpatient physical therapy, speech-language pathology providers and comprehensive outpatient rehabilitation facilities.

Medically Unlikely Edits (MUEs) for Practitioners, DME Providers and Facilities

Also within CMS NCCI guidelines, MUEs reflect the maximum number of units that a provider would typically bill 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 Guidelines

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. 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 Relative Value Units (RVU) is considered the reimbursable code.

Global Surgical Period Editing/Medical Visit Editing

CMS publishes rules surrounding payment of an Evaluation and Management (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 000, 010, or 090 day global surgical period.

Procedures assigned a 090 day global surgery period are defined as a major surgical procedure. If an E/M service is provided on the same date of service as a the major surgical procedure decision to perform the surgical procedure, then the E/M service would be separately reportable with using the Modifier 57, Decision for Surgery. Any other E/M service provided on the same date of service are not separately reportable and would be included in the payment for the surgical procedure under the global period. E/M services for a major procedure (90-day period) that are reported 1 one day preoperatively on the same date of service or during the 90-day postoperative period are not recommended for separate reimbursement.

Procedures assigned a 000 or 010 global surgical period are defined as minor procedures. 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 E/M service included in all surgical procedures.

Global Maternity Editing

Global periods for maternity services are classified as “MMM” when an evaluation and management service is billed during the antepartum period (270 days), on the same date of service or during the postpartum period (45 days). E/M services are not recommended for separate reimbursement if the procedure code includes antepartum and/or postpartum care.

Diagnostic Services Bundled to Inpatient Admission (3-Day Payment Window)

This rule identifies outpatient diagnostic services 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 bundled into the inpatient admission and therefore are not separately reimbursable.

Multiple Code Rebundling

This rule analyzes if a provider billed two or more procedure codes when a single more comprehensive code should have been billed to 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 is applied when the procedure code is billed in excess of these guidelines.

Duplicate Edits

Code editing evaluates prospective claims to determine if there is a previously paid claim for the same member and provider that is a duplicate to the prospective claim. The software also looks 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 analyzes multiple services within the same range of services performed on the same day.

National Coverage Determination Edits

CMS establishes guidelines that identify whether some medical items, services, treatments, diagnostic services or technologies can be paid under Medicare. These rules evaluate diagnosis to procedure code combinations.

Provider-Preventable Conditions

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

Section 2702 of the federal Affordable Care Act (ACA) requires all providers to report all provider-preventable conditions (PPCs) that occur during treatment of Medi-Cal beneficiaries that did not exist prior to the provider initiating treatment and regardless of whether the provider seeks reimbursement for services to treat the PPC.

The Centers for Medicare & Medicaid Services (CMS) defines two types of PPCs:

- Health care-acquired conditions (HCACs), also known as hospital-acquired conditions (HACs). These should be reported on a UB-04 claim form when they occur in an inpatient acute care hospital, using designated ICD HAC codes with the accompanying not present on admission (POA) indicator code N.
- Other provider-preventable conditions (OPPCs).These should be reported when they occur on a UB-04 or CMS-1500 claim form as billed procedure code modifiers in any health care setting related to a surgery or invasive procedure.

Unlike HCACs, OPPCs are not confined to an inpatient setting but may occur in either an inpatient or outpatient setting. Outpatient settings include hospitals, outpatient departments, clinics, ambulatory surgical centers (ASCs), federally qualified health centers (FQHCs), and physicians' offices. CMS and the Department of Health Care Services (DHCS) identify three OPPCs for Medi-Cal:

- Surgery/invasive procedure performed on the wrong body part
- Surgery/invasive procedure performed on the wrong patient
- Wrong surgery/invasive procedure

Affected Providers

Inpatient acute care hospitals must report all PPCs and OPPCs. All other facilities that conduct surgery or invasive procedures only report OPPCs. If a facility has both an acute inpatient care hospital unit and a skilled nursing facility (SNF) unit, the facility must report PPCs and OPPCs.

Reporting Instructions

DHCS requires providers to actively report all PPCs for Medi-Cal beneficiaries on the DHCS secure online reporting portal. Providers must report all PPCs when the provider first learns the patient had a PPC and confirms the patient is a Medi-Cal beneficiary. DHCS understands this might be after the patient has been discharged, including discovery during coding and billing.

After completing the online form, providers can use the Print Screen button to create a paper copy for submission to Health Net. Providers must fax this information to Health Net Clinical Review Unit via secure fax at 1-877-808-7024. Providers must include a fax coversheet and mark it Protected Health Information: Confidential.

ICD HAC Lists

PPCs are found on the designated ICD HAC Lists, as follows:

- ICD-10 HAC List - Refer to the CMS website at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.html under the Downloads section and select the current year.
- ICD-9 HAC List - Refer to the CMS website at www.cms.gov/medicare/medicare-fee-for-service-payment/hospitalacqcond/downloads/fy_2013_final_hacscodelist.pdf.

Present-On-Admission Indicators

The POA indicator is a required field on the UB-04 and defines whether the condition was present at the time of admission or occurred during the inpatient hospital stay. The POA indicator N must be assigned to HAC-identified ICD diagnosis code sets on all inpatient claims.

OPPC Modifiers

Providers must also report OPPC modifiers in any health care setting on the UB-04 and CMS-1500 using the appropriate modifier below:

- PA - Surgery/invasive procedure performed on the wrong body part
- PB - Surgery/invasive procedure performed on the wrong patient
- PC - Wrong surgery/invasive procedure

Payment Reduced or Prohibited

Section 2702 of the ACA reduces or prohibits payments to health care providers for PPCs and OPPCs. To comply with CMS's ruling and guidance from DHCS, Health Net and its delegated participating physician groups (PPGs) are required to evaluate claims as follows.

PPCs

Health Net and its delegated PPGs evaluate UB-04 inpatient acute hospital claims, specific to billed PPCs (ICD HAC Codes), identifying PPCs that are ineligible for payment. Based on All Patient Refined Diagnosis Related Groups (APR-DRG), the reimbursement methodology payment is adjusted to reflect non-reimbursement for the HAC.

OPPCs

Health Net and its delegated PPGs evaluate all procedure claims (UB-04 and CMS-1500), specific to OPPC Modifiers (PA, PB and PC), and do not reimburse for the services rendered.

Health Net or its delegated PPG informs the submitting provider of nonpayment of PPC-related services, when applicable, via a notification transmitted with the Remittance Advice.

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 Marketing Guidelines
- Provider Offshore Subcontracting Attestation
- Communicable Diseases Reporting
- DMHC-Required Statement on Written Correspondence
- Federal Lobbying Restrictions
- Health Net Affiliates
- Material Change Notification
- Nondiscrimination
- Drug Utilization Review Requirements

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 Marketing Guidelines

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

Providers are responsible for making sure member-facing materials meet respective marketing guidelines:

- Marketing Guidelines for Providers Serving Medi-Cal members (PDF)
- Marketing Guidelines for Providers Serving CalViva Health Medi-Cal Members (PDF)
- Marketing Guidelines for Providers Serving Community Health Plan of Imperial Valley Medi-Cal Members (PDF)

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

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.

Drug Utilization Review Requirements

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

The health plan and entities delegated to fill prescriptions for outpatient drugs (“applicable entities”) must:

- Operate a drug utilization review (DUR) program.[1]
- Submit the following to the Department of Health Care Services (DHCS):
  - Updated policies and procedures that address each of the requirements detailed below.
  - Annual DUR Report.

Claims review requirements

The requirements include the topics listed below.

Concurrent utilization alerts:

- Describe the process for claims review (retrospective) that monitors when the member is concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics. The Plan and applicable entities are provided claims data, including for antipsychotic medications. The Plan and applicable entities are expected to perform, retrospectively, regular care management activities, including a review of concurrent use of opioid and antipsychotic medications, and take action accordingly on issues of concern to them.

What’s excluded from the program:

- The above described claims review requirements do not apply to the Plan members who are receiving hospice or palliative care; receiving treatment for cancer; residents of a long-term care facility, a facility described in section 1905(d) of the Act, or of another facility for which frequently abused drugs are dispensed for residents through a contact with a single pharmacy; Plan members who are receiving opioid agonist medications for treatment of substance use disorder; or other individuals the state elects to treat as exempted from such requirements.

Monitoring of antipsychotic medications used by children

The Plan and applicable entities are required to have a process to monitor and manage appropriate use of all psychiatric drugs to include antipsychotics, mood stabilizers and anti-depressant medications for all children under age 18 and all foster children. Based on the DUR program monitoring findings, the DUR program must have a process to address and improve concerning findings.

Identification of fraud, waste and abuse

Describe the process for identifying and addressing fraud and abuse of controlled substances by members, health care providers who are prescribing drugs to members, and pharmacies dispensing drugs to members. Also describe the actions that will be taken based on issues identified through program-monitoring findings.

[1]The DUR program must comply with Medicaid-related DUR provisions contained in section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (H.R. 6, the SUPPORT Act, P.L. 115-271).

Consent

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

This section contains general information on provider requirements for obtaining consent for medical treatment and services.

Select any subject below:

- Consent for Breast and Prostate Center Treatment
- Consent for Treatment
- Human Sterilization and Informed Consent

Consent for Breast and Prostate Center Treatment

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

Breast Cancer Treatment Information and Consent Requirements

A standardized summary discussing breast cancer treatment options and their risks and benefits must be given to members prior to a biopsy, notwithstanding whether treatment for breast cancer is planned or given. Providers may contact the Medical Board of California, Breast Cancer Treatment Options to request a free summary brochure. This information is also available from the National Cancer Institute.

The summary does not supplant the physician's duty to obtain the member's informed consent. In addition to distributing the brochure, physicians should discuss the risks, benefits and possible alternatives to any planned procedures with the member and document the discussion in the medical record.

Every physician who screens or performs biopsies for breast cancer must post a sign that is consistent with the brochure, which includes specific prescribed language. The sign must be posted close to the area where the breast cancer screening or biopsy is performed or at the patient registration area. The sign must be at least 8 1/2" x 11", conspicuously displayed, and in English, Spanish and Chinese. Refer to the California Health and Safety Code reference is 109275.

Prostate Cancer Treatment Information to Members

Providers are required to tell members receiving a digital rectal exam that a prostate-specific antigen (PSA) test is available for prostate cancer detection.

The National Cancer Institute provides information about the detection, symptoms, diagnosis, and treatment of prostate cancer on their website.

The Prostate Cancer Foundation Prostate Cancer Patient Guide provides information to patients on prostate cancer treatment options, and is available at The Prostate Cancer Foundation's website. This booklet must be given by physicians upon examination of the prostate gland, to certain patients as specified by The Medical Board of California.

Consent for Treatment

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

A member has the right to refuse any recommended medical procedure and to have sufficient information to make consent informed and meaningful. A legal guardian must make all medical decisions on behalf of a member who is not competent to make his or her own decisions.

If the physician or a court of competent jurisdiction determines that a member requires a representative other than a legal guardian to make medical decisions, that representative must be one of the following (in the order stated):

- Person designated under a Durable Power of Attorney for Health Care (DPAHC)
- Conservator specifically authorized by a court to make health care decisions
- Next of kin
- Any other surrogate designated consistent with applicable laws
- A person appointed by a court or, if the member is a minor, someone lawfully authorized to represent the minor

Physicians are responsible for providing members with sufficient information in lay terms, so that they can make informed decisions. All information must be disclosed that allows a reasonable person in the member's position to accept or reject a recommended procedure.

When to Use a Consent Form

Simple and common procedures, such as blood tests or urinalysis, do not require use of a consent form (except when required by law, such as for sensitive services). Consent does not need to be obtained if an emergency exists.

A consent form is used in conjunction with a thorough discussion with the member in order to obtain informed consent for any surgical, special diagnostic or special therapeutic procedure or when there is a statutory requirement. Any member requiring translation services must receive the form. Physicians must document in the member's medical record that the oral discussion leading to consent took place. Informed consent must be obtained in writing and must be signed by the member or legal representative. Consent forms must include:

- Member's name
- Physician's name
- Name of the procedure to be performed
- Authorization for a specified physician and assistants to perform a specified procedure
- Written explanation of the nature of the procedure, expected benefits of the procedure, expected discomfort, complications, or risks to the member, description of any alternative methods of treatment, and description of what will likely happen if the procedure is not performed
- Member's signature or legal representative's signature along with a copy of the legal document granting legal representation. A relative's signature, in the case of a documented existing medical emergency, does not need a court order
- Date and time
- Witness' signature

Providers with questions about legal consent should seek legal counsel. This explanation does not supplant advice of counsel.

Human Sterilization and Informed Consent

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

Providers must inform Medi-Cal members before they undergo sterilization procedures and providers must obtain the member's consent.

Sterilization performed because pregnancy would be life-threatening to the mother (therapeutic sterilization) is included in this requirement; however, sterilization that is the unavoidable secondary result of a medical procedure, and the procedure is not being done in order to achieve it, is not. Procedures that would ordinarily require consent are excluded if the member is already sterile.

Required Information

Providers must provide members to be sterilized with the Department of Health Care Services (DHCS)-published brochure on sterilization before obtaining consent. The following are the only sterilization information booklets approved by DHCS:

- Permanent Birth Control for Women
- Metodo Anticonceptivo Permanente Femenino
- Permanent Birth Control for Men

- Metodo Anticonceptivo Permanente Masculino

Providers can log in to the DHCS website to download and print the booklets.

A physician or designee who obtains consent for the sterilization procedure must offer to answer any questions the member may have regarding the procedure. In addition, all of the following must be discussed with the member seeking to be sterilized:

- A full description of available alternative methods of family planning and birth control
- A description of benefits or advantages that may be expected as a result of the sterilization
- A thorough explanation of the specific sterilization procedure to be performed, including information on whether the procedure is established or new
- The name of provider performing the procedure. If another provider is substituted, the member must be notified prior to anesthesia of the new provider's name and the reason for the change
- Advice that the sterilization procedure is considered irreversible
- A full description of the discomforts and risks that may accompany or follow the procedure, including an explanation of the type and possible side effects of any anesthesia
- Approximate length of hospital stay, recovery time and any cost to the member
- Advice that the sterilization will not be performed for at least 30 days (except in the case of emergency abdominal surgery or premature birth, and then only when specific criteria is fully met)
- Advice that the member is free to withhold or withdraw consent at any time before the procedure without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the member might be entitled

The provider must fully and correctly complete the Consent Form PM 330 after discussing the above topics with the member. Refer to the Certification of Informed Consent for Reproductive Sterilization discussion below for about completing the Consent Form PM 330.

Certification of Informed Consent for Reproductive Sterilization

The Department of Health Care Services (DHCS) Consent Form PM 330 (English PDF, Spanish PDF) is the only form approved by DHCS for certification of informed consent. Before obtaining consent and completing the PM 330 for any sterilization procedure, a provider or providers' designee must discuss and furnish the following information to the member seeking sterilization:

- A full description of available alternative methods of family planning and birth control.
- A description of benefits or advantages that may be expected as a result of the sterilization.
- A thorough explanation of the specific sterilization procedure to be performed, including information on whether the procedure is established or new.
- The name of the provider performing the procedure. If another provider is substituted, the member must be notified of the new provider's name and the reason for the change prior to anesthesia.
- Advice that the sterilization procedure is considered irreversible.
- A full description of the discomforts and risks that may accompany or follow the procedure, including an explanation of the type and possible side effects of any anesthesia.
- Approximate length of the hospital stay, recovery time and any cost to the member.
- Advice that the sterilization will not be performed for at least 30 days (except in the case of emergency abdominal surgery or premature birth, and then only when specific criteria is met).

- Advice that the member is free to withhold or withdraw consent at any time before the procedure without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the member might be entitled.

The provider must fully and correctly complete the PM 330 after discussing the above topics with the member. The form must include the name of the provider or clinic furnishing the procedure information and the provider or clinic performing the procedure (lines 1 and 5 on the PM 330). These lines on the form may be pre-stamped or typed. The name of the procedure must be included on lines 2, 6, 13, and 20 and must be consistent throughout the form and match the name of the procedure on the claim submission. These lines may also be pre-stamped or typed. Providers must cross out the alternative final paragraph on the form that is not used. If the minimum waiting period of 30 days has been met, providers must cross out paragraph 2. If the minimum waiting period has not been met, providers must cross out paragraph 1.

The PM 330 must be signed and dated by the member to be sterilized, the interpreter (if one is used in the consent process), the person who secured the consent (for example, physician or intake nurse), and the provider performing the sterilization. Providers must attach a fully completed informed consent form to all sterilization procedure claims. Claims for sterilization procedures are not paid unless the informed consent form is attached.

Providers must note in the member's medical record that the provider gave the member the DHCS-published brochure about sterilization and a copy of the consent form. Providers must retain a copy of the signed consent form in the member's medical record.

Conditions Under Which Sterilization May Be Performed

Sterilization may be performed only if:

- The member is at least age 21 at the time consent is obtained.
- The member is not mentally incompetent.
- The member is able to understand informed consent.
- The member is not institutionalized.
- The member has voluntarily given informed consent in accordance with all prescribed requirements.
- At least 30 days, but not more than 180 days, have passed between the date of informed consent and the date of the sterilization.

Refer to the Exceptions to Time Limitations discussion below for information regarding the time requirement in the case of emergency abdominal surgery or premature delivery.

Conditions Under Which Informed Consent May Not Be Obtained

Informed consent may not be obtained while the member to be sterilized is:

- In labor or within 24 hours postpartum or post-abortion.
- Seeking to obtain or obtaining an abortion.
- Under the influence of alcohol or other substances that affect the member's awareness.

Exceptions to Time Limitations

Sterilization may be performed at the time of emergency abdominal surgery or premature delivery if at least 72 hours have passed after the member gave written informed consent to be sterilized and the written informed consent to be sterilized was given at least 30 days before the member originally intended to be sterilized, or the written informed consent was given at least 30 days before the expected date of delivery.

Informed Consent Process Requirements, Documentation and Noncompliance

The following criteria must be met for compliance with the informed consent process for Health Net members:

- The informed consent process must be conducted either by a physician or the physician's designee
- Suitable arrangements are made to ensure that the information is effectively communicated to a member who is deaf, blind or otherwise disabled
- An interpreter is provided if the member to be sterilized does not understand the language used on the consent form or the language used by the person obtaining the consent
- The member to be sterilized is permitted to choose a witness who is present when consent is obtained
- The sterilization operation is requested without fraud, duress or undue influence

Medical Record Documentation

There must be documentation in the progress notes of the member's medical record that a discussion regarding sterilization has taken place, including the answers given to specific questions or concerns expressed by the member.

The original signed consent form must be filed in the medical record. A copy of the signed consent form must be given to the member, and a copy placed into the member's hospital medical record at the place where the service is performed (for example, hospital or outpatient surgery center). Providers must also note the fact that the Department of Health Care Services (DHCS)-published brochure on sterilization and a copy of the consent form were given to the member.

If the procedure is a hysterectomy, a copy of the Hysterectomy Informed Consent (PDF) form must be placed in the medical record. The form is obtained from the hospital performing the procedure.

Office Documentation

All participating providers are responsible for maintaining a log of all sterilization procedures performed. This sterilization procedures log (PDF) must indicate the member's name, the date of the sterilization, the member's medical record number, and the type of procedure performed.

Non-Compliance

The Health Net Public Programs Quality Improvement (PPQI) Department monitors participating providers for compliance with the consent process for sterilization. Deficiencies are to be remedied through corrective action and follow-up auditing. DHCS also performs audits for compliance. Health Net, its affiliated plans, and DHCS are required to refer non-compliant providers to the California Board of Medical Quality Assurance.

Special Considerations for Hysterectomy

A hysterectomy may not be performed solely for the purpose of rendering an individual permanently sterile. If a hysterectomy is performed, a Hysterectomy Informed Consent (PDF) form must be completed in addition to the other required forms.

Coordination of Benefits

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

This section contains general information for providers on coordination of benefits.

Select any subject below:

- Overview

Overview

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

Coordination of benefits (COB) is required before submitting claims for members who are covered by one or more health insurers other than Medi-Cal. Medi-Cal is always the payer of last resort, including Medicare and TRICARE.

COB Claim Submission and Payment

Submission of a COB Claim

Coordination of benefits (COB) claims must be submitted within 180 days following the date that the member and provider receive the other coverage's Explanation of Benefits (EOB).

When the provider learns that a Health Net Medi-Cal member has other group health coverage, the provider must:

- File the provider claim with the primary carrier first
- After the primary carrier has paid, submit a copy of the explanation of payment or EOB with the claim to Health Net or the responsible capitated subcontractor, if one exists

Payment Calculations

As the payer of last resort, Health Net's Medi-Cal plan coordinates benefits. In order for Health Net to document records and process claims correctly, include the following information on all coordination of benefits (COB) claims:

- Name of the other carrier
- Subscriber identification number with the other carrier

How to bill Medi-Cal after billing other health coverage

The provider must present acceptable forms of proof to the Plan that all sources of payment have been exhausted, which may include:[1]

- A denial letter from the other health coverage (OHC) for the service.
- An EOB that shows the service is not covered by the OHC.

Prior authorization for out-of-network providers

Where a benefit is not covered by the member's primary insurance and the service is covered and requires authorization by Health Net Medi-Cal, an out-of-network provider may leverage a letter of agreement (LOA) or similar mechanism. Without an LOA or similar agreement, the provider may be at risk for billed amounts exceeding the allowable FFS rate. [1]

Follow these guidelines to bill Medi-Cal after OHC[2]

1. Medi-Cal may be billed for the balance, including OHC copayments, OHC coinsurance and OHC deductibles. Medi-Cal will pay up to the limitations of the Medi-Cal program, less the OHC payment amount, if any.
2. Medi-Cal will not pay the balance of a provider's bill when the provider has an agreement with the OHC carrier/plan to accept the carrier's contracted rate as payment in full.
3. An EOB or denial letter from the OHC must accompany the Medi-Cal claim.
4. The amount, if any, paid by the OHC carrier for all items listed on the Medi-Cal claim form must be indicated in the appropriate field on the claim. Providers should not reduce the charge amount or total amount billed because of any OHC payment. Refer to claim form completion instructions in the Medi-Cal provider manual for more information.
5. When you bill, use Medi-Cal-approved HCPCS codes, CPT® codes and modifiers.
6. Do not bill with HCPCS codes, CPT codes or modifiers where OHC paid, but which Medi-Cal does not recognize or allow.
7. If services normally require a Treatment Authorization Request (TAR), the related procedures must be followed. Refer to the Prior Authorization list for more information.

[1]Information taken or derived from *Medi-Cal Managed Care Enrollment and What this Means for Members and Providers* fact sheet.

[2]Information taken or derived from Medi-Cal Provider Manual, Part 2. files.medi- cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/othhlth.pdf.

Dual Health Net Coverage

Dual Health Net coverage refers to members that are covered under two Health Net plans. Claims must be submitted to the primary plan first. The Health Net Medi-Cal plan is the secondary coverage under coordination of benefit (COB) rules. The secondary claim must be submitted with the primary Health Net remittance advice, identification and group numbers, indicating the primary Health Net identification number in the Other Coverage box.

Copayments

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

Counties Covered

- Los Angeles
- San Diego

This section includes general information on the collection and verification of copayments.

Select any subject below:

- Verifying and Clearing Share-of-Cost

Verifying and Clearing Share-of-Cost

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

Participating providers must access the Medi-Cal eligibility verification system to determine whether a Health Net member must pay a share-of-cost (SOC). Providers may access the eligibility verification system through the Point of Service device, Affiliate Computer Services (ACS) by telephone or under Transactions on the Medi-Cal website at www.medi-cal.ca.gov. The eligibility inquiry message includes SOC dollar amount and any remaining SOC, if applicable. Members with unmet SOC are enrolled with Health Net in a pended status and the eligibility verification system will indicate Potential Health Net Member.

Providers may collect SOC payments from members on the date of service, or allow them to pay at a later date or through an installment plan. SOC installment plans are between the provider and the member. Health Net does not reimburse providers for SOC payments not paid by the member.

Providers must perform an SOC transaction to clear SOC immediately on receiving payment or accepting obligation from the member for services rendered. Clearing SOC means that the Medi-Cal eligibility verification system shows the member has paid or obligated for entire SOC amount owed. To clear SOC, providers must access the Medi-Cal eligibility verification system and enter the following:

- Provider number
- Provider identification number (PIN)
- Member identification number
- Beneficiary identification card (BIC) issue date
- Billing code and service charge

The SOC information is updated and a response is displayed on the screen or delivered over the telephone. Providers must continue to clear SOC until it is completely cleared. Once SOC is met and the eligibility verification system is updated, members' status will change to Active and eligibility is retroactive to the first of the month.

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

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.

Site Evaluations

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

Health Net or its designee conducts a full-scope facility site review (FSR) for all contracting Medi-Cal primary care physician (PCP) office sites. FSRs are conducted upon initial contract and then cyclically every three years or earlier as new locations are identified (such as when a PCP moves office locations). Additionally, FSRs are completed as a response to member complaints relating to any practice facility issues, regardless of practitioner specialty.

Events that initiate an investigation to conduct a site visit include, but are not limited to:

- Physical accessibility.
- Physical appearance.
- Adequacy of waiting and examining room space.

When there is an event that initiates a site investigation, a Health Net registered nurse from State Health Programs or a designee conducts a full-scope FSR using an approved California Medi-Cal Managed Care Division of Department of Health Care Services Facility Site Review Tool, which assesses the following:

- Access and safety.
- Personnel.
- Office management.
- Clinical services.
- Preventive services.
- Infection control.
- Medical record-keeping practices.
- Medical record documentation.

The FSR tool has multiple criteria and includes critical elements related to patient safety, access, medication administration, and infection control. Exempt pass is 90 percent and above, conditional pass is 80-89 percent and a fail is 79 percent and below. Corrective action plans (CAPs) are required for any deficiencies in the

critical elements and if the facility site review score is 89 percent and below. Specific time frames for the CAP must be met.

Participating providers who refuse the FSR or do not complete the CAP within a specified time frame are referred to the Health Net credentialing committee for administrative denial or termination, which applies to Medi-Cal. Sites that have complied with the CAP requirements remain in the Health Net network.

Refer to the Facility Site Review under the Quality Improvement section for more information.

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 Letter Translation Assistance for Members
- Notification Delays
- Required Elements for Member Notification Letters
- Required Elements for Provider Notification Letters
- Requirements for Notification of Utilization Management Decisions

Denial Letter Translation Assistance for Members

Provider Type: Physicians | Participating Physician Groups (PPG)

Health Net provides no-cost translation and interpretation to all Medi-Cal members who receive denial of coverage or modification of service letters from Health Net or an affiliated participating physician group (PPG). This service is available through the Access to Interpreter Services and is offered as a supplement to translation and interpretation services provided by the member's PPG.

Health Net requests that PPGs with delegated utilization management (UM) functions attach a Health Net Language Assistance Notice (PDF) , Community Health Plan of Imperial Valley (CHPIV) Language Assistance Notice (PDF) or CalViva Health Language Assistance Notice (PDF) for denial or modification notifications sent to Health Net, CHPIV and CalViva Health Medi-Cal members. Refer to the Health Industry Collaboration Effort (HICE) website at www.iceforhealth.org/home.asp for HICE-approved Notice of Action (NOA) letter templates.

When a member calls the Health Net Medi-Cal Member Services Department , Community Health Plan of Imperial Valley Member Services Department or CalViva Health Medi-Cal Member Services Department (for Fresno, Kings and Madera counties) requesting translation or interpretation services, if Health Net did not issue the letter, a Health Net Member Services representative contacts the member's PPG and requests a copy of

the denial or modification letter that was sent to the member. The PPG must submit the letter to Health Net within 48 hours in an editable format and at or below a 6th grade reading level.

Notification Delays

Participating Physician Groups (PPG) | Hospitals

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

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

Health Net or PPGs with delegated UM functions are required to notify both the provider and member in writing about the delay, either immediately on expiration of the allowed time or as soon as Health Net or the PPG with delegated UM functions becomes aware that it will not meet the time requirement, whichever comes first. The provider must also be notified initially by telephone. Refer to the Health Industry Collaboration Effort (HICE) website to obtain the ICE Notice of Action (NOA) template located under Approved ICE Documents. The notification delay letter must include the reason for the delay, specific information pertaining to the additional information or consultation being requested, and the anticipated date of the decision. Once the additional information is received, the same time limits apply.

Required Elements for Member Notification Letters

Provider Type: Participating Physician Groups (PPG) | Hospitals

Communications regarding decisions to approve requests must state the specific health care service approved. The notice of action (NOA) letters, developed by the California Department of Health Care Services (DHCS) as required by SB 59 (1999, Chapter 539), are to be used when notifying Medi-Cal managed care members of service authorization decisions. Refer to the Industry Collaboration Effort (ICE) website at www.iceforhealth.org/library.asp to view the NOA templates located under Approved ICE Documents.

Member notification letters indicating a denial, delay modification or termination of service must include:

- A clear and concise explanation of the reasons for the decision
- A description of the criteria or guidelines used, including a citation of the specific regulations or participating physician group (PPG) authorization procedures supporting the action
- The clinical reasons for the decisions regarding medical necessity

- Member rights information

PPGs may use the ICE NOA templates for provider notifications, in which case the NOAs are modified to include the name and direct telephone number of the health care professional responsible for the decision to deny, delay, modify, or terminate requested services.

Additional Requirements

Member notification letters to Medi-Cal managed care members are subject to additional requirements following the decision by the federal district court in Jackson v. Rank (E.D.Cal.1986).

In addition to the requirements stated above, member notification of deferral, denial, modification, or termination of requests for prior authorization for payment of services must inform the member of the following:

- The member's right to, and method for obtaining, a state hearing to contest the denial, deferral or modification action
- The member's right to self-representation at the state hearing, or to be represented by legal counsel, friend or other spokesperson
- The action taken by Health Net or PPG on the request for prior authorization and the reason for such action, including the underlying contractual basis or Medi-Cal authority
- Health Net's name and address of the health plan and the state toll-free telephone number for obtaining information on legal service organizations for representation

The ICE NOA template includes the required DMHC statement. Providers may also refer to the DMHC Required Statement for additional requirements.

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 | Participating Physician Groups (PPG)

Health Net and its participating physician groups (PPGs) to which utilization management (UM) functions have been delegated are required to comply with timeliness standards for UM decisions and notifications. Health Net has adopted the timeliness standards approved by the Industry Collaboration Effort (ICE) and the National Committee for Quality Assurance (NCQA).

For current standards, refer to the ICE website at www.iceforhealth.org/home.asp to locate the Approved ICE Documents for the commercial and Medi-Cal ICE UM Timeliness Standards.

Disenrollment

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

This section contains general information and procedures regarding member disenrollment requirements.

Member Disenrollment Procedure

The following document applies only to Participating Physician Groups (PPG), Hospitals, and Ancillary Providers.

A member may disenroll at any time and without cause by contacting the Health Care Options (HCO) enrollment contractor, who then issues disenrollment forms directly to the member.

Members in a mandatory aid code must simultaneously re-enroll in another health plan or the HCO enrollment contractor assigns them a health plan. Members in non-mandatory aid codes may choose a new health plan or return to the Medi-Cal fee-for-service (FFS) program.

Disenrollment of a member is mandatory when:

- Member requests disenrollment, subject to any lock-in restrictions on disenrollment under the Federal lock-in option, if applicable.
- Member’s eligibility for enrollment with the health plan is termed or eligibility for Medi-Cal has ended, including the death of the member.
- Member's enrollment violated state marketing and enrollment laws, and DHCS or member requested dis-enrollment.

- Member requests disenrollment as a result of plan merger or reorganization.
- Member moves out of the plan's approved service area.
- Member's Medi-Cal aid code changes to an aid code not covered under the health plan

Health Net continues to be responsible for the member's health care until disenrollment is approved by the Department of Health Care Services (DHCS), not the plan. The disenrollment request may take 30 days to complete.

Provider Request to Disenroll a Non-Compliant Member

To request disenrollment of a member, providers must contact the Health Net Medi-Cal Member Services Department , Community Health Plan of Imperial Valley Member Services Department or CalViva Health Medi-Cal Member Services Department (for Fresno, Kings and Madera counties). Providers are asked to describe the circumstances leading them to request the Member Non-Compliant disenrollment and may be asked to submit documentation regarding their requests.

On notification, the Health Net Medi-Cal Member Non-Compliance Unit, the Customer Service Advocate (CSA) will contact the member and provide guidance. If necessary, the CSA will reassign the member to a new primary care physician (PCP) within the plan.

A provider-initiated member non-compliant disenrollment request based on the breakdown of the provider-member relationship is considered good cause, only if one or more of the following circumstances occur:

- The member is repeatedly verbally abusive to plan providers, ancillary or administrative staff, or other plan members.
- The member physically assaults a plan provider, staff person or plan member, or threatens another person with a weapon. In this instance, the provider is expected to file a police report and bring charges against the member at the time of the incident.
- The member is disruptive to provider operations in general.
- The member habitually uses providers not affiliated with Health Net for non-emergency services without required authorizations.
- The member has allowed fraudulent use of the Health Net identification card to receive services from Health Net providers.
- The member is non-compliant with prescribed medication or treatment.
- The member has multiple missed appointments.

Provider non-compliant request is a formal written complaint from a contracted provider (PCP, PPG, Specialists, Health Care Services, other Health Net units) against a member who exhibits inappropriate behavior. The Provider is required to fax a detailed letter regarding the member non-compliance incident including specific details such as:

- Who: (Member Full Name and Cin#)
- What: (Type of non-compliance)
- When: (Dates and times)
- Where: (Did the incident take place?)

The letter must provide details of what the provider has done to manage the member's behavior such as providing the member with education, to bring them back into complying. This includes referrals to pain management, case management, mental health etc.

If the letter is not received within 30 days from the time the non-compliance incident is reported to the health plan, the case will be closed.

Formal letter and all supporting document's must be faxed or mailed to Non-Compliance Unit.

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:

- Eligibility Verification
- Children
- Share of Cost for Medi-Cal Members

Eligibility Verification

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

When a patient seeks medical attention from a participating physician group (PPG), hospital or other provider, that provider must attempt to determine eligibility before providing care. If the provider verifies eligibility according to the steps outlined below, the provider is compensated even if the patient is later determined to be ineligible. If the provider does not verify eligibility, the Plan does not accept financial responsibility for any services performed on an ineligible patient.

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

- Online: For step-by-step guidance on how to verify eligibility on the 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) or Save Time Navigating the Provider Portal – CalViva (PDF) booklet.

  Patient History provides specific member eligibility, copayments, claims status and other services. Providers may also search by dates of service to refine the search.

- Refer to the interactive voice response (IVR) system by phone, 24 hours a day, seven days a week and follow the prompts for Health Net Medi-Cal Provider Services Center, Community Health Plan

of Imperial Valley Provider Services Center or CalViva Health Provider Services Center (for Fresno, Kings and Madera counties). Select the appropriate option to verify a member's eligibility, copayments, benefits, claims status, and more.

- Via Point of Service (POS) device, Affiliate Computer Services (ACS) or claims and eligibility real-time systems (CERTS) available through the Medi-Cal eligibility website at www.medi-cal.ca.gov:
  - Providers who have access to EDS POS devices may swipe the member's Medi-Cal Beneficiary Identification Card (BIC) through the device to get information about the member's current eligibility status, health plan affiliation, and PCP name and phone number. Providers may also use ACS, an automated interactive voice response system, to verify eligibility, share of cost and other services using a touch-tone phone and PIN
    - If further information is required about the member's PCP or PPG affiliation, providers may call the Eligibility Verification Line as listed on www.medi-cal.ca.gov
  - CERTS is available online to verify eligibility for pharmacy providers
- Another option is available online through TransUnion® MedConnect website at www.meddatahealth.com/login.aspx for those providers who have an account. Providers may log in and enter the member's Plan ID number to get information about current eligibility, health plan affiliation and assigned primary care physician (PCP).
- 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 contact their vendor/clearinghouse to submit transactions via this method using an EDI transaction or clearinghouse product.

For dual special needs plan (D-SNP) member eligibility information, refer to Dual-Eligible Medicare Beneficiaries.

Children

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

Newborn Coverage

Babies born to a Medi-Cal mother are covered for the month of birth and the following month. Some newborns will have their own client index numbers (CINs) and are loaded in the system separately. Newborns who do not have separate CINs are still deemed eligible under the mother's Medi-Cal beneficiary identification card (BIC) or CIN during the month of delivery and the following month. No separate capitation is paid for the newborn during these two months.

Newborns in foster care are also eligible for shared mother/child coverage during the month of birth and the following month. Foster parents of newborns must present a photocopy of the natural mother's BIC or CIN to obtain covered services for the newborn during the month of delivery and the following month.

Share of Cost for Medi-Cal Members

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

Certain Medi-Cal members may be required to pay, or agree to pay, a monthly share of cost (SOC) toward their medical expenses before Medi-Cal becomes financially responsible. SOC is similar to a deductible. Typically, a Medi-Cal member's SOC is determined by the county welfare department and is based on the member's income in excess of maintenance need levels, which is defined as the amount of an individual's income that Medi-Cal determines is used to cover living expenses, such as food, clothing and housing. Medi-Cal rules require that members pay income in excess of their maintenance need level toward medical bills before Medi-Cal begins to pay.

Determining SOC

Providers must access the Medi-Cal eligibility verification system to determine whether a member must pay an SOC. The message returned by the eligibility system includes the SOC dollar amount the member must pay. After accessing the system via one of the following methods, the system sends a message to the provider, indicating the member's SOC:

- Point of service (POS) device.
- Automated Eligibility Verification System (AEVS), which is an interactive response system that allows providers to verify current member eligibility or for the prior 12 months, obtain information about SOC, identify any service restrictions placed on the member, and clear SOC liability.
- State-approved vendor software.
- Medi-Cal website at www.medi-cal.ca.gov.

Meeting SOC

When the provider verifies a member's eligibility and an SOC is indicated for the member, it will be under one of two scenarios, as follows:

- Met share of cost - This means the member is active with Health Net and SOC has been met. In order for a certification date to display in the Medi-Cal Eligibility Data System (MEDS), a county eligibility worker must manually add information for each member, each month. AEVS accesses the most current member information for a specific month of eligibility. After eligibility is confirmed, a 10-character eligibility verification confirmation (EVC) number is provided. Health Net recommends that providers enter the EVC in the remarks area of the claim; however, the EVC is not required for claims processing.
- Unmet share of cost - This means the member is a potential Health Net member for which SOC has not been met. These members must pay their SOC in order to be eligible for services with Health Net. Health Net designates these members as eligible when Health Net is listed as the health plan, but the SOC has not been met. The member is listed as "Cancelled Pending a Potential Enrollee."

If the member has not met SOC, no EVC number is provided unless the member is dually eligible (eligible for services under more than one aid code). For a dually eligible member who is eligible for certain services with no SOC and the remaining services with an SOC, the aid code and corresponding eligibility message and an EVC number are given in the eligibility response for the non-SOC aid code only. An SOC message is then given for the SOC aid code.

Certifying SOC

Medi-Cal does not provide payment for provider services until the member's monthly SOC has been certified online. Certifying SOC means that the Medi-Cal eligibility verification system shows the member has paid or become obligated (as defined in the Obligating Payment section below) for the entire monthly dollar SOC amount owed.

Clearing SOC

When a member has fulfilled his or her SOC, the provider must access the Medi-Cal eligibility verification system and enter his or her provider number, provider identification number (PIN), member identification number, member identification card (BIC) issue date, billing code, and service charge. This clears the member's SOC responsibility. SOC information is updated, and a response is displayed on the screen or relayed over the telephone.

Several clearance transactions may be required to fully certify SOC. In other words, providers must continue to clear SOC until it is completely certified. Clearing SOC is also referred to as "spending down" the SOC. Providers must perform an SOC clearance transaction immediately upon receiving payment or accepting obligation from the member for services rendered. Delays in performing the SOC clearance transaction may prevent the member from receiving other medically necessary services.

Providers should submit only one SOC clearance transaction for each rendered service used to clear the member's SOC, even if a payment plan is used to meet the obligation. All medically necessary health services, including medical services, supplies, devices and prescription medications, whether Medi-Cal covered or not, can be used to meet SOC for Medi-Cal and County Medical Services Program (CMSP) purposes.

Autocertification of SOC

In some cases, such as with long-term care (LTC) services, auto-certification can occur and a certification date will not be displayed for SOC members in MEDS. The auto-certification process works when the Statewide Automated Welfare Systems (SAWS) sends a transaction to MEDS that allows the SOC to be automatically certified each month and leaves it up to the facility to collect the SOC. This allows the member to be enrolled in the health plan.

When a provider checks eligibility and receives an EVC for services, this is an indication that the SOC has been met. If the member has not met the SOC, MEDS will show a health care plan (HCP) status code of 55 with eligibility verification requiring SOC spend down.

Although there may be no certification date for a member, they are still managed care- or plan-eligible regardless of if the member has met their SOC.

Obligating Payment

Providers may collect SOC payments from members on the date that services are rendered, or providers may allow a member to obligate payment for rendered services. Obligating payment means the provider allows the member to pay for the services at a later date or through a payment plan. The provider must use obligated payments to clear SOC. SOC obligation agreements are between the member and the provider and should be in writing and signed by both parties for protection. There is no reimbursement for SOC payments obligated but not paid by the member.

Frequently Asked Questions

Q: Is it an error that members are being enrolled into Health Net when their SOC has not been met yet?

A: No, it's not an error that members are being enrolled into Health Net when their SOC has not been met yet. Members are determined to be eligible for enrollment into the plan. Eligibility is activated in the plan whenever the member's SOC has been satisfied. These members have a status code of 55, which states that they are eligible for Medi-Cal through the plan but must first satisfy their SOC.

Q: Is there a process in which members can be enrolled in Health Net before they have fully met their SOC and pay their SOC amount directly to the managed care plan?

A: Yes, there is a process by which members are enrolled in Health Net before they have fully met their SOC, and this process is performed on a county level. The SOC is never directly paid to the managed care plan; the SOC is always paid at the location where the member receives his or her services. The provider will report to the plan that the member's SOC has been satisfied, which triggers activation of eligibility for that month. At that point, the plan will begin paying for medical services incurred.

Q: If a member shows an active enrollment and an SOC that has not been certified, why is the member showing an HCP Stat 01 (enrolled in plan) instead of a 55 hold?

A: This could be an indication of an LTC member, in which the eligibility has been automatically certified on the first of the month, and has been coded correctly in MEDS (eligibility status beginning with a 1 or 2). The screen displays correct eligibility, and the member should have no issues receiving medical services. With most LTC members, their SOC gets certified on the first of the month when their bill gets paid. Even though the provider inquiry screen displays "LTC SOC/Spend down," an EVC number is provided, which is an indication that the SOC has already been certified and a billing number is provided to bill Medi-Cal eligible services.

Q: When a member is in LTC, does the system automatically certify the SOC or is it the facilities' responsibility?

A: SOC is certified differently for LTC members with specific aid codes. The system will automatically certify the SOC, in some cases. LTC facilities may be required to perform SOC clearance transactions when a recipient with an unmet SOC is admitted, or when a recipient's SOC exceeds the total charges of the Medi-Cal rate for a given month's stay. Providers receiving an eligibility verification that indicates a member has an LTC SOC

should not clear the SOC online; the member is automatically eligible as of the first of the month. The facility does not need to clear the SOC first but can bill the member for the SOC amount.

For more information about using the Medi-Cal website, access the Quick Start Guide on the Medi-Cal website at www.medi-cal.ca.gov/pubs/quickstart.htm.

Eligibility Reports

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

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

Select any subject below:

- Eligibility Reports
- Molina Healthcare Eligibility Reports

Eligibility Reports

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

Eligibility Reports provide information about member assignment to participating physician groups (PPGs) and hospitals (when applicable) for members enrolled in all lines of business.

Health Net generates Eligibility Reports twice a month, on approximately the first and the fifteenth. Reports generated at the beginning of the month reflect member eligibility as of the first of the month. Reports generated mid-month include any retroactive member eligibility to date.

Other health coverage information

Medi-Cal managed care plans (MCPs) are required to be the payer of last resort for services when a member has other health care coverage (OHC). PPGs can access the necessary OHC information on PPGs Capitation Eligibility Report ACE_RPT_BRM_42P SEQ. The reports will help PPGs to correctly identify OHC and avoid unnecessary costs.

Do not process claims for a member whose Medi-Cal eligibility report indicates OHC, other than an OHC code of A or N, unless the provider presents proof that all sources of payment have been exhausted, or the provided service meets the requirement for billing Medi-Cal directly.

To obtain OHC activity, refer to the report sections below:

- **Detail Record**: Provides member information.
- **COB Record**: Provides OHC demographic information.

When a claim is denied due to the presence of OHC, the minimum OHC information in your notifications to providers must include, but is not limited to:

- The name of the OHC provider (COB Carrier Name on the eligibility report).
- Contact or billing information.

120-day initial health appointment report

Health Net also generates the following report to help Medi-Cal providers keep track of members who need Department of Health Care Service (DHCS)-required examinations:

- 120-Day Initial Health Appointment Report - Lists members who have not had an initial health appointment (IHA) according to Health Net encounter data. Unlike eligibility reports, the 120-Day IHA report includes the number of days the member has been enrolled in Health Net's Medi-Cal plan and the member's age.

Report layout

Additional information on eligibility report field descriptions is available as follows:

- Sample 120-Day Initial Health Appointment Report (PDF)
- Sample Medi-Cal Eligibility Report Field Descriptions - Report key (PDF). Frequently Asked Questions (PDF)
- Sample Eligibility Report ACE_RPT_BRM_42P SEQ (PDF)

Electronic Eligibility File 227

Health Net sends the Medi-Cal electronic eligibility file (277 byte format (PDF)) to capitated participating physician groups (PPG), capitated hospitals and some direct network physicians. It lists assigned members eligible for the reporting month, terminated members and members' eligibility effective dates with their affiliated primary care physicians (PCPs).

Terminated members appear on the report during the month of termination and the following month. Members who were assigned to and terminated from a PPG during the same month (due to events such as retroactive PCP change or inappropriate assignment) display the same date for the Effective Date and Termination Date fields.

The file also displays the member's Medi-Cal redetermination date for use in identifying members who are nearing the date of Department of Health Care Services (DHCS) redetermination of their eligibility for Medi-Cal benefits and may need to reapply.

Molina Healthcare Eligibility Reports

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

The following information is applicable to Los Angeles County only.

Molina Healthcare distributes eligibility reports monthly to provide information on member enrollment in a participating physician group (PPG). Molina generates its Eligibility Listing: Staff Model Roster report the first week of each month and mails it to PPGs.

Molina members who have changed providers by the 25th of a month are on the next month's eligibility listing. Members who have changed providers after the 25th of a month are on the month following the next month's eligibility listing.

If a member arrives at a primary care physician's (PCP's) office to receive care and does not appear on the current month's eligibility listing, the provider should contact the Molina Healthcare Provider Services and Inquiry Unit.

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:

- Coverage Explanation
- Additional Monitoring Responsibilities
- Hospital Request for Authorization to Provide Post-Stabilization Services
- Out-of-Area Emergency or Urgently Needed Care
- PPG Responsibilities
- Procedures to Report System & Protocol Failures

Coverage Explanation

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

Emergency and urgent care services are covered anywhere in the United States, including the United States Territories. Emergency, urgent, or any other health care services provided outside of the United States are not covered, except for emergency care requiring hospitalization in Canada and Mexico.

Members could be referred to seek medical support by reaching Health Net's 24 hours Nurse advice line (N24) to speak with a nurse. Providers may contact the Medi-Cal Provider Services Department, Community Health Plan of Imperial Valley Provider Services Center or CalViva Health Medi-Cal Provider Services Center (for Fresno, Kings and Madera counties) with questions.

If a medical emergency occurs, members should be directed to the nearest emergency room for care or call 911. Members are encouraged to use the 911 emergency response system as appropriate. Members should notify their primary care physician (PCP) as soon as possible. Emergency services are available 24 hours a day, 7 days a week.

If a member goes to the emergency room and the doctor or nurse tells the member to contact his or her PCP because the member do not need emergency care, he or she should call his or her doctor immediately for direction.

Emergency Department Medical Screening Exam

A medical screening exam (MSE) is an initial assessment of a member to determine whether an emergency condition exists and whether the member should be treated in the emergency department or may be safely treated at another level of care. Hospital emergency departments are required to evaluate all members seeking care. An MSE performed by a physician, nurse practitioner (NP), registered nurse (RN), or physician assistant (PA) in an emergency department does not require prior authorization regardless of the outcome.

Physicians Authority for Discharge

All members are discharged from an emergency facility only on the order of a treating physician.

Timely Follow-Up Care

If the medical staff at the hospital emergency department determines that an emergency exists, they must render medical treatment until the condition is stabilized. Then, the hospital must receive authorization for further care through the PCP or on-call designee.

If the medical staff at the hospital emergency department determines that the condition is not an emergency, the member is responsible for arranging follow-up care with the PCP. Members are ordinarily given written instructions in the emergency department that state whether follow-up care is needed and, if so, how soon they need to be seen by their PCP. A sample instruction letter, Medi-Cal Member Instructions for Post-Emergency Care (PDF), is available for use. Emergency departments should also contact the member's PCP to arrange for follow-up care; particularly in circumstances where there are active or ongoing care needs or care coordination issues. PCPs must provide timely follow-up care to members when emergency care is deemed not necessary in an emergency department after a Medical Screening Examination (MSE) or if follow-up care is indicated after treatment in the emergency department. PCPs should see members within the time frame suggested by the hospital emergency department instructions.

After-Care Instructions

Emergency departments are responsible for providing written post-emergency care instructions to all members seen in an emergency room. Refer to the Emergency Department MSE discussion above for the most current information about post-emergency care instructions and timely follow-up care.

Refer to definition of an emergency for more information.

Medical Emergency in Primary Care Facility

If a medical emergency occurs anywhere in the primary care facility, a physician should be summoned immediately by calling "code blue in room X." (or other designated terminology)

The physician who arrives first determines the need for basic life support or emergency medical services (EMS). Dial 911 if EMS is required. If a physician is not readily available, the highest-ranking medical staff should determine the need for cardiopulmonary resuscitation (CPR) and EMS.

Mid-level practitioners (physician assistants (PAs) and nurse practitioners (NPs)) are not permitted to administer advanced cardiac life support techniques, whether alone or under the supervision of a physician. They may, however, administer basic life-support (BLS) and perform the following:

- Start IV with solution of normal saline
- Administer oxygen
- Insert airway

The following basic emergency medical supplies and equipment must be available in all facilities:

- Benadryl 50 mg/ml
- Adrenaline 1:1,000/cc
- Nitrostat 1/150 gr. (0.4 mg)
- Solu-Medrol 40 mg/1 cc Mix-o-Vial
- Airways - three sizes (small, medium and large)
- Pediatric and adult Ambu bag

Emergency Transportation

If a member in a facility has a medical emergency requiring hospitalization, the attending physician must arrange ambulance transportation by a licensed ambulance company to the nearest emergency room.

If there is no contracting emergency transportation service and emergency transportation is needed, dial 911 or other local emergency number to obtain ambulance service. The receiving hospital calls for authorization when the member arrives.

Notification Requirements

Emergency departments must notify the member's primary care physician (PCP) whenever a member requires an emergency room visit. If an emergency care visit results in the member being admitted to the facility, the emergency department is required to notify Health Net's hospital notification department within 24 hours or the next business day. If the PPG is fully capitated for inpatient care and the notification is received by Health Net, it will be referred to the appropriate PPG for authorization.

For Los Angeles County only: Molina Healthcare is Health Net's subcontracting health plan for the Medi-Cal managed care program in Los Angeles County. Notification, for a member assigned to Molina Healthcare and regarding an emergency care visit resulting in the member being admitted to the facility, may be given by telephone or by faxing a copy of the face sheet toMolina Healthcare. Notification to Health Net is not required.

Additional Monitoring Responsibilities

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

When a participating primary care physician (PCP) is contacted by an out-of-area provider to determine benefit coverage for a Health Net member, the participating PCP must:

- Verify that the member has Health Net coverage.
- Verify that the member receives health care services from the PCP.
- Inform the out-of-area provider that Health Net only covers out-of-area emergency admissions (less any applicable copayments or deductibles).
- Provide any follow-up care or obtain out-of-area authorization from Health Net.

The out-of-area provider or PCP is responsible for notifying the Hospital Notification Unit of all out-of-area emergency hospitalizations. The Medical Management Department monitors the out-of-area emergency hospital care, conducts concurrent review and determines whether the member can be transferred safely into the service area.

Claims are retrospectively reviewed to determine medical necessity and eligibility for payment of out-of-area services.

Hospital Request for Authorization to Provide Post-Stabilization Services

Participating Physician Groups (PPG)

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

A PPG in a dual-risk relationship with a hospital is responsible for complete utilization management (UM) for members to which the dual-risk relationship applies. Such UM includes confirming eligibility, issuing authorizations or tracking numbers, and arranging for member transfers or discharges, as appropriate. A PPG participating in a dual risk relationship should notify Health Net of any member admissions to non-participating hospitals. Notification to Health Net must be done immediately for the Plan to abide by the regulatory requirements of having a response within 30 minutes of the initial request.

Health Net calls the hospital back with the information necessary to initiate transfer of the member or provide an authorization for post-stabilization care. For hospitals in California, pursuant to enactment of Assembly Bill 1203 (2008), which amended Health and Safety Code section 1262.8 (b)(3), after the emergency condition of the patient has been stabilized, a non-participating hospital is required to provide Health Net with the identity of

the treating physician and surgeon's diagnosis and relevant medical information reasonably necessary for Health Net to coordinate with the PPG to assume management of the member's care by arranging for transfer of the member, or to provide authorization for medical necessity post-stabilization care.

Under Health and Safety Code section 1317.1(j) a patient is "stabilized" or "stabilization" has occurred when, in the opinion of the treating provider, the patient's medical condition is such that, within reasonable medical probability, no material deterioration of the patient's condition is likely to result from, or occur during, the release or transfer of the patient. For hospitals outside of California, post-stabilization services are not subject to authorization as it is included in ER services pursuant to the No Surprises Act.

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

Out-of-Area Emergency or Urgently Needed Care

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

For information on out-of-area emergency or urgently needed care, refer to the Emergency Services, Coverage Explanation section.

PPG Responsibilities

Participating Physician Groups (PPG)

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

Select any subject below:

- Notification of Admission
- Emergency Room Closures

Notification of Admission

Provider Type: Participating Physician Groups (PPG)

The treating emergency department of a participating hospital is required to complete and send the hospital face sheet to Health Net's Hospital Notification Department for hospital admissions. The participating physician

group (PPG) is required to notify the Health Net Medical Management Department and supply the PPG authorization number if treatment has been authorized.

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

24-Hour Access

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

Emergency Room Closures

Participating Physician Groups (PPG)

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

Procedures to Report System & Protocol Failures

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

Emergency department provider will contact Medi-Cal Provider Services Center, Community Health Plan of Imperial Valley Provider Services Center or CalViva Health Medi-Cal Provider Services Center (for Fresno, Kings and Madera counties) if they experienced a failure in utilizing the Health Plan's systems and/or emergency services protocols. Health Plan will work with Provider to ensure any corrective action is implemented to resolve the issue.

Encounters

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

This section contains general information about encounter data submission.

Select any subject below:

Overview

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

To comply with the requirements of the Department of Health and Human Services (DHHS), the Centers for Medicare & Medicaid Services (CMS), the California Department of Health Care Services (DHCS), the California Disproportionate Share Hospital (DSH) Program, the Managed Risk Medical Insurance Board (MRMIB), and the National Committee for Quality Assurance (NCQA), Health Net requires information from its providers on members' use of health services.

Capitated participating physician groups (PPGs), hospitals and ancillary providers are required to provide complete encounter data about professional services rendered to Health Net members. These services include office visits; X-rays; laboratory tests; surgical procedures; anesthesia; physician visits to the hospital; inpatient, outpatient, emergency room, out-of-area, or skilled nursing facility (SNF) services; and all professional referral services. Capitated participating facilities (and physician groups with dual-risk contracts) are required to provide encounter data no less than monthly about institutionally-based services rendered to Health Net members.

Encounter data submissions must include all member-paid cost-share amounts, such as copayments, coinsurance and deductibles, applicable to the member's benefit. In addition, any rejected encounter data must be corrected and resubmitted in order for complete information and correct member-paid cost-share amounts to be captured and accumulated. Encounter data submission is also an integral part of the Health Net Quality of Care Improvement Program (QCIP) (applicable only for HMO and Point of Service (POS) products) and Healthcare Effectiveness Data and Information Set (HEDIS®). Refer to the Quality Improvement (QI) topic for more information about QCIP.

Dual-Risk Contracts Encounter Data Submission

Participating Physician Groups (PPG) | Hospitals

Participating physician groups (PPGs) who are contracting for dual risk are responsible for submitting encounter data to Health Net monthly for all professional and hospital services in a complete, accurate and

timely manner. Health Net requires PPGs to submit their encounter data according to the terms of the Provider Participation Agreement (PPA).

The following applies to Medicare dual-risk contracts:

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

Inpatient Admissions

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

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

Error Notification

Participating Physician Groups (PPG) | Ancillary | Hospitals

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

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

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

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

Noncompliance with Encounter Data Submission

Participating Physician Groups (PPG) | Ancillary | Hospitals

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

Professional and Institutional Capitated Encounter Submission Requirements

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

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

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

Capitated providers are contractually required to submit complete and correct data for all professional and institutional services performed. Before submitting encounter data, the submitter should contact the Health Net Encounter Department to discuss submission format and data requirements. Health Net currently accepts the ANSI 837 5010 X12 format.

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

Enrollment

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

This section contains general information and procedures regarding member enrollment.

Select any subject below:

Member Enrollment

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

The Department of Health Care Services (DHCS) established the Health Care Options (HCO) referral process to provide Medi-Cal beneficiaries with information on the benefits of receiving health care services through managed care plans and to help the beneficiary choose a managed care plan. The HCO enrollment contractor is also responsible for assigning beneficiaries who fail to choose a health plan on the Medi-Cal Choice form.

Beneficiaries who have questions regarding the enrollment process can be referred to the HCO enrollment contractor.

Initial Eligibility or Annual Redetermination

The HCO enrollment contractor sends an enrollment packet to all Medi-Cal beneficiaries who do not make a choice at an HCO enrollment contractor presentation. The enrollment packet contains provider directories, a health plan comparison chart, enrollment instructions, Medi-Cal Choice form, and Medi-Cal Choice booklet.

Medi-Cal Choice Form for Enrollment

The beneficiary must select a health plan in his or her designated county and complete and mail back the Medi-Cal Choice form to the HCO enrollment contractor within 30 days of receiving the Medi-Cal Choice form from the HCO enrollment contractor. If the beneficiary does not select a health plan, the HCO enrollment contractor assigns one based on DHCS criteria.

Health plans and affiliated physicians may not submit Medi-Cal Choice forms on behalf of Medi-Cal beneficiaries. The HCO enrollment contractor mails enrollment forms directly to Medi-Cal beneficiaries.

Auto Assignments

The HCO enrollment contractor notifies the applicant or beneficiary in writing of the assignment to a Medi-Cal health plan at least 10 business days prior to submitting the documents to the DHCS. If the assignment is not appropriate, or if the beneficiary wishes to enroll in a different Medi-Cal health plan, the beneficiary must contact the HCO enrollment contractor to enroll in another Medi-Cal health plan. If a beneficiary chooses a health plan but neglects to choose a primary care physician (PCP), the health plan automatically assigns a PCP. Refer to the Primary Care Physician Selection and Assignment discussion under the Member Rights and Responsibilities topic for additional information.

Member Information Mailed

A packet containing provider directories, a health plan comparison chart, enrollment instructions, Medi-Cal Choice form, and Medi-Cal Choice booklet is mailed to new members by the state's enrollment contractor.

New Member Files

Health Net receives an enrollment tape from the HCO enrollment contractor and a Medi-Cal Eligibility Data System (MEDS) tape from DHCS. The HCO enrollment contractor data is uploaded into Health Net's computer system to create a new member record, and the MEDS tape is run against the new member record to update eligibility. This process creates a new member file for the purpose of producing identification cards.

Identification Card and Member Material Distribution

Health Net sends new members a welcome letter and packet, which includes the Evidence of Coverage (EOC), provider directory, preventive care services, and other important plan information. The materials are in the language preference indicated by the member. The ID cards and the new member packets are mailed within seven days of the member's effective date of enrollment.

Member Identification Number

Health Net has adopted the Client Index Numbers (CINs), issued by the Department of Health Care Services (DHCS), as the identification (ID) numbers for all Health Net Medi-Cal managed care members. The CIN is formatted as an alphanumeric code, beginning with eight digits followed by a letter at the end.

In compliance with California law (SB 168 (ch. 720, 2001)), the CIN replaces the member's Social Security number (SSN) as the member ID number 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 member's CIN and SSN for identification purposes. Health Net also continues to use SSNs for internal verification and administrative purposes as allowed by law

Use of Social Security Numbers

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

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

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

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

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

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

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

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

Participating providers are subject to the same regulations.

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

ID Cards

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

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

Select any subject below:

- Member ID Card

Member ID Card

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

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

- A new member enrolls
- A member changes his or her name, physician or participating physician group (PPG)
- The medical plan changes at renewal and the copayment changes

Refer to the samples to view a picture and descriptions of the fields on the:

- Identification card (Medi-Cal mainstream) (PDF)
- Identification card (Medi-Cal CalViva Health) (PDF)
- Identification card (Medi-Cal Community Health Plan of Imperial Valley) (PDF)
- Identification card (Medi-Cal Molina Healthcare) (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

The following applies to these counties: Kern, Los Angeles, Riverside, Sacramento, San Bernardino, San Diego, San Joaquin, Stanislaus, Tulare.

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)

The following applies to these counties: Fresno, Kings, Madera.

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
- Medi-Cal and Cal MediConnect Medical Records Reviews
- Medical Record Documentation

Confidentiality of Medical Records

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

Members are entitled to confidential treatment of member communications and records. Case discussion, consultation, examination, claims and treatment are confidential and must be conducted discreetly. A provider shall permit a patient to request, and shall accommodate requests for, confidential communication in the form and format requested by the patient, if it is readily producible in the requested form and format, or at alternative locations. The confidential communication request shall apply to all communications that disclose medical information or provider name and address related to receipt of medical services by the individual requesting the confidential communication. Written authorization from the member or authorized legal representative must be obtained before medical records are released to anyone not directly concerned with the member's care, except as permitted or as necessary for administration by the health plan.

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

Provider agrees that all health information, including that related to patient conditions, medical utilization and pharmacy utilization, available through the portal or any other means, will be used exclusively for patient care and other related purposes as permitted by the HIPAA Privacy Rule.

PHI is considered confidential and encompasses any individual health information, including demographic information collected from a member, which is created or received by Health Net and relates to the past, present or future physical, mental health or condition of a member; the provision of health care to a member; or the past, present or future payment for the provision of health care to a member; and that identifies the member or there is a reasonable basis to believe the information may be used to identify the member. Particular care must be taken, as confidential PHI may be disclosed intentionally or unintentionally through many means, such as conversation, computer screen data, faxes, or forms. Disclosure of PHI must have prior, written member authorization.

Confidentiality of Medical Information

Sensitive services are defined as all health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, and includes services described in Sections 6924-6930 of the Family Code, and Sections 121020 and 124260 of the California Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the services.

Assembly Bill 1184 (2021), amends the Confidentiality of Medical Information Act to require health care plans to take additional steps to protect the confidentiality of a subscriber's or enrollee's medical information regardless of whether there is a situation involving sensitive services or a situation in which disclosure would endanger the individual.

These steps include:

- A protected individual (member) is not required to obtain the primary subscriber or other enrollee's authorization to receive sensitive services or to submit a claim for sensitive services if the member has the right to consent to care.
- Not disclose a member's medical information related to sensitive health care services to the primary subscriber or other enrollees, unless the member's authorization is present.
- Notify the subscriber and enrollees that they may request confidential communications and how to make the request. This information must be provided to "enrollees" at initial enrollment and annually.
- Respond to confidential communications requests within:
  - 7 calendar days of receipt via electronic or phone request or
  - 14 calendar days of receipt by first-class mail
- Communications (written, verbal or electronic) regarding a member's receipt of sensitive services should be directed to the member's designated mailing address, email address, or phone number. For protected individuals who may not have designated an alternative mailing address, the provider and/or Plan is required to send the communications to the address or phone number on file in the name of the protected individual.
- Confidential communication includes:
  - Bills and attempts to collect payment.
  - A notice of adverse benefits determinations.
  - An explanation of benefits notice.
  - A plan's request for additional information regarding a claim.
  - A notice of a contested claim.
  - The name and address of a provider, description of services provided, and other information related to a visit.
  - Any written, oral, or electronic communication from a plan that contains protected health information.

Agencies Must Be Authorized To Receive Medical Records

The relationship and communication between a participating provider and member is privileged and the medical records containing information about the relationship is confidential. The participating provider's code of ethics, as well as California and federal law, protect against the disclosure of the contents of medical records and protected health information (PHI), whether written, oral or electronic, to individuals or agencies that are not properly authorized to receive such information.

Requirements for a Valid Authorization for Release of Information

Providers must obtain signed authorization from the member to use or disclose the member’s medical information. You also need to give instructions to members on how to access additional copies or digital versions of the signed authorization. The signed authorization must:

- Be written in plain language and no smaller than 14-point font.
- Be dated and signed with an electronic or handwritten signature by the member or person authorized to act on behalf of member.

- Specify the type of individuals authorized to disclose information about the member.
- Specify the nature of the information authorized to be disclosed.
- State the name or functions of the persons or entities authorized to receive the information.
- Specify the purposes for which the information is collected.
- Specify the length of time the authorization shall remain valid.
- State an expiration date or event. The expiration date for a valid signature is up to one year unless the person signing the authorization requests a specific date beyond a year, or the authorization is related to an approved clinical trial1 after which the provider, health care service plan, pharmaceutical company, or contractor is no longer authorized to disclose the medical information.

Real Time Data Exchange of Health Information

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

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

Exceptions

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

- Physician practices of fewer than 25 physicians, rehabilitation hospitals, long-term acute care hospitals, acute psychiatric hospitals, critical access hospitals, and rural general acute care hospitals with fewer than 100 acute care beds, state-run acute psychiatric hospitals, and any nonprofit clinic with fewer than 10 health care providers until January 31, 2026.
- Abortion and abortion-related services.

Basic Principles

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

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

- Needed for payment
- Necessary for treatment or coordination of care

- Used for health care operations (including, but not limited to, Healthcare Effectiveness Data and Information Set (HEDIS®) reporting, appeals and grievances, utilization management, quality improvement, and disease or care management programs)
- Where permitted or required by law

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

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

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

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

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

Procedure

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

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

Release of medical information guidelines must address:

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

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

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

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

Medical Record Documentation

Provider Type: Physicians | 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
- Medi-Cal 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.

Medi-Cal Medical Record Documentation Standards

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

Medi-Cal providers are required to meet both Health Net and the Department of Health Care Services (DHCS) Medi-Cal medical record documentation standards. The following documentation guidelines are excerpts, but not limited to only these criteria and must be followed and all of the elements must be included in the medical records of Medi-Cal 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). If a primary language other than English is noted and forms in the member’s medical record are in another language, there must be an English version of that form in that member’s medical record also.
- The refusal or request of interpreter services by an LEP-speaking health plan member must be documented in the medical record. Providers are required to document in the medical record the refusal of qualified interpreter services and the preference of a health plan member to use an adult family member or friend as an interpreter.
- Documentation - Medical record entries and corrections must be documented in accordance with acceptable legal medical documentation standards; allergies and reactions, chronic problems, and ongoing and continuous medications must be documented in a consistent and prominent location; all signed consent forms and the ofference of advanced health care directive information and education to members 18 and older must be included and reviewed every 5 years.
    - Telephone advice - notation of the date of the call, time, details of the conversation, and signature and title of the staff member handling the call.
    - Urgent and emergency documentation - notation of the date, time, means of arrival, history of illness or accident, physical findings, diagnostic tests, treatment received, diagnostic impression, and discharge summaries.
- 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 - All new Medi-Cal members must receive an Initial Health Appointment (IHA), which includes an age-appropriate history and physical examination within 120 days of enrollment. This includes risk assessments such as Adverse Childhood Experiences (ACEs), Social Determinants of Health (SDOH) with 120 days of enrollment and yearly thereafter.
    - Members may be seen initially during a visit for episodic care. Regardless of the reason for the initial visit, the PCP or other provider within the primary care setting, should conduct the IHA at the first health care contact and document the assessment in the medical record.
- Adult preventive care and anticipatory guidance, according to the United States Preventive Services Task Force (USPSTF) - Notation of periodic health evaluations, assessment of immunization status, vaccine administration documentation and vaccine information status publication date, 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, colon CA screening, obesity, diabetes, osteoporosis, Hep B & C, HIV, sexually transmitted infections (STI), alcohol/drug/tobacco and intimate partner violence screening.

- Pediatric preventive care and anticipatory guidance, according to the AAP - Notation of age-appropriate physical exams; 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, depression, suicide risk, sudden cardiac arrest and sudden cardiac death, STI, alcohol/drug/tobacco screening.
- DHCS requires providers to document each member's need for Advisory Committee on Immunization Practices (ACIP)-recommended immunizations as part of all regular health visits and to report the administration of immunizations within 14 days.
    - Providers must enroll in and use the California Immunization Registry (CAIR) website at CAIRweb.org to report and track patient immunization records online.
- 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; initial and subsequent comprehensive prenatal assessments (ICA) and trimester reassessments; postpartum visit four to six weeks after delivery - this interval may be modified according to the needs of the member, such as HEDIS timelines of 21-56 days after delivery; individualized care plan (ICP); domestic violence and abuse screenings; human immunodeficiency virus (HIV), alpha fetoprotein (AFP), and genetic screenings; Women, Infants, and Children (WIC) referrals; and assessments of infant feeding status, maternal depression, psycho social, family planning.

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.

Medi-Cal Medical Records Reviews

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

Health Net's Facility Site Review (FSR) Compliance Department conducts periodic medical record reviews (MRRs) to measure provider compliance with current Department of Health Care Services (DHCS) medical record documentation standards.

The Health Net FSR Compliance Department continually develops and offers materials to simplify the documentation process. Refer to Facility Site Review to obtain materials about legal and regulatory requirements on providers' responsibilities, such as:

- The Facility Site Review Tool.
- The Facility Site Review Standards.
- The Medical Record Review Tool
- The Medical Record review Standards

These materials and other items are available assist providers in understanding and complying with the required documentation standards.

Medical Record Review Scheduling, Frequency, Scoring, and Compliance

Health Net and all other managed care health plans are required to collaborate in conducting medical record reviews (MRRs). On a county-by-county basis, the plans cooperatively determine which plan is responsible for performing a single audit of a primary care physician (PCP) site. When needed, the plan administers a corrective action plan (CAP). The collaborative effort serves to reduce the frequency of audits of the PCP's office by eliminating unnecessary duplication by multiple plans. Health Net's State Health Programs Quality Improvement Department is responsible for conducting collaborative reviews on behalf of Health Net.

Representatives from the responsible plan contact the provider office prior to the MRR to discuss audit policies and procedures. A packet containing documentation materials is sent to the provider prior to the site review to enable the office to prepare for the audit. Copies of the MRR tool and related regulatory requirements are available at The Department of Health Care Services (PDF).

The responsible plan shares the audit results and CAP with the other participating health plans. DHCS reviews the results of MRRs and may audit a random sample of provider offices to ensure they meet DHCS standards.

MRRs of new providers are conducted within 90 calendar days from the date members are first assigned to the provider. An extension of an additional 90 calendar days may be granted if the provider has fewer than 10 assigned members.

Written results are provided to the provider at the close of the audit by the health plan. A passing score for the MRR is 90%. Providers receiving scores between 80 and 89% (considered a conditional pass) on an MRR audit are required to complete a corrective action plan (CAP). Providers may be re-reviewed in 12 months, or sooner, if deemed appropriate, to assess compliance with the CAP.

For an initial medical record review (MRR), new members are not assigned to a PCP who receives a non-passing score (below 80%) until all corrections are verified and the CAP is closed. Providers who do not comply with the CAP within the established time frames are removed from the network.

After the initial audit, participating providers are re-audited at least every three years. A full-scope site audit, which includes both the MRR and Facility Site Review (FSR), is conducted at this time. Providers must receive a conditional passing score of at least 80% on both reviews. Medical record review audit results are shared among Medi-Cal managed care plan. Sites receiving a non-passing score from one plan are considered to have a non-passing score by all other Medi-Cal managed care plan.

Practitioners who do not comply with a CAP or fail to achieve threshold in three consecutive audit are forwarded to Health Net's Credentialing Committee for administrative termination. The termination is applicable

to the Medi-Cal contracting line of business and practice locations and remains in effect for three years from the date of the committee's final decision.

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:

- Overview
- Advance Directives
- Member Confidentiality
- PCP Selection and Assignment

Overview

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. These member rights and responsibilities apply to members' relationships with Health Net, and all participating providers responsible for member care.

Health Net members are notified of their rights and responsibilities via the annual member mailing and the Evidence of Coverage (EOC). The following text is taken directly from the Health Net Medi-Cal member's handbook.[1]

All counties excluding CalViva Health (Fresno, Kings and Madera)

Health Net members have these responsibilities:

- **Act courteously and respectfully.** You are responsible for treating your doctor and all providers and staff with courtesy and respect. You are responsible for being on time for your visits or calling your doctor's office at least 24 hours before the visit to cancel or reschedule.
- **Give up-to-date, accurate and complete information.** You are responsible for giving correct information and as much information as you can to all of your providers, and to Health Net. You are responsible for getting regular check-ups and telling your doctor about health problems before they become serious.

- **Follow your doctor's advice and take part in your care.** You are responsible for talking over your health care needs with your doctor, developing and agreeing on goals, doing your best to understand your health problems, and following the treatment plans and instructions you both agree on.
- **Use the emergency room only in an emergency.** You are responsible for using the emergency room in cases of an emergency or as directed by your doctor. Emergency care is a service that you reasonably believe is necessary to stop or relieve sudden serious illnesses or symptoms, and injury or conditions requiring immediate diagnosis and treatment.
- **Report wrong-doing.** You are responsible for reporting health care fraud or wrong-doing to Health Net Community Solutions. You can do this without giving your name by calling Health Net Fraud and Abuse Hotline toll-free at 866-685-8664.The Fraud Hotline operates 24 hours a day, seven days a week. All calls are strictly confidential.

Health Net members have these rights:

- To be treated with respect and dignity, giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information such as medical history, mental and physical condition or treatment, and reproductive or sexual health.
- To be provided with information about the plan and its services, including covered services, practitioners, and member rights and responsibilities.
- To receive fully translated written member information in your preferred language, including all grievance and appeals notices.
- To make recommendations about Health Net's member rights and responsibilities policy.
- To be able to choose a primary care provider within Health Net's network.
- To have timely access to network providers.
- To participate in decision making with providers regarding your own health care, including the right to refuse treatment.
- To voice grievances, either verbally or in writing, about the organization or the care you got.
- To know the medical reason for Health Net's decision to deny, delay, terminate or change a request for medical care.
- To get care coordination.
- To ask for an appeal of decisions to deny, defer or limit services or benefits.
- To get no-cost interpreting services for your language.
- To get no-cost legal help at your local legal aid office or other groups.
- To formulate advance directives.
- To ask for a State Hearing if a service or benefit is denied and you have already filed an appeal with Health Net and are still not happy with the decision, or if you did not get a decision on your appeal after 30 days, including information on the circumstances under which as expedited hearing is possible.
- To disenroll from Health Net and change to another health plan in the county upon request.
- To access minor consent services.
- To get no-cost written member information in other formats (including braille, large-size print, audio format and accessible electronic formats) upon request and in a timely fashion appropriate for the format being requested and in accordance with Welfare & Institutions Code Section 14182 (b)(12).
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- To truthfully discuss information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand, regardless of cost or coverage.
- To have access to and get a copy of your medical records, and request that they be amended or corrected, as specified in 45 Code of Federal Regulations (CFR) §164.524 and 164.526.

- Freedom to exercise these rights without adversely affecting how you are treated by Health Net, your providers or the State.
- To have access to family planning services, Freestanding Birth Centers, Federally Qualified Health Centers, Indian Health Clinics, midwifery services, Rural Health Centers, sexually transmitted infection services and emergency services outside Health Net's network pursuant to the federal law.
- To request Appeal of a denied claim up to 60 days from the date on the notice you receive. This notice is called the “Notice of Adverse Benefit Determination (NABD).” The Appeal process is through the State Fair Hearing. You can also ask how to continue with your health care during the Appeal process.

Fresno, Kings, Madera Counties

CalViva Health members have these responsibilities:

- **Act courteously and respectfully.** You are responsible for treating your doctor and all providers and staff with courtesy and respect. You are responsible for being on time for your visits or calling your doctor's office at least 24 hours before the visit to cancel or reschedule.
- **Give up-to-date, accurate and complete information.** You are responsible for giving correct information and as much information as you can to all of your providers, and to our plan. You are responsible for getting regular check-ups and telling your doctor about health problems before they become serious.
- **Follow your doctor's advice and take part in your care.** You are responsible for talking over your health care needs with your doctor, developing and agreeing on goals, doing your best to understand your health problems, and following the treatment plans and instructions you both agree on.
- **Use the emergency room only in an emergency.** You are responsible for using the emergency room in cases of an emergency or as directed by your doctor. Emergency care is a service that you reasonably believe is necessary to stop or relieve sudden serious illnesses or symptoms, and injury or conditions requiring immediate diagnosis and treatment.
- **Report wrong-doing.** You are responsible for reporting health care fraud or wrong-doing to CalViva Health. You can do this without giving your name by calling the CalViva Health Fraud and Abuse Hotline toll-free at 866-863-2465. The Fraud Hotline operates 24 hours a day, 7 days a week. All calls are strictly confidential.

CalViva Health members have these rights:

- To be treated with respect and dignity, giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information such as medical history, mental and physical condition or treatment, and reproductive or sexual health.
- To be provided with information about the plan its services, including Covered Services practitioners, and member rights and responsibilities.
- To receive fully translated written member information in your preferred language, including all grievance and appeals notices.
- To make recommendations about CalViva Health's member rights and responsibilities policy.
- To be able to choose a primary care provider within CalViva Health's network.
- To have timely access to network providers.
- To participate in decision making with providers regarding your own health care, including the right to refuse treatment.

- To voice grievances, either verbally or in writing, about the organization or the care you got.
- To know the medical reason for CalViva Health's decision to deny, delay, terminate or change a request for medical care.
- To get care coordination.
- To ask for an appeal of decisions to deny, defer or limit services or benefits.
- To get no-cost interpreting services for your language.
- To get no-cost legal help at your local legal aid office or other groups.
- To formulate advance directives.
- To ask for a State Hearing if a service or benefit is denied and you have already filed an appeal with CalViva Health and are still not happy with the decision, or if did not get a decision on your appeal after 30 days, including information on the circumstances under which an expedited hearing is possible.
- To disenroll from CalViva Health and change to another health plan in the county upon request.
- To access minor consent services.
- To get no-cost written member information in other formats (including braille, large-size print, audio and accessible electronic formats) upon request and in a timely fashion appropriate for the format being requested and in accordance with Welfare & Institutions Code Section 14182 (b)(12).
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- To truthfully discuss information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand, regardless of cost or coverage.
- To have access to and get a copy of your medical records, and request that they be amended or corrected, as specified in 45 Code of Federal Regulations §164.524 and 164.526.
- Freedom to exercise these rights without adversely affecting how you are treated by CalViva Health, your providers or the State.
- To have access to family planning services, Freestanding Birth Centers, Federally Qualified Health Centers, Indian Health Clinics, midwifery services, Rural Health Centers, sexually transmitted infection services and emergency services outside CalViva Health's network pursuant to the federal law.
- To request an Appeal of a denied claim up to 60 days from the date on the notice you receive. This notice is called the “Notice of Adverse Benefit Determination (NABD).” The Appeal process is through the State Fair Hearing. You can also ask how to continue with your health care during the Appeal process.

IMPERIAL COUNTY

Community Health Plan of Imperial Valley members have these rights:

- To be treated with respect and dignity, giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information such as medical history, mental and physical condition or treatment, and reproductive or sexual health.
- To be provided with information about the health Plan and its services, including covered services, practitioners, and member rights and responsibilities.
- To get fully translated written member information in your preferred language, including all grievance and appeals notices.
- To make recommendations about the Plan's member rights and responsibilities policy.
- To be able to choose a primary care provider within the Plan's network.
- To have timely access to network providers.
- To participate in decision making with providers regarding your own health care, including the right to refuse treatment.
- To voice grievances, either verbally or in writing, about the organization or the care you got.

- To know the medical reason for the Plan's decision to deny, delay, terminate or change a request for medical care.
- To get care coordination.
- To ask for an appeal of decisions to deny, defer or limit services or benefits.
- To get no-cost interpreting and translation services for your language.
- To get no-cost legal help at your local legal aid office or other groups.
- To formulate advance directives.
- To ask for a State Hearing if a service or benefit is denied and you have already filed an appeal with the Plan and are still not happy with the decision, or if did not get a decision on your appeal after 30 days, including information on the circumstances under which an expedited hearing is possible.
- To disenroll (drop) from the Plan and change to another health plan in the county upon request.
- To access minor consent services.
- To get no-cost written member information in other formats (such as braille, large-size print, audio and accessible electronic formats) upon request and in a timely fashion appropriate for the format being requested and in accordance with Welfare and Institutions Code (W&I) section 14182 (b)(12).
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- To truthfully discuss information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand, regardless of cost or coverage.
- To have access to and get a copy of your medical records, and request that they be amended or corrected, as specified in 45 Code of Federal Regulations (CFR) sections §164.524 and 164.526.
- Freedom to exercise these rights without adversely affecting how you are treated by the Plan, your providers or the state.
- To have access to family planning services, Freestanding Birth Centers, Federally Qualified Health Centers, Indian Health Clinics, midwifery services, Rural Health Centers, sexually transmitted infection services and emergency services outside the Plan's network pursuant to the federal law.
- To request an Appeal of an Adverse Benefit Determination within 60 calendar days from the date on the Notice of Adverse Benefit Determination (NABD) and request how to continue benefits during the in-plan appeal process through the State Fair Hearing, when applicable.

Community Health Plan of Imperial Valley members have these responsibilities:

- Act courteously and respectfully. You are responsible for treating your doctor and all providers and staff with courtesy and respect. You are responsible for being on time for your visits or calling your doctor's office at least 24 hours before the visit to cancel or reschedule.
- Give up-to-date, accurate and complete information. You are responsible for giving correct information and as much information as you can to all of your providers, and to our Plan. You are responsible for getting regular check-ups and telling your doctor about health problems before they become serious.
- Follow your doctor's advice and take part in your care. You are responsible for talking over your health care needs with your doctor, developing and agreeing on goals, doing your best to understand your health problems, and following the treatment plans and instructions you both agree on.
- Use the emergency room only in an emergency. You are responsible for using the emergency room in cases of an emergency or as directed by your doctor. Emergency care is a service that you reasonably believe is necessary to stop or relieve sudden serious illnesses or symptoms, and injury or conditions requiring immediate diagnosis and treatment.
- Report wrong-doing. You are responsible for reporting health care fraud or wrong-doing to the Plan. You can do this without giving your name by calling the Fraud and Abuse Hotline toll-free at 866-685-8664. The Fraud Hotline operates 24 hours a day, 7 days a week. All calls are strictly confidential.

[1] The actual statements of member rights and responsibilities are in accordance with the National Committee for Quality Assurance (NCQA) and the Centers for Medicare & Medicaid Services (CMS) and may vary slightly from what is listed. In addition to member rights and responsibilities, medical services must be provided in a culturally competent manner without regard to race, color, national origin, creed, ancestry, religion, language. sex, marital status, sexual orientation, gender identity, age, health status, physical or mental disability, or any identification with any other persons or groups defined in Penal Code 422.56.

Advance Directives

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

An advance directive is a formal document, written in advance of an incapacitating illness or injury in which one can assign decision-making for future medical treatment. California legally recognizes the durable power of attorney for health care (DPAHC) and the Natural Death Act declaration as advance directives for adults.

The DPAHC designates a person to make health care decisions if the principal becomes mentally incapacitated. The Natural Death Act allows an adult to sign a declaration declining life-sustaining treatment, including artificially administered nutrition and hydration, if the person becomes terminally ill or permanently unconscious.

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 4374 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 additional information on Advance Directive, refer to the member's Evidence of Coverage (EOC).

Physician Responsibilities for Documenting Life-Sustaining Procedures

Complete documentation is essential whenever life-sustaining procedures are withheld or withdrawn, and must include:

- Member diagnosis and prognosis, including test results or other evidence for the attending physician's opinion and a second opinion confirming attending physician's conclusions
- Whether the member is likely to regain mental function and the facts on which determination of the member's mental incapacity was based
- A statement that the member or surrogate has been fully informed of the facts and the consequences of withholding or withdrawing life-sustaining procedures and that the surrogate decision-maker has consented to the withholding or withdrawing of such procedures
- A copy of any durable power of attorney for health care (DPAHC) declaration or non-statutory living will signed by the member
- Any desires verbally expressed by the member and a description of any discussion with family members or other surrogate
- A copy of a certified letter of guardianship or conservatorship (when one exists)
- Clear written orders to withhold or withdraw specific medical procedures

Member Confidentiality

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

Members are entitled to confidential treatment of member communications and records. Case discussion, consultation, examination, and treatment are confidential and are to be conducted discreetly. Written authorization from the member or an authorized legal representative must be obtained before medical records are released to anyone not directly concerned with care, except as permitted or necessary in the administration of the health plan.

Office Procedure

All participating providers must maintain an office procedure that guards against unauthorized disclosure of confidential member information. This procedure should contain the following elements:

- Written authorization from the member or a legal representative before medical records are made available to anyone not directly concerned with care, except where otherwise permitted or required by law or subpoena
- All signed authorizations for release of medical information, which have been reviewed for specific authorization and for any limitations
- Each medical record, which has been reviewed prior to making it available to anyone other than the member or legal representative
- Only the portion of the medical record specified in the authorization, which has been made available to the requester and is separated from the remainder

Any portion of the medical record not covered by the authorization must be withheld.

Physicians are encouraged to have their office staff sign a confidentiality statement to ensure that they understand their responsibility in maintaining member confidentiality.

Release of Medical Information Form

All providers should maintain a properRelease of Medical Information form (PDF) for all record requests in the member's medical record.

PCP Selection and Assignment

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

Selection Criteria

Newly enrolled members must choose a PCP within 30 days from the time they become a member of Health Net. If the member does not select a PCP, Health Net will choose one within 10 miles or 30 minutes of the member's residence. The member can choose the same PCP or different PCPs, for all family members within Health Net, if the PCP is available.

If the member has a doctor they want to keep, or if the member wants to find a new PCP, they can go to the Provider Directory for a list of all PCPs and other providers in the Health Net network. The Provider Directory has other information to help the member choose a PCP. If the member needs a Provider Directory, the member can call the Member Services Department. The member may also find the Provider Directory on the Health Net website at www.healthnet.com

Primary Care Physician Changes

Fresno, Kings, Madera Counties

Health Net reimburses fee-for-service (FFS) Medi-Cal primary care physicians (PCPs) only for services provided to a Health Net Medi-Cal member assigned to the PCP at the time the care is provided. When a Health Net member seeks care from a PCP to whom the member is not assigned, a change in PCP assignment must be made prior to providing care in order for the claim to be paid. This is done by either calling the CalViva Health Member Services or CalViva Health Provider Services department or by having the provider or the member complete and fax the Request for PCP-PPG Change form – English (PDF) or Request for PCP-PPG Change form – Spanish (PDF) with the following information to the CalViva Health Member Services Department:

- The form must be completely filled out
- The provider must include the effective date the member changed to a new requested PCP/PPG
- The member or the member's legal guardian's signature must be on the Request for PCP/PPG Change form (changes can only be made if the form is signed and acknowledged by the member or member's legal guardian).

- The Requested PCP Change form may take up to 15 days from the date of faxing the form for the PCP/PPG change to be completed and reflect on Health Net's portal.

Allow five days from the date of faxing the form for the PCP change to be entered into Health Net's records.

Amador, Calaveras, Inyo, Kern, Los Angeles, Mono, Riverside, Sacramento, San Bernardino, San Diego, San Joaquin, Stanislaus, Tulare and Tuolumne Counties

Members requesting a primary care physician (PCP) change may complete a Request for PCP-PPG Change form – English (PDF) or Request for PCP-PPG Change form – Spanish (PDF) and fax it to the Health Net Medi-Cal Member Services, or contact the Medi-Cal Member Services Department by phone to request the change Department.

Imperial County

Members requesting a primary care physician (PCP) change may complete a Request for PCP-PPG Change form – English (PDF) and fax it to the Community Health Plan of Imperial Valley Member Services – English or Request for PCP-PPG Change form – Spanish (PDF) or contact the Medi-Cal Member Services Department by phone to request the change Department.

Prescription Drug Program

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

The following medications are covered under Health Nets Medi-Cal plan:

- Medications administered while the member is hospitalized or in an emergency room
- Medications administered in a providers office or infusion center billed through the medical benefit
- Home infusion or other medication-related services billed through the medical benefit

The following medications are covered by the Medi-Cal Rx program

- Self-administered and provider-administered medications listed on the Medi-Cal Rx Contract Drug List (CDL) and billed through a pharmacy
- Self-administered and provider-administered medications not listed on the Medi-Cal Rx CDL billed through a pharmacy (prior authorization may be required)
- Medications prescribed by a psychiatrist that are on the Medi-Cal Rx CDL and filled at a participating Medi-Cal Rx pharmacy
- A 72-hour supply of a covered medication in a medical emergency.

- Medical supplies, including personal home-use blood pressure monitors and blood pressure cuffs for use with personal, home blood pressure monitoring devices, and therapeutic continuous blood glucose monitors are a covered benefit under Medi-Cal Rx.

Medications for the treatment of AIDS and HIV are excluded from Health Nets coverage responsibilities and are covered under the DHCS Medi-Cal FFS program and Medi-Cal Rx. Refer to the discussion of carve-out medications in this section for more information.

Health Net Medi-Cal does not cover health care services for California Childrens Services (CCS)-eligible conditions, but they are covered under the CCS program. Prescriptions written for children with CCS active conditions need to be written by a CCS-paneled provider and billed directly to CCS.

Due to the passage of federal legislation (HR 3971), where federal financial contribution has been discontinued for all medications used to treat sexual or erectile dysfunction, the state of California has decided to discontinue coverage of such medications under the Medi-Cal program, unless used to treat a condition other than sexual or erectile dysfunction.

Carve-Out Medications

The Department of Health Care Services (DHCS) has carved out selected psychotherapeutic, coagulation factors, HIV-related medications and medications to treat alcohol or drug dependence from Health Nets coverage responsibilities. These medications are covered by the Medi-Cal Rx program. Pharmacies bill Medi-Cal Rx directly for these medications.

For a list of carved-out AIDS and HIV treatment medications, refer to the Excluded Medications for HIV and AIDS discussion in the AIDS Waiver Program section of the Public Health topic.

For a list of carved-out psychotherapeutic medications, refer to the Excluded Psychotherapeutic Medications discussion in the Mental Health section of the Public Health topic.

Health Net Medi-Cal does not cover health care services, including prescription medications, for California Childrens Services (CCS)-eligible conditions, but they are covered under the CCS program. Prescriptions written for children with CCS-active conditions must be written by a CCS-paneled provider and billed directly to CCS.

Medi-Cal Rx Contract Drug List

The Medi-Cal Rx Contract Drug List (CDL) is available on Health Nets provider portal, located under Pharmacy Information Drug Information for California State Health Programs. The Medi-Cal Rx CDL is found on the Medi-Cal Rx website.

Certain medications on the Medi-Cal Rx CDL require prior authorization for coverage. Medications not found on the Medi-Cal Rx CDL may require prior authorization.

Prior Authorization can be requested in the following ways:

- By going to cover my meds.
- By logging into the portal and submitting the PA through our Prior Authorization tool. Login from the provider portal and access the secured Prior Authorization tool.
- By sending a completed PA form through fax to Medi-Cal Rx fax number.

- By submitting a NCPDP P4 Transaction through Pharmacy POS system.
- By sending a completed PA form through mail to Medi-Cal Rx Customer Service Center

For additional information, refer to the Medi-Cal Rx Options for PA Submission Guide.

Medi-Cal Rx will notify providers of the status of prior authorization requests.

Special Infant Formula

Nutritional supplements and replacements are a conditional benefit for Health Net's Medi-Cal members and may be covered subject to prior authorization. Requests for oral formula that are obtained under the pharmacy benefit should be submitted to Medi-Cal Rx. Requests requiring a pump, supplies needed to administer the formula, or formula that cannot be billed through the pharmacy should be submitted to Health Net Medi-Cal Health Services Department.

Depending on capitation status, the request is then forwarded to the Health Net Medi-Cal Health Services Department or to the appropriate participating physician group (PPG) to facilitate further prior authorization.

Special infant formula requests for members with conditions that make them eligible for services through public health carve-out programs must be referred to the public health program agencies. Such carve-out programs include California Children's Services (CCS) and Genetically-Handicapped Persons Program (GHPP).

In Los Angeles County, practitioners affiliated with Molina Healthcare, a subcontracting health plan, must follow Molina's prior authorization requirements when requesting special infant formulas for Health Net members assigned to Molina Healthcare. Contact the Molina Pharmacy Department for more information.

Prior Authorizations

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

This section contains general information on prior authorizations requirements.

Select any subject below:

- Requesting Prior Authorization or Coordinating a PCP Referral
- Advanced and Cardiac Imaging
- Notification of Inpatient Admissions
- Prior Authorization
- How to Secure Prior Authorization on Health Net Provider Portal
- Request for Prior Authorization Form
- Services Not Requiring Prior Authorization
- Peer-to-Peer Review Requests

Requesting Prior Authorization or Coordinating a PCP Referral

Provider Type: Physicians | Hospitals | Ancillary

Refer to the Prior Authorization (PA) Requirements List to determine which services require prior authorization and for information on where to submit PA requests based on the type of service, drug, device or procedure. For services not delegated to PPGs, providers must follow applicable prior authorization requirements. For Molina members, providers must follow Molina Health Care prior authorization requirements.

To request prior authorization or coordinate a primary care physician (PCP) referral for services:

- The PCP completes the request form and sends it to the specialist. This ensures that the member is seeking services from in-network providers, helps monitor the care provided to members and provides instructions to the specialist regarding authorized services.
- The PCP and specialist retain a copy of the IP or OP prior authorization form in the member's chart.
- Fax a copy of the prior authorization form to the Health Net Prior Authorization Department
    - This ensures that Health Net identifies case management needs and assists the member with coordination of care, when appropriate.
    - This also enables Health Net to assist in the detection of and referral to appropriate agencies for carve-out services, such as California Children's Services (CCS).
- Specialists submitting paper claims to Health Net must include the prior authorization form with the claim.
    - This supports the PCP-to-specialist referral and helps prevent delays in payment.
- Specialists submitting electronic claims must indicate the name of the referring provider in box 23 of the CMS-1500 claim form

The PCP or specialist must give the Health Net Prior Authorization Department as much advance notice as possible when requesting prior authorization. For routine elective inpatient or outpatient services, fax requests for prior authorization at least five days before the anticipated date of service. It is recommended not to schedule services prior to receiving the review decision. The Medical Management Department needs time to notify the provider of the review decision prior to the services being rendered.

Required Information

Submit the following information when requesting prior authorization:

- Member's name
- Member's identification number
- Member's date of birth
- Diagnosis
- Requesting physician's name, address, telephone and fax numbers, and contact person
- Place where services are provided
- Physician's name (physician receiving referral), ancillary provider name and facility name
- Procedures
- Date of service

The Health Net Prior Authorization Department reviews the information and calls back with the review decision. If the service is authorized, an authorization number is given.

Submission of Prior Authorization Requests

Fax the prior authorization form to the Health Net Prior Authorization Department. Use the fax number on the form to submit requests 24 hours a day, seven days a week.

Advanced and Cardiac Imaging

Provider Type: Physicians

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

Prior Authorization Requirements

The following outpatient procedures require prior authorization from Evolent, with the exception of emergency room, urgent care, and observation setting for advanced and cardiac imaging:

- 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

Prior Authorization Requests

Prior authorization requests must be submitted to Evolent online or by telephone as follows. Evolent does not accept fax submissions.

- Online - Post-log in at www.RadMD.com, 24 hours a day, 7 days a week, except when maintenance is performed once every other week after business hours.
- Evolent, available Monday through Friday, from 8 a.m. to 8 p.m.

Expedited authorization requests may only be submitted by telephone.

To expedite the request process, providers must have the following information ready before logging in to the Evolent website or calling (*denotes required information):

- Name and office telephone number of ordering provider*
- Member name and identification (ID) number*
- Requested examination*
- Name of provider office or facility where the service will be performed*
- Anticipated date of service (if known)
- Details justifying the examination*
- Symptoms and their duration
- Physical exam findings, including findings applicable to the requested services, conservative treatment the member has already completed (such as physical therapy, chiropractic or osteopathic manipulation, hot pads, massage, ice packs, and medication)
- Results and/or reports of preliminary procedures already completed (such as X-rays, CTs, lab work, ultrasound, scoped procedures, referrals to specialist, and specialist evaluation)
- Reason the study is being requested (such as further evaluation, rule out a disorder)

The following information may also be requested:

- Clinical notes
- Reports of previous procedures
- Specialist reports/evaluation

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.

Notification of Inpatient Admissions

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

All inpatient admissions must be brought to the attention of the Health Net Hospital Notification Unit within 24 hours of the admission or one business day when an admission occurs on a weekend. Hospital admission notification does not replace the authorization process. These notifications may be submitted by faxing the member's admission face sheet to the Health Net Hospital Notification Unit. Failure to notify according to the requirements in the Provider Participation Agreement (PPA) may result in a denial of payment.

Prior Authorization

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

Prior authorization ensures medical necessity of services and level of care, and the use of participating providers, as well as to prevent unanticipated denials of coverage.

Refer to the PA Requirements List to determine which service require prior authorization and for information on where to submit PA requests based on the type of service, drug, device or procedure.

Health Net has delegated the prior authorization process to some participating physician groups (PPGs). Prior authorizations for members assigned to a capitated PPG are subject to any additional rules imposed by the PPG. PPGs may not impose prior authorization requirements that conflict with the member's right to self-refer for services. Refer to the PPG for authorization requirements.

When to submit prior authorization requests to local county CCS agency

Specialists are required to send copies of consultation and treatment plans to the member's primary care physician (PCP) and all participating providers are required to refer any services related to a California Children's Services (CCS)-eligible condition to the local county CCS agency for authorization. CCS-eligible services must be provided by a CCS-paneled provider at CCS-approved facilities.

Request for Prior Authorization Form

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

Refer to the Prior Authorization (PA) Requirements List and Forms to determine which service require prior authorization and for information on where to submit PA requests based on the type of service, drug, device or procedure.

- The following forms are the primary method used by Health Net to manage the referral and authorization process for fee-for-service (FFS) providers directly contracting with Health Net.
- Providers are required to complete all fields on the form as follows to expedite the process of these requests.
    - Inpatient (IP):
        - Inpatient California Medi-Cal Prior Authorization – Medi-Cal (PDF),
        - Inpatient California Medi-Cal Prior Authorization – Community Health Plan of Imperial Valley or
        - Inpatient California Medi-Cal Prior Authorization – CalViva Health (PDF)
    - Outpatient (OP)
        - Outpatient California Medi-Cal Authorization – Medi-Cal (PDF), or
        - Outpatient California Medi-Cal Prior Authorization – Community Health Plan of Imperial Valley
        - Outpatient California Medi-Cal Authorization – CalViva Health (PDF)

- If the number of units or visits is not indicated in the Professional field, only one visit is authorized by Health Net. That visit must take place within 60 days of the order date. If more than one consultation is required, another request must be submitted to Health Net for review.
- Designate the type of request (urgent or elective).
- Designate service requested to determine prior authorization requirements.
- ICD-10 codes and CPT codes and descriptions are required fields.
- Providers must attach all pertinent medical information in order for the request to be reviewed for medical necessity.

Services Not Requiring Prior Authorization

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

Prior authorization is not required for the following services, and services may be obtained from any qualified in-network or out-of-network provider:

- Emergency services
- Minor Consent Services.
- Abortion services may be obtained from any qualified in-network or out-of-network provider.
- Family planning, sexually transmitted infection (STI) diagnosis and treatment, HIV testing and counseling, and sexual assault services may be obtained from any qualified in-network or out-of-network provider. .
- Drug and alcohol abuse treatment and mental health treatment - these services are not covered by Health Net's Medi-Cal managed care plan and may be obtained through the county drug and alcohol program and the county mental health program.

Referral and prior authorization are not required for Comprehensive Prenatal Services Program (CPSP) services. Services may be obtained from any participating CPSP providers.

Other services that do not require prior authorization include:

- Certain services for American Indian members, including:
  - An American Indian member can obtain covered services from an out-of-network Indian health care provider without requiring a referral from a network primary care provider (PCP) or prior authorization.
  - MAO 638 Indial Health Services facilities or provider , whether in the Plan’s network or out-of-network, can provide referrals directly to network providers without a referral from a network PCP or prior authorization. An American Indian member may receive services from an out-of-network Indian health care provider even if there are in-network Indian health care providers available.
- Department of Health Care Services (DHCS)-required immunizations when provided from the local health department (LHD) (LHD must submit immunization records with any claim)
- Pregnancy care with a participating in-network obstetrician.
- Preventive services from a participating provider.
- Services for emergency medical conditions.
- Specialist referral (initial referral to participating specialist).
- Urgently needed services when the member is outside their county

- Certified nurse midwife and obstetrical/gynecological (OB/GYN) services from a participating provider
- Biomarker testing for an insured with advanced or metastatic stage 3 or 4 cancer (must be FDA-approved)

Health Net has delegated the prior authorization process to some participating physician groups (PPGs). Prior authorizations for members assigned to a capitated PPG are subject to any additional rules imposed by the PPG. PPGs may not impose prior authorization requirements that conflict with the member's right to self-refer for services. Refer to the PPG for authorization requirements. PPGs may not impose prior authorization requirements that conflict with the member's right to self-refer for certain services.

Peer-to-Peer Review Requests

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

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

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

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

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

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

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

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

How to request a peer-to-peer review

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

Product Descriptions

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

This section contains general information about Health Net health plans.

Select any subject below:

- Medi-Cal Managed Care

Medi-Cal Managed Care

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

The Department of Health Care Services (DHCS) administers the state's Medi-Cal managed care programs. Medi-Cal managed care differs from commercial managed care in that it integrates private health care with publicly funded health programs.

Health Net's Medi-Cal managed care service area includes the counties of Amador, Calaveras, Inyo Kern, Los Angeles, Mono, Sacramento, San Diego, San Joaquin, Stanislaus, Tulare and Tuolumne. In Riverside and San Bernardino counties, Health Net is a subcontracting health plan to Molina Healthcare. Additionally, Health Net is a subcontracting health plan for CalViva Health in Fresno, Kings and Madera counties and Community Health Plan of Imperial Valley (CHPIV) in Imperial County.

In Amador, Calaveras, Inyo, Kern, Los Angeles, Mono, San Joaquin, Stanislaus, Tulare and Tuolumne counties, Medi-Cal beneficiaries have the option of enrolling in Health Net, the mainstream or commercial plan in the state's Two-Plan Managed Care Program. In Los Angeles County, Health Net subcontracts with Molina Healthcare to provide care for approximately one-third of Health Net's Medi-Cal beneficiaries. All of these members have Health Net identification cards. Providers must follow the prior authorization and utilization management (UM) procedures of Molina for its assigned Health Net fee-for-service (FFS) members, or the procedures of the participating physician group (PPG) for capitated members.

CalViva Health is the local initiative health plan for the Medi-Cal managed care counties in Fresno, Kings and Madera. CalViva Health is partnering with Health Net to serve Medi-Cal beneficiaries in these counties. Under the direction of the Fresno-Kings-Madera Regional Health Authority, CalViva Health selected Health Net as its contractor to provide administrative and network services under the Two-Plan model expansion in the three-county region. Health Net continues to hold most provider network contracts in Fresno, Kings and Madera counties as CalViva Health's subcontractor.

CHPIV is the Local Health Authority (LHA) for Medi-Cal managed care in Imperial County. CHPIV is a full-service health plan contracting with the Department of Health Care Services (DHCS) to provide services to Medi-Cal managed care enrollees under the Single Plan model in all ZIP Codes in Imperial County. CHPIV contracts with Health Net to provide certain administrative and health care services to CHPIV members on CHPIV’s behalf. Health Net holds most provider contracts in Imperial County as CHPIV’s subcontractor.

Health Net Medi-Cal members in Sacramento and San Diego counties are participants in the Geographic Managed Care (GMC) program. The benefits under the GMC program are very similar to the Two-Plan Managed Care program benefits with a few minor variations.

In Riverside and San Bernardino counties, Health Net is a subcontracting health plan to Molina. These members have Molina identification cards. Providers must follow the prior authorization and UM procedures of Health Net for FFS members or the procedures of the PPG for capitated members in these two counties.

Provider Oversight

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

This section contains general information on provider oversight requirements and monitoring.

Select any subject below:

Provider Oversight Overview

Participating Physician Groups (PPG)

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

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

- Alerting the delegated entity regarding possible areas of non-compliance
- Sharing information regarding regulations

    - Available in the Delegation Oversight Interactive Tool
- Developing corrective action plans (CAPs)
    - Managed within the Delegation Oversight Interactive Tool
- Sharing best practices
- Offering guidance regarding on-site review by outside agencies

Delegation Oversight Committee

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

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

Credentialing and Recredentialing

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

HEDIS® Reporting

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

Member Complaints, Appeals & Grievances

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

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

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

Preventive Care Guidelines

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

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

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

Notice to Change PPA

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

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

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

Appeals and Grievances

Provider Type: Participating Physician Groups (PPG)

Health Net does not delegate member appeals or grievances, except for Molina. The Health Net State Health Programs Quality Improvement Health Equity Committee (QIHEC) reviews quarterly Medi-Cal appeals and

grievance reports to assess emerging patterns of appeals and grievances, and to formulate potential plan policy/process changes and/or procedural improvements.

For more information on member appeals or grievances, refer to the discussions of Member Appeals and Grievances.

Outpatient Pharmacy Benefits and Services Carve Out

Health Net Medi-Cal pharmacy benefits and services transitioned from managed care to the State's responsibility under the pharmacy benefit program known as Medi-Cal Rx. Appeals and grievances for these benefits and services are the responsibility of Medi-Cal Rx. Disputes regarding the denial of a referral or a prior authorization request should be directed to DHCS State Fair Hearing and not to Health Net. If Health Net receives a grievance related to these services, Health Net will redirect those grievances to Medi-Cal Rx contractor, Magellan Medicaid Administration, Inc. (Magellan), in a timely manner and in the manner outlined by DHCS. If Health Net receives an appeal related to these services, DHCS State Fair Hearing process is responsible. Health Net will redirect those appeals to DHCS State Fair Hearing.

Calendar of Required PPG Submissions

Provider Type: Participating Physician Groups (PPG)

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

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

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

Delegated Service	LOB Detail	Report Description	Frequency	Due Date
UM	Medicare (HMO-H0562, SAP-H3561), Commercial, Medi-Cal, Medi-Cal CalViva, Medi-Cal Community Health Plan of Imperial Valley and Medi-Cal Molina	UM Work Plan	Annually Semi-annual Quarterly	All LOB Initial - Annual: February 15 MCR & COMM - Semi-annual: August 15 Medi-Cal, Medi-Cal Molina and CalViva - Quarterly: Last day of the month following the end of the quarter
Claims	Medicare (HMO-H0562, SAP-H3561)	Provider Dispute Organization Determinations - MCR	Monthly	15th calendar day of the following month
Claims	Medicare (HMO-H0562, SAP-H3561)	Organization Determinations Claims - MCR	Monthly	15th calendar day of the following month
Claims	Medicare (HMO-H0562, SAP-H3561	Claims Reopens	Quarterly	15th of the month following the end of the quarter
Claims	Commercial	AB72 IDRP Delegated Contact List	Annually	31-Oct-22
Claims	Commercial	Claims Organization Determinations-COMM	Monthly	15th calendar day of the following month
Claims	Commercial	Provider Disputes Organization	Monthly	15th calendar day of the following month

Delegated Service	LOB Detail	Report Description	Frequency	Due Date
		Determinations - COMM		
Claims	Commercial	Federal Employee Health Benefit Program (FEHBP) Claim Reports	Semi-annual	Semi-annual - April 1 and October 1
Claims	Commercial	Provider Dispute Summary Report - COMM	Quarterly	15th of the month following the end of the quarter
Claims	Commercial	Claims Settlement Practice Report - COMM	Quarterly	15th of the month following the end of the quarter
Claims	Commercial	Timeliness Summary Reports - COMM	Quarterly	15th calendar day of the following month after each quarter end.
Claims	Medi-Cal, Medi-Cal_CalViva, Medi-Cal Community Health Plan of Imperial Valley and Medi-Cal_Molina	Claims Organization Determinations - MCAL, CALV, MOLN	Monthly	15th calendar day of the following month
Claims	Medi-Cal, Medi-Cal_CalViva, Medi-Cal Community Health Plan of Imperial Valley	Provider Disputes Organization Determinations - MCAL, CALV, MOLN	Monthly	15th calendar day of the following month

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

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

Organization Determinations

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

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

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

Reporting Elements & Submission

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

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

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

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

Conditions of PCP Panel Closures by Health Net

Provider Type: Physicians | Participating Physician Groups (PPG)

Health Net established the member assignment threshold for an individual primary care physician (PCP) to a maximum of 2,000 members in compliance with standards established by the California Department of Managed Health Care (DMHC) and California Department of Health Care Services (DHCS). An individual PCP may employ up to four physician extenders. Members assigned to a PCP and his or her extenders may not exceed 4,000 members combined. Each extender has a maximum capacity of 1,000 members.

Health Net ensures compliance by continuously monitoring our network for capacity limits and the full-time-equivalent member-to-physician ratios as follows:

- PCPs - 2,000:1
- Physician extenders - 1,000:1

Health Net may close participating PCPs' panels to new Health Net members when PCPs without physician extenders have more than 2,000 Health Net members assigned to them.

Health Net reviews the following to determine the appropriateness of the panel size, and contacts the participating physician group (PPG) or PCP to assess the PCP's status.

- PCP status: active, prior patients or full capacity
- Physician extenders (allows for an additional 1,000 members per PCP, up to four extenders)
- PCP practice located in rural area with few PCPs

Health Net sends notification to PCPs advising of panel closures once they exceed the maximum capacity. Health Net monitors access and availability and reopen the panel to additional member assignments when the number of members assigned to the PCP's panel falls within acceptable standards.

Corrective Action Plan

Provider Type: Participating Physician Groups (PPG) | Hospitals

When a delegated entity is not in compliance with the Plan policies, contractual obligations or regulatory requirements, the Delegation Oversight Department may implement a corrective action process to correct the deficiencies.

- Delegate is notified of deficiency and requested to submit a corrective action plan (CAP) to address the deficiency and implement monitoring measures to avoid reoccurrence of deficiency.
    - The delegation oversight compliance auditor reviews the CAP for appropriateness and completeness and notifies the delegate of whether the CAP is approved.
    - If the Plan does not approve the CAP, the delegate is notified and asked to revise and resubmit the CAP to the Plan.
- If the delegate does not submit a CAP, or complete the actions in their CAP in a timely manner, the deficiency may be escalated to the Delegation Oversight Workgroup (DOW), Compliance and Network Management Leadership and or at a JOM to discuss deficiencies or to recommend further actions.
- If the delegate remains deficient it may be escalated to the Delegation Oversight Committee (DOC) to take formal actions up to and including de-delegation.

Credible Allegations of Fraud

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

Medi-Cal managed care plans (MCPs) must take certain actions when the Department of Health Care Services (DHCS) has determined that a credible allegation of fraud exists against a participating MCP network provider. To comply with this regulation, Health Net adheres to the course of action described below upon receipt of information that DHCS has determined a credible allegation of fraud exists against a participating provider.

Requirements

If Health Net is notified that a credible allegation of fraud has been identified against a participating provider relating to the provision of Medi-Cal services, Health Net takes one or more of the following four actions and submits supporting documentation to DHCS:

1. Terminates the provider from its network.
2. Temporarily suspends the provider from its network pending resolution of the fraud allegation.
3. Temporarily suspends payment to the provider pending resolution of the fraud allegation.
4. Conducts additional monitoring, including audits of the provider's claims history and future claims submission for appropriate billing.

If Health Net elects the fourth action, Health Net follows the steps below and submits documentation to DHCS:

Step 1: Immediately implements enhanced monitoring as follows:

- Monitors relevant claims, claim lines, and encounter data, and completes the initial review within 30 calendar days.
- Provides weekly updates to DHCS until a determination is made as to whether an onsite visit is necessary.
- Makes an initial determination as to whether an onsite visit is necessary after completing the initial review of relevant claims/encounter data. Health Net consults with DHCS on the need for an onsite review within 10 business days of completing the initial review. Health Net is required to obtain DHCS approval if the initial determination concludes an onsite visit is not warranted.

Step 2: If Health Net's initial determination identifies a potential incident(s) of fraud, waste or abuse, or otherwise validates DHCS's credible allegation of fraud finding, Health Net must:

- Commence an audit for the subject provider or subcontractor within 10 business days of validating the credible allegation of fraud, waste or abuse, or within 10 days of validating DHCS's credible allegation of fraud. The audit must be conducted earlier if Health Net identifies activity that warrants immediate action.
- Provide DHCS with a copy of the final audit report and findings within 45 days.
- Provide DHCS with a copy of the corrective action plan it has imposed on the Medi-Cal provider, which will include specific milestones and timelines for completion.
- Provide DHCS with biweekly updates related to the corrective action plan.
- Audit the provider or subcontractor again within six months of closing the corrective action plan to confirm amelioration of the findings.
- Terminate the provider from Health Net's network should there be repeat findings that are significant in nature. Health Net is required to obtain approval from DHCS in situations where the provider is not to be terminated from Health Net's network.
- Provide DHCS with an outline of oversight activity that Health Net will conduct to ensure there is no further fraud, waste or abuse.

Delegated providers

Health Net's delegated providers are required to adhere to the course of action described above upon receipt of information that DHCS has determined a credible allegation of fraud exists against a participating provider.

If the delegated provider elects to terminate a participating provider from its network upon notification from DHCS that a credible allegation of fraud has been found against the participating provider relating to the provision of Medi-Cal services, the delegated provider must notify the Health Net regional Provider Network Management Department in writing, pursuant to the requirements of the provider's Health Net Provider Participation Agreement (PPA). Delegated providers that elect to not terminate a participating provider from its network must provide an explanation for electing this option and are required to continue to monitor the provider and provide the Health Net Provider Network Management Department with a report of oversight activity that is being conducted.

Delegated providers are required to have policies and procedures to detect and deter FWA, including a compliance program as defined in Title 42 CFR section 438.608(a). PPGs must comply with all applicable state and federal laws and regulations, including state and federal false claim acts.

PPGs must report any suspected case of FWA to Health Net within 10 calendar days through the Health Net Fraud Hotline. Additionally, if a PPG receives information about a change in circumstances that may affect a member’s eligibility (e.g., a change in residence or income or the death of a member) they must promptly

contact the Health Net Medi-Cal Provider Services Center Community Health Plan of Imperial Valley Provider Services Center or CalViva Health Provider Services Center.

Health Net Delegation Oversight will monitor and evaluate your compliance to all requirements through:

- Health Net annual Compliance audit
  - Review of Compliance program policies and procedures including:
    - Compliance program description (requirements defined in Title 42 CFR section 438.608(a))
    - Mechanisms for detection and prevention of FWA
    - Training program for employees and providers
    - Plan for routine internal monitoring
    - Disciplinary guidelines for non-compliance
  - Proof of process execution (meeting minutes, staff interviews, logs, etc.)
  - Evidence of routine monitoring
- Additional activities as identified

Fraud, Waste and Abuse

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

Health Net takes the detection, investigation, and prosecution of fraud, waste and abuse (FWA) very seriously, and has a FWA program that complies with the State of California and federal laws.

Fraud means an intentional deception or misrepresentation made by persons with the knowledge that the deception could result in some unauthorized benefit to themselves or some other person, and includes any act that constitutes fraud under applicable federal or state law, including 42 CFR section 455.2 and W&I Code section 14043.1(i).

Waste is the overutilization or inappropriate utilization of services and misuse of resources.

Abuse means practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes member practices that result in unnecessary cost to the Medi-Cal program.

Some of the most common FWA practices include:

- Unbundling of codes.
- Up-coding services.
- Excessive use or misrepresentation of quantity or units.
- Claims for services not rendered or failure to adequately document services.
- Services provided by non-credentialed providers without documentation indicating supervised services.
- Intentional misrepresentation of services rendered.
- Deliberate application for duplicate reimbursement.
- Intentional improper billing practices.
- Provision of unnecessary services.
- Failure to maintain adequate records to substantiate services.

- Failure to provide services that meet professionally recognized standards of health care.
- Conducting excessive office visits or writing excessive prescriptions.

Health Net, in conjunction with its parent company, Centene, operates a FWA Special Investigations Unit (SIU). Health Net routinely conducts audits to ensure compliance with billing regulations. Health Net has developed a proactive FWA prevention program designed to collect, analyze and evaluate data in order to identify suspected FWA. Detection tools have been developed to identify patterns of problematic healthcare service use, including overutilization, unbundling, upcoding, misuse of modifiers and other common schemes. SIU performs retrospective and prospective investigations which, in some cases, may result in taking actions against providers who commit waste, abuse, and/or fraud. Health Net is required to recoup all identified overpayments after review of claims and medical records.

These actions may include but are not limited to:

- Education.
- Corrective Action Plan.
- Utilization review.
- Prepayment review.
- Recoupment of identified overpayments.
- Termination of provider agreement or other contractual arrangement.
- Referral of potential FWA to the California Department of Health Care Services, the California Department of Justice, and any other applicable agencies.

Health Net is required to report any findings of suspected FWA by providers or vendors under its Medi-Cal Plans to the state.

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.

Provider Enrollment Requirement Through DHCS

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

Providers who wish to participate in Health Net's Medi-Cal Network must be enrolled in Medi-Cal through the Department of Health Care Services (DHCS) in an approved status in accordance with DHCS regulations.

Monitoring and Enrollment

Health Net continues to monitor Medi-Cal enrollment status for participating providers, and first-tier, downstream and related entities (FDRs). In addition, delegated participating physician groups (PPGs) who are contracting with Health Net must verify that their network of providers involved in servicing Medi-Cal members are enrolled in Medi-Cal through DHCS.

DHCS enrollment applications can be located by provider type at DHCS.

Monitoring Provider Exclusions

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

The Centers for Medicare & Medicaid Services (CMS) and the California Department of Health Care Services (DHCS) both require contractors, their subcontractors and other delegated entities to monitor federal and state exclusions lists. The parties or entities on these lists are excluded from various activities, including rendering services to Medicare, Medicaid and any other federal health care program enrollees (unless in the case of an emergency, as stated in 42 CFR §1001.1901), and employing or contracting with excluded parties to provide services to these enrollees. Health Net requires that its participating physician groups (PPGs), hospitals, ancillary providers, and physicians frequently monitor federal and state exclusion lists.

Monitoring for Excluded Parties

The names of parties that have been excluded from participation in federal health care programs are published in the Office of the Inspector General U.S. Department of Health and Human Services (OIG-HHS) List of Excluded Individuals and Entities (LEIE), CMS Preclusion List, Medi-Cal Suspended and Ineligible Provider List (SIPL), Medi-Cal Restricted Provider Database (RPD), Office of Personnel Management (OPM) under the Federal Employee Health Benefit Plan (FEHBP), and on the General Services Administration's (GSA) Exclusions Extract Data Package (EEDP) (or Excluded Parties List System (EPLS), which was replaced by the EEDP), as referenced through the System for Award Management (SAM) website.

Providers on any of these lists, except for the RPD, will be terminated from all products, federal and non-federal. Providers on the RPD will only be terminated from the Medi-Cal line of business.

Health Net and Provider Responsibilities

Health Net is required to monitor federal and state exclusion lists to ensure that Health Net is not hiring, contracting or paying excluded parties or entities for services rendered to enrollees in Health Net's plans. Health Net's contracted providers and their downstream subcontractors or delegated entities must check the LEIE, CMS Preclusion List, SIPL, RDP, FEHBP and EEDP exclusion lists prior to hiring or contracting with any new employee, temporary employee, volunteer, consultant, governing body member, subcontractor, or other delegated entity for Medicaid or Part C and Part D related activities. Health Net, its contracted providers, and their downstream subcontractors or delegated entities must frequently 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 at https://oig.hhs.gov/exclusions.

The current LEIE is available on the OIG-HHS website. Frequently asked questions (FAQs) and additional information about the LEIE is available at OIG.

Providers on the OIG list will be terminated from all products, federal and non-federal.

CMS Preclusion List

The CMS Preclusion List is published by the Centers for Medicare & Medicaid Services to identify precluded providers. It is updated monthly and available on the Healthnet.com site, after logging on, under the regulatory section.

Providers on the CMS Preclusion List will be terminated from all products, federal and non-federal.

SIPL

The SIPL is published by DHCS to identify suspended and otherwise ineligible providers. It is updated monthly and available on the DHCS Medi-Cal website > Resources > 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.

FEHBP

The OPM, under the OIG-HHS, imposes suspension and debarment actions for entities contracted with the FEHBP. The current FEHBP suspended and debarred report is available at Healthnet.com. Registered providers can log into the provider portal to access the reports located under the regulatory section.

Providers on the FEHBP list will be terminated from all products, federal and non-federal. Additionally, a 12-month claims look-back review must occur for all identified participating and non-participating providers. Federal Employee Health Benefit Plan members identified through the claims review must receive notification that the provider is no longer available to receive services from.

EEDP

The GSA's EEDP is a government-wide compilation of various federal agency exclusions and replaces the Excluded Parties List System (EPLS). Exclusions contained in the EEDP are governed by each agency's regulatory or legal authority. The EEDP also includes parties and entities from other federal exclusion databases. All parties or entities listed on the EEDP are subject to exclusion from Medicaid participation. The current EEDP is available on the SAM website.

Providers on the EEDP list will be terminated from all products, federal and non-federal.

Restricted Provider Database (RPD)

The RPD is published by DHCS to identify providers placed under a payment suspension while under investigation based upon a credible allegation of fraud (Title 42, Code of Federal Regulations (CFR) section 455.23 and Welfare and Institution Code (WIC) section 14107.11. Search Part 455 of the CFR and search WIC. The sanction action is specific to the individual rendering provider's National Provider Identifier and/or Tax Identification Number as listed on the database file. Subcontractors and delegated entities may continue contractual relationships with providers on the RPD that are listed under a "payment suspension only"; however, reimbursements for Medi-Cal covered services must be withheld. Contracts must be terminated with providers on the RPD that are not listed under a "payment suspension only." Subcontractors and delegated entities choosing to terminate a provider's contract must notify Health Net per the language in the *Provider Participation Agreement* (*PPA*) and within the required advance notification turnaround times included in the Medi-Cal provider operations manual under Provider Oversight > Facility and Physician Additions, Changes and Deletions > Closure and Termination available in the Provider Library online. Providers under a payment

suspension will be indicated as such under the "comment" column of the database file. The RPD data file is updated monthly and is available at Healthnet.com. Registered providers can log into the provider portal to access the report located under the regulatory section.

Providers on the RPD list will be terminated from the Medi-Cal line of business only.

Claims Payment For Excluded Parties

Health Net, its PPGs, vendors, hospitals, and ancillary providers cannot pay participating and nonparticipating parties or entities included on these lists for any services using federal funds, except for emergency services provided by excluded providers under certain circumstances, see 42 CFR §1001.1901. Providers contracting with Health Net must have a documented process in place to ensure compliance with these guidelines, and notify enrollees who obtain services from excluded parties and make claims payments as allowed under these exceptions. This documentation is subject to audit upon request from Health Net or CMS.

Regulatory Citations for Excluded Requirements

Medicaid managed care programs, their subcontractors and other delegated entities must abide by the regulations documented in the Social Security Act 1862(e)(1)(B), 5 CFR §890.1043(a)(b)(c), 42 CFR §422.503(b)(4)(vi)(F), 422.752(a)(8), and 1001.1901, and California Welfare and Institutions Code sections 14043.6 and 14123.

Additional regulations that require sponsors to include CMS requirements in their contracts, as well as monitor their subcontractors and other delegated entities, are available in 42 CFR §422.504(i)(4)(B)(v) and 423.505(i)(3)(v).

Fresno, Kings and Madera

The Centers for Medicare & Medicaid Services (CMS) and the California Department of Health Care Services (DHCS) both require contractors, their subcontractors and other delegated entities to monitor federal and state exclusion lists. The parties or entities on these lists are excluded from various activities, including rendering services to Medicare, Medicaid and any other federal health care program enrollees (unless in the case of an emergency, as stated in 42 CFR §1001.1901), and employing or contracting with excluded parties to provide services to these enrollees. CalViva Health requires that its participating physician groups (PPGs), hospitals, ancillary providers, and practitioners continuously monitor federal and state exclusion lists. This communication provides the names of each federal exclusion list, governing regulations and CMS guidance, including links to publicly available exclusion lists.

Monitoring for Excluded Parties

The names of parties that have been excluded from participation in federal health programs are published in the Office of the Inspector General U.S. Department of Health and Human Services (OIG-HHS) List of Excluded Individuals and Entities (LEIE), CMS Preclusion List, Medi-Cal Suspended and Ineligible Provider List (SIPL), Medi-Cal Restricted Provider Database (RPD), Office of Personnel Management (OPM) under the Federal Employee Health Benefit Plan (FEHBP) and on the General Services Administration's (GSA) Exclusions Extract Data Package (EEDP), as referenced through the System for Award Management (SAM) website.

Providers on any of these lists, except for the RPD, will be terminated from all products, federal and non-federal. Providers on the RPD will only be terminated from the Medi-Cal line of business.

CalViva Health and Provider Responsibilities

CalViva Health is required to monitor federal and state exclusion lists to ensure that CalViva Health is not hiring, contracting or paying excluded parties or entities for services rendered to enrollees in CalViva Health's Medi-Cal plans. Contracted providers and their downstream subcontractors or delegated entities must check the LEIE, CMS Preclusion List, SIPL, RDP, FEHBP and EEDP exclusion lists prior to hiring or contracting with any new employee, temporary employee, volunteer, consultant, governing body member, subcontractor, or other delegated entity for Medicaid-related activities. Medicaid managed care entities, their subcontractors and other delegated entities must frequently 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 at https://oig.hhs.gov/exclusions.

The current LEIE is available on the OIG-HHS website. Frequently asked questions (FAQs) and additional information about the LEIE is available at OIG.

Providers on the OIG list will be terminated from all products, federal and non-federal.

CMS Preclusion List

The CMS Preclusion List is published by the Centers for Medicare & Medicaid Services to identify precluded providers. It is updated monthly and available on the Healthnet.com site, after logging on, under the regulatory section.

Providers on the CMS Preclusion List will be terminated from all products, federal and non-federal.

SIPL

The SIPL is published by DHCS to identify suspended and otherwise ineligible providers. It is updated monthly and available on the DHCS Medi-Cal website > Resources > References > Suspended & Ineligible Provider List. Additional information about the list is located in the Medi-Cal Suspended and Ineligible Provider List introduction.

CalViva Health, 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 for emergency services provided by excluded providers under certain circumstances. Contracting providers must have a documented process in place to ensure compliance with these guidelines, and notify enrollees who obtain services from excluded parties and make claims payments as allowed under these exceptions. This documentation is subject to audit upon request from CalViva Health or CMS.

Providers on the SIPL will be terminated from all products, federal and non-federal.

FEHBP

The OPM, under the OIG-HHS, imposes suspension and debarment actions for entities contracted with the FEHBP. The current FEHBP suspended and debarred report is available at Healthnet.com. Registered providers can log into the provider portal to access the reports located under the regulatory section.

Providers on the FEHBP list will be terminated from all products, federal and non-federal. Additionally, a 12-month claims look-back review must occur for all identified participating and non-participating providers. Federal Employee Health Benefit Plan members identified through the claims review must receive notification that the provider is no longer available to receive services from.

EEDP

The GSA's EEDP is a government-wide compilation of various federal agency exclusions, and replaces the Excluded Parties List System (EPLS). Exclusions contained in the EEDP are governed by each agency's regulatory or legal authority. The EEDP also includes parties and entities from other federal exclusion databases. All parties or entities listed on the EEDP are subject to exclusion from Medicaid participation. The current EEDP is available on the SAM website.

Providers on the EEDP list will be terminated from all products, federal and non-federal.

Restricted Provider Database (RPD)

The RPD is published by DHCS to identify providers placed under a payment suspension while under investigation based upon a credible allegation of fraud (Title 42, Code of Federal Regulations (CFR) section 455.23 and Welfare and Institution Code (WIC) section 14107.11. Search Part 455 of the CFR and search WIC. The sanction action is specific to the individual rendering provider's National Provider Identifier and/or Tax Identification Number as listed on the database file. Subcontractors and delegated entities may continue contractual relationships with providers on the RPD that are listed under a "payment suspension only"; however, reimbursements for Medi-Cal covered services must be withheld. Contracts must be terminated with providers on the RPD that are not listed under a "payment suspension only." Subcontractors and delegated entities choosing to terminate a provider's contract must notify Health Net per the language in the *Provider Participation Agreement* (*PPA*) and within the required advance notification turnaround times included in the Medi-Cal provider operations manual under Provider Oversight > Facility and Physician Additions, Changes and Deletions > Closure and Termination available in the Provider Library online. Providers under a payment suspension will be indicated as such under the "comment" column of the database file. The RPD data file is updated monthly and is available at Healthnet.com. Registered providers can log into the provider portal to access the report located under the regulatory section.

Providers on the RPD list will be terminated from the Medi-Cal line of business only.

Regulatory Citations for Excluded Requirements

Medicaid managed care programs, their subcontractors and other delegated entities must abide by the regulations documented in the Social Security Act 1862(e)(1)(B), 5 CFR §890.1043(a)(b)(c), 42 CFR §422.503(b)(4)(vi)(F), 422.752(a)(8), and 1001.1901, and California Welfare and Institutions Code sections 14043.6 and 14123.

Additional regulations that require sponsors to include CMS requirements in their contracts, as well as monitor their subcontractors and other delegated entities, are available in 42 CFR §422.504(i)(4)(B)(v) and 423.505(i)(3)(v).

Imperial Valley

The Centers for Medicare & Medicaid Services (CMS) and the California Department of Health Care Services (DHCS) both require contractors, their subcontractors and other delegated entities to monitor federal and state exclusion lists. The parties or entities on these lists are excluded from various activities, including rendering

services to Medicare, Medicaid and any other federal health care program enrollees (unless in the case of an emergency, as stated in 42 CFR §1001.1901), and employing or contracting with excluded parties to provide services to these enrollees. Community Health Plan of Imperial Valley requires that its participating physician groups (PPGs), hospitals, ancillary providers, and practitioners continuously monitor federal and state exclusion lists. This communication provides the names of each federal exclusion list, governing regulations and CMS guidance, including links to publicly available exclusion lists.

Monitoring for Excluded Parties

The names of parties that have been excluded from participation in federal health programs are published in the Office of the Inspector General U.S. Department of Health and Human Services (OIG-HHS) List of Excluded Individuals and Entities (LEIE), CMS Preclusion List, Medi-Cal Suspended and Ineligible Provider List (SIPL), Medi-Cal Restricted Provider Database (RPD), Office of Personnel Management (OPM) under the Federal Employee Health Benefit Plan (FEHBP) and on the General Services Administration's (GSA) Exclusions Extract Data Package (EEDP), as referenced through the System for Award Management (SAM) website. Providers on any of these lists, except for the RPD, will be terminated from all products, federal and non-federal. Providers on the RPD will only be terminated from the Medi-Cal line of business.

Community Health Plan of Imperial Valley and Provider Responsibilities

Community Health Plan of Imperial Valley is required to monitor federal and state exclusion lists to ensure that Community Health Plan of Imperial Valley is not hiring, contracting or paying excluded parties or entities for services rendered to enrollees in Community Health Plan of Imperial Valley's Medi-Cal plans. Contracted providers and their downstream subcontractors or delegated entities must check the LEIE, CMS Preclusion List, SIPL, RPD, FEHBP and EEDP exclusion lists prior to hiring or contracting with any new employee, temporary employee, volunteer, consultant, governing body member, subcontractor, or other delegated entity for Medicaid-related activities. Medicaid managed care entities, their subcontractors and other delegated entities must frequently 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. Frequently asked questions (FAQs) and additional information about the LEIE is available at OIG. Providers on the OIG list will be terminated from all products, federal and non-federal.

CMS Preclusion List

The CMS Preclusion List is published by the Centers for Medicare & Medicaid Services to identify precluded providers. It is updated monthly and available on the Healthnet.com site, after logging on, under the regulatory section.

Providers on the CMS Preclusion List will be terminated from all products, federal and non-federal.

SIPL

The SIPL is published by DHCS to identify suspended and otherwise ineligible providers. It is updated monthly and available on the DHCS Medi-Cal website > Resources > References > Suspended & Ineligible Provider List. Additional information about the list is located in the Medi-Cal Suspended and Ineligible Provider List

introduction. Community Health Plan of Imperial Valley, 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 for emergency services provided by excluded providers under certain circumstances. Contracting providers must have a documented process in place to ensure compliance with these guidelines, and notify enrollees who obtain services from excluded parties and make claims payments as allowed under these exceptions. This documentation is subject to audit upon request from Community Health Plan of Imperial Valley or CMS.

Providers on the SIPL will be terminated from all products, federal and non-federal.

FEHBP

The OPM, under the OIG-HHS, imposes suspension and debarment actions for entities contracted with the FEHBP. The current FEHBP suspended and debarred report is available at Healthnet.com. Registered providers can log into the provider portal to access the reports located under the regulatory section.

Providers on the FEHBP list will be terminated from all products, federal and non-federal. Additionally, a 12-month claims look-back review must occur for all identified participating and non-participating providers. Federal Employee Health Benefit Plan members identified through the claims review must receive notification that the provider is no longer available to receive services from.

EEDP

The GSA's EEDP is a government-wide compilation of various federal agency exclusions, and replaces the Excluded Parties List System (EPLS). Exclusions contained in the EEDP are governed by each agency's regulatory or legal authority. The EEDP also includes parties and entities from other federal exclusion databases. All parties or entities listed on the EEDP are subject to exclusion from Medicaid participation. The current EEDP is available on the SAM website.

Providers on the EEDP list will be terminated from all products, federal and non-federal.

Restricted Provider Database (RPD)

The RPD is published by DHCS to identify providers placed under a payment suspension while under investigation based upon a credible allegation of fraud (Title 42, Code of Federal Regulations (CFR) section 455.23 and Welfare and Institution Code (WIC) section 14107.11. Search Part 455 of the CFR and search WIC. The sanction action is specific to the individual rendering provider's National Provider Identifier and/or Tax Identification Number as listed on the database file. Subcontractors and delegated entities may continue contractual relationships with providers on the RPD that are listed under a "payment suspension only"; however, reimbursements for Medi-Cal covered services must be withheld. Contracts must be terminated with providers on the RPD that are not listed under a "payment suspension only." Subcontractors and delegated entities choosing to terminate a provider's contract must notify Health Net per the language in the *Provider Participation Agreement* (*PPA*) and within the required advance notification turnaround times included in the Medi-Cal provider operations manual under Provider Oversight > Facility and Physician Additions, Changes and Deletions > Closure and Termination available in the Provider Library online. Providers under a payment suspension will be indicated as such under the "comment" column of the database file. The RPD data file is updated monthly and is available at Healthnet.com. Registered providers can log into the provider portal to access the report located under the regulatory section.

Providers on the RPD list will be terminated from the Medi-Cal line of business only.

Regulatory Citations for Excluded Requirements

Medicaid managed care programs, their subcontractors and other delegated entities must abide by the regulations documented in the Social Security Act 1862(e)(1)(B), 5 CFR §890.1043(a)(b)(c), 42 CFR §422.503(b)(4)(vi)(F), 422.752(a)(8), and 1001.1901, and California Welfare and Institutions Code sections 14043.6 and 14123.

Additional regulations that require sponsors to include CMS requirements in their contracts, as well as monitor their subcontractors and other delegated entities, are available in 42 CFR §422.504(i)(4)(B)(v) and 423.505(i)(3)(v).

Sub-Delegated Functions

Provider Type: Participating Physician Groups (PPG)

For delegated entities that subcontract with another entity to carry out delegated quality management (QI), utilization management (UM), member connections, and credentialing and recredentialing functions, the Delegation Oversight Department is enforcing the following National Committee for Quality Assurance (NCQA) requirements:

- QI for quality management
- UM for utilization management
- MEM for member connections
- CR for credentialing and recredentialing

The Plan performs audits and requires that delegated entities demonstrate how they ensure that the subcontractor performing delegated QI, UM, member connections, and credentialing and recredentialing functions on the delegated entities behalf is meeting NCQA standards and any additional regulatory state and/or federal requirements. More specifically, the Plan requires proof of an agreement between the provider group and subcontractor entity that delineates the rights and responsibilities of each party and requirements for review of subdelegated activities.

Definitions

The current Health Plan Standard and Guidelines, published by NCQA, define delegation and sub delegation as follows:

- Delegation - Occurs when the organization (Health Net) gives another entity (such as a participating physician group (PPG) or independent practice association (IPA) the authority to carry out a function that the organization would otherwise perform.
- Sub delegation - Occurs when the organization's delegate (such as a PPG or IPA that contracts with Health Net to perform a specific function) gives a third entity the authority to carry out a delegated function.

Contractual Financial and Administrative Requirements

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

This section contains general information on contractual financial and administrative requirements.

Select any subject below:

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

Provider Type	Category	Standard
PPG	Average Claims Liability	between 2.5 & 3.5 months
PPG	General and Administrative Expenses	= or < 0.15
Hospital	Total Operating Expense	= or < 1.0
PPG, Hospital	Total Z-Score	= or > 1.81

If the PPG is determined to be noncompliant, a corrective action plan (CAP) must be filed simultaneously with the financial survey to the Department of Managed Health Care (DMHC).

PPGs With Sub-Delegating Risk Arrangements

PPGs with sub-delegating risk arrangements are required to monitor and evaluate the financial viability of their delegated and capitated participating providers and maintain adequate procedures to ensure providers' reports and financial information confirms each provider is financially solvent according with section 1300.75.4.5(a)(1) of Title 28 of the California Code of Regulations (CCR) and with Health Net's financial benchmark as outlined above. When requested by Health Net, PPGs are required to provide copies of their monitoring policies and procedures within 30 days of Health Net's request.

Financial Survey Filing Requirements

Participating Physician Groups (PPG) | Hospitals

The following Department of Managed Health Care (DMHC) filing requirements are included for those participating physician groups (PPGs) that assume financial risk on a capitated or fixed periodic payment basis for the cost of health care services rendered to health plan members (sections 1300.75.4, 1300.75.4.2, 1400.75.4.7, 1300.75.4.8, and 1300.76 of Title 28 of the California Code of Regulations (CCR)).

PPGs and hospitals must submit the quarterly and annual audited financial statements to Health Net's Financial Oversight Department.

Filing Types	Requirements	Filing Period	Filing Deadline
Quarterly Financial Survey	PPGs submit an electronic quarterly financial survey report to DMHC and Health Net no later than 45 calendar days following the close of each quarter of its fiscal year. (Note: PPGs with financial statements prepared in the fiscal year submit the most recent quarter.) Hospitals submit quarterly financial surveys to Health Net directly. (Note: Hospitals with financial statements prepared in the fiscal year must submit the most recent quarter.)	Q1 Q2 Q3 Q4	May 15 August 15 November 15 February 15
Annual Financial Survey	PPGs submit an electronic annual audited financial survey including auditors notes and opinion letter to DMHC and Health Net not more than 150 calendar days after the close of PPG's fiscal year determined by the DMHC, and based upon PPG's annual audited financial statement prepared in accordance with	Annual	May 31

Filing Types	Requirements	Filing Period	Filing Deadline
	generally accepted auditing standards. Hospitals submit annual audited financial surveys including auditors notes and opinion letter to Health Net directly.		

If a PPG organization reports deficiencies in any of the six DMHC grading criteria listed below, the PPG must submit a self-initiated corrective action plan (CAP) proposal in an electronic format to DMHC and Health Net (section 1300.75.4.8 of Title 28 of the CCRs). The grading criteria are:

- tangible net equity (TNE): must be positive
- required tangible net equity: Positive TNE shall be at least equal to the greater of:
  - (A) one percent (1%) of annualized revenues; or,
  - (B) four percent (4%) of annualized non-capitated medical expenses.
- working capital: must be positive
- cash-to-claims ratio: 0.75
- claims timeliness percentage: 95%
- incurred but not reported (IBNR) methodology, both documented and used in estimation of IBNR liabilities: three months

Late Filing for Financial Survey Requirements

Health Net is required by the DMHC to follow up on late filing of the financial survey (section 1300.75.4.5 of Title 28 of the CCR). As soon as the PPG files with DMHC, the PPG must immediately submit the confirmation of the filing to the Financial Oversight Department. Late-filing PPGs can be downloaded from the DMHC website.

Physician Incentive Plan

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

The California Department of Managed Health Care (DMHC), the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) require that providers and health plans furnish to requesting members general information regarding the contractual incentive plans currently in place. Information provided would be general information on how the provider is reimbursed for delivering covered services. Specific financial information is not required.

PPG Networking Contractual Requirements

Participating Physician Groups (PPG)

Participating physician groups (PPGs) may contract with providers to furnish necessary services to members. The California Department of Managed Health Care (DMHC) and the Centers for Medicare & Medicaid Services (CMS) require health plans to collect and review the contract and subcontract templates at least annually to ensure that they contain required elements and wording and do not contain prohibited elements or wording. Contract and subcontract templates, with a cover letter, must be submitted on request and on issuance of a new template.

PPG Network

PPGs must provide the plan with a list of names, practice locations, federal tax identification numbers, professional practice names, and the business hours for all member physicians and other participating providers who contract with the PPG. The list must be submitted in a form acceptable to the plan as stated in the Provider Participation Agreement (PPA).

Proof of Executed Contracts

DMHC requires the plan to ensure that all providers in the network have executed contracts. The plan requires that the cover page and signature page of each provider and physician contract be submitted on execution, on credentialing or re-credentialing, and on request to the provider relations and contracting specialist (formally provider network administrator (PNA)) assigned to the PPG.

Provider Education

Each PPG is responsible for having a written process that assists in timely distribution of plan policies, procedures, manuals, updates, newsletters, and reports. PPGs are required to:

- Publish and distribute provider operations manuals and updates to all providers, taking steps to ensure that new providers receive these materials promptly.
- Maintain provider and member service education programs for each primary care physician's (PCP's) office.

Use of Performance Data

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

Health Net is subject to various statutory, regulatory and accreditation requirements, and must ensure that all agreements comply with any such mandates. Accreditation from the National Committee for Quality Assurance (NCQA) is critical to both the health plan and network providers, and ensures that Health Net meets the highest possible standards of excellence and care.

One of the requirements of NCQA is that Health Net may use practitioner performance data for quality improvement activities. Therefore, Health Net's contract templates have been updated with the following language:

Provider agrees to cooperate with quality management and improvement (QI) activities; maintain the confidentiality of member information and records pursuant to this agreement; and allow Health Net to use provider's performance data.

Delegated Medical Management

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

This section contains general information on delegated medical management.

Select any subject below:

- Overview
- Delegation
- Delegation Oversight Interactive Tool
- PPG Responsibilities for Referral Tracking

Overview

Provider Type: Participating Physician Groups (PPG) | Hospitals

Participating physician groups (PPGs) with delegated utilization management (UM) status are required to consistently meet Health Net's UM standards related to inpatient care, outpatient care, discharge planning, case management, retrospective review, and timeliness of authorizations and denials. Health Net's UM standards are updated as necessary to comply with standards established by federal and state regulatory agencies and accreditation entities, such as the National Committee for Quality Assurance (NCQA). Delegation of UM activities allow for autonomy based on PPG capabilities and creates accountability to Health Net. Health Net audits PPGs for accountability and reporting of PPG activities.

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

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

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

Program Description

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

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

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

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

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

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

Policy Development

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

UM Committee

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

Delegated Prospective Review of Emergency Services

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

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

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

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

Encounter Data

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

Aggregate data analysis allows the PPG to assess overall trends of utilization. Reports of all services approved following the PPG utilization management (UM) program are submitted to Health Net through encounter data. The encounter data system assists in tracking and trending utilization patterns across Health Net's provider network. A successful encounter-reporting schedule is important to assure that service data is submitted to

Health Net in an accurate and timely manner. Contact the Encounter Department for assistance. Failure of the PPG to submit timely and accurate data, as well as failure to meet these standards, results in development of a corrective action plan (CAP).

Shared Risk UM Responsibilities

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

PPG Responsibilities

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

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

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

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

PPG Responsibilities Regarding Nonparticipating Hospitals

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

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

Plan Responsibilities

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

- Assigning a UM nurse to receive concurrent reviews from PPGs (by telephone or onsite) on selected cases, or, as required for the purpose of assisting in arranging for the provision of care at the correct level and in members' discharge planning.
- Assigning a regional medical directors (RMDs) and provider relations & contracting specialist (formally provider network administrator) to act as a liaison with network providers to resolve contractual, operational and service problems.
- Having the Member Services Department function as a liaison between members and the PPG.

- Performing member satisfaction surveys and initiating intervention as needed.
- Assigning a UM Compliance Auditor to conduct pre-contractual evaluations, annual evaluations, and perform oversight and monitoring of the PPG to evaluate the PPG's UM program using the Delegation Oversight Interactive Tool (DOIT), including a review of denial and appeal process, and assisting the PPG in complying with these policies, state and federal regulations and accreditation standards.
- Providing non-participating hospitals in California with one contact telephone number to call to request authorization to provide post-stabilization services to a patient who has received emergency services. After receiving the required information from the PPG, Health Net contacts the nonparticipating hospital with directions for transferring the patient or an authorization for medically necessary post-stabilization care. If the telephone call is not returned within 30 minutes, authorization is deemed to be granted (pursuant to enactment of Assembly Bill 1203 (2008), which amended Health and Safety Code section 1262.8 (b)(3) and section 1371.4. (This does not apply to Medicare Advantage HMO members.).

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

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

DSNP prior authorization timelines

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

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

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

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

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

Services not covered under Medicare but covered under Medi-Cal

- Asthma remediation
- Community Based Adult Services
- Community Supports
- Community transition services/nursing facility transition services to a home
- Day habilitation programs
- Durable medical equipment (DME) that is covered by Medi-Cal
- Environmental accessibility adaptation (home modification)
- Housing deposit (up to $6,000)
- Housing tenancy and sustaining services
- Housing transition navigation
- Long-term care

- Medically tailored meals
- Nursing facility transition/diversion to assisted living facilities
- Personal care services and homemaker services
- Recuperative care
- Respite services
- Short-term post-hospitalization housing
- Sobering centers

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

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

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

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

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

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

Delegation

Provider Type: Participating Physician Groups (PPG)

Health Net uses the Delegation Oversight Interactive Tool (DOIT) to evaluate structural and process elements. Refer to the Utilization Management (UM)-Delegation Agreement for more information on these elements.

Health Net may delegate responsibility for activities associated with UM and Care Management services to its PPGs. Prior to participating with Health Net, and at least annually thereafter, Health Net conducts a review of each PPG. Health Net uses DOIT and other tools to evaluate the provider's facility and ability to deliver high-quality health care consistently and perform necessary administrative functions. Based on the audit scores and findings, if certain thresholds and criteria are met, the Delegation Oversight Committee (DOC) may deem it proper to delegate certain specific functions to the PPG to perform. If approved for delegation, a delegation agreement is forwarded to the PPG for signature. The delegation agreement includes a matrix that delineates the specific responsibilities delegated to, and accepted by, the PPG.

Upon delegation, Health Net may delineate specific and certain medical management functions for performance improvement. Performance improvement plans shall be shared with PPGs at regular intervals. Health Net and PPG medical directors are required to afford and actively participate in implementation of performance improvement plans.

Health Net systematically monitors and tracks provider compliance for all delegated providers because Health Net remains accountable to state and federal regulatory agencies for provider compliance even if certain functions are delegated.

Delegation Program Monitoring and Evaluation

Health Net may delegate responsibility for activities associated with utilization management (UM) and Care Management to participating providers. The DOC determines delegation status for each of the above functions, based initially on the results of pre-delegation comprehensive evaluation.

The DOC renders delegation decisions and provides guidance regarding delegation responsibilities through reports of annual audit results, oversight and monitoring, and periodic reviews of PPG specific data as reported from the Health Net Quality Improvement (QI) staff. This data includes, but is not limited to, complaints, access audit performance, member satisfaction results, and other quality of care data. Health Net may revoke, partial or complete delegation at any time if the committee determines that the PPG is no longer capable of performing delegated functions.

The DOC communicates delegation decisions for new PPGs or additional lines of business, as well as any recommendations and requests for root cause analysis and/or corrective action plans, to the PPG in writing by a series of standardized letters. The letters describe the functions or activities for which delegation is approved or denied, a delegation agreement, a delineation of the responsibilities of the PPG and the health plan, and the time frames for responses and submission of any required corrective plans. Health Net always remains accountable for all care and service delivered to members.

Delegation agreements for existing delegates are updated and signed as needed.

Health Net and PPGs may schedule operations meetings based on PPG requests or business needs identified by Health Net. Other criteria affecting PPG performance may necessitate additional meetings as determined by representatives. The meetings are multidisciplinary and provide a forum for both parties to discuss operational issues and PPG performance measures, which may include: access audit results, accreditation updates, UM audit results, care management audit results, appeals and grievance issues, denial issues, medical management issues, claims issues, eligibility, encounter data submission, pharmacy issues, required submissions report, provider profiles, and other information relevant to the member population served. Representatives from the PPG, Health Net and participating hospitals (if any) are included in the meetings.

Screening of prospective, concurrent and retrospective quality issues is conducted by the Quality Improvement staff upon notification of potential quality of care concerns. Indicators that may be reviewed include:

- Access - delay in authorization
- Access - delay in diagnosis
- Access - delay in service
- Communication
- Continuity of care
- Denial or delay of referral or authorization
- Denial of treatment
- Emergency services
- Encounter data submission
- Financial viability
- Inadequate care
- Inappropriate care or treatment
- Inappropriate denial of treatment
- Messy or unsanitary environment
- Misdiagnosis or inability to diagnose
- PPG claims and UM timeliness
- Physician incentive plan reporting
- Provider education
- Refusal to treat or care for members
- Rude, inappropriate or insensitive behavior
- Satellite addition and deletion
- Unprofessional and unethical behavior
- Urgent issues
- Utilization, credentialing and claims delegation oversight

Transitioning Delegated Functions

Delegated providers interested in transitioning any of their delegated functions, such as utilization management, claims, care management, or credentialing, to a new or different subcontracted entity or management services organization (MSO) must request approval from Health Net a minimum of 90 calendar days in advance of the anticipated transition date.

Submit written requests to your Provider Network Management (PNM) representative at least 90 calendar days in advance of the transition with the following information:

- Name of the new entity
- Delegated functions to transition to the new entity
- Contact name with contact information at the new entity
- Date of proposed transition

Approval or denial of the delegation transition to another entity is provided by Health Net once Health Net performs a comprehensive assessment and evaluation of the new entity.

Delegated providers are prohibited from initiating any transition plans to the new entity without Health Net's prior approval. Failure to comply with adequate notification and approval can jeopardize a provider's participation in Health Net's provider network.

Revoking Delegation

The DOC may, prior to any of the steps discussed in the Corrective Action Plan topic, decide to revoke delegation or send Health Net staff to the PPG for oversight and to assist in achieving compliance. When revoking delegation, Health Net follows written policies and procedures to ensure that there is no adverse effect on members.

Program Evaluation for Delegation

Oversight of PPG

Oversight of PPG operations includes annual ongoing review and monitoring of the written description of the utilization management (UM) program and operational assessment using the Delegation Oversight Interactive Tool (DOIT). PPG oversight includes, but is not limited to:

- Monitoring of denials.
- Compliance with health care criteria.
- Compliance with Health Net's approval and denial decision timelines standards.

During the assessment, the UM compliance auditor reviews policies and procedures, including the UM program to validate adherence to compliance standards. The UM compliance auditor will provide the PPG with details on all findings and request the PPG to outline a plan for improvement, where needed. The UM compliance auditor will review this plan and verify that it is appropriate based on the failures identified prior to approval.

Additional PPG documentation may be requested to complete the evaluation. The completed evaluation, with recommendations from the UM compliance auditor, is reviewed and presented to the Delegation Oversight Workgroup (DOW) and forwarded to the Delegation Oversight Committee (DOC). PPGs with extensive improvement plans are monitored closely until the changes are effective. A non-compliant PPG may be referred to the DOC for further action. Status reports are made to the DOC. PPGs not able to maintain the required standards are referred to the DOC for possible revocation of specified delegated activities.

In the event that a PPG disagrees with audit findings or the delegation decision of the DOC, the PPG may present the issue in dispute, in writing, to the chairperson of the DOC within 10 business days of receipt of the determination.

Delegation Assessments

Health Net evaluates the PPG's UM program pre-contractually and at least annually thereafter. To guide the assessment and provide consistency, Health Net uses a standard set of evaluation criteria driven by regulatory requirements and guidelines. Criteria is applied based on the lines of business delegated to the PPG.

The UM compliance auditors will perform these evaluations. The UM compliance auditor communicates with PPGs regarding the UM and care management (CM) program and standards. The UM compliance auditors are the principal liaison for regulatory requirements between Health Net and the PPGs and play an integral role in helping PPGs maintain compliance with Health Net's expectations.

Delineation of Delegation Responsibilities

Structural elements are basic requirements that must be developed in order to maintain an effective utilization management (UM) program. These elements are developed and approved to provide a process to support UM activities. The elements of a provider's UM program are reviewed, revised and approved annually. Health Net

uses the Delegation Oversight Interactive Tool (DOIT) for evaluating structural and process elements. Refer to the Utilization Management (UM)-Delegation Agreement for more information.

Revocation of Delegated Medical Management

Health Net reserves the right to revoke delegated status when the PPG has failed to meet and maintain established standards. Capitation payments may be adjusted when revocation of medical management functions occurs.

Delegated Review Processes - Concurrent, Prospective and Retrospective

Participating physician group (PPG) utilization review (UR) staff should perform concurrent reviews daily. PPGs may be required to communicate their concurrent review findings to Health Net medical management staff daily, or as requested by the Utilization Management (UM) and Care Management (CM) staff. The objective of PPG concurrent reviews is to assess clinical information during a member's hospital stay, coordinate the discharge plan, assist in determining medical necessity at the correct level of care, and perform the quality improvement screening.

The first review occurs within 24 hours of admission to confirm that the member is in the appropriate setting and is receiving medically necessary care, and to begin discharge planning. The PPG utilization management nurses review the member's continued stay using standardized nationally recognized criteria, such as InterQual® Guidelines. If a concurrent review does not confirm the need for continued stay, alternative care or a less acute level of care must be considered.

PPGs must develop processes to identify and manage variant bed days and provide timely notification of denials to Health Net to facilitate claims adjudication.

Health Net is responsible for a concurrent review of out-of-area admissions for delegated PPGs, except for PPGs with financial responsibility for out-of-area services, according to the PPG's Provider Participation Agreement (PPA). Refer to the Out-of-Area Services discussion for more information. PPGs are responsible for working with Health Net to determine and facilitate the transfer of a member back into the network when appropriate, and the member is stable.

Prospective Review Process

A prospective review is performed to determine the medical necessity of elective referrals to specialty or ancillary care, inpatient admissions and outpatient procedures.

Requests for prior authorization of elective referrals, admissions or procedures are received by the participating physician group (PPG) from the primary care physician (PCP) or specialist. The PPG determines medical necessity through the use of standardized nationally recognized criteria and approves or denies the request. Refer to the Referrals and Prior Authorization topics for additional information.

Performance standards for turn-around times for review of, determination and decision notification for requests for prior authorization vary by line of business and the urgency of the request. Refer to the Utilization Management Timeliness Standards for Commercial, Medi-Cal and Medicare plans on the Industry Collaboration Effort (ICE) website at www.iceforhealth.org/library.asp.

The PPG is obligated to provide oversight and documented monitoring of the utilization review process for medical appropriateness whenever this process is performed by a sub-delegated review organization. The PPG may not sub-delegate a function or activity to an entity whose delegation status with Health Net is currently denied or revoked for that function or activity. PPGs must notify Health Net prior to any sub-delegation agreement.

The UM Compliance Auditor periodically educates the PPG on plan tools, provides performance data, and evaluates performance using the provider assessment tools. Failure to meet the standards results in development of an issue in the DOIT and requires the PPG to create and action plan to remediate all findings. The PPG will submit an action plan for approval by the UM compliance auditor, who will review the action plan to ensure it is appropriate to address all findings. Once approved, the PPG must update the UM compliance auditors through DOIT of the status of each action plan. Once completed, the UM compliance auditor will decide if retesting is required for the issue.

Retrospective Review Process

A retrospective review is conducted on individual cases and with aggregate decision data. An individual case review helps to identify specific matters arising from an episode of care (for example, emergency room claims are reviewed for medical necessity and coverage). Problems identified through the retrospective review process are communicated to the PPG to identify and manage variant bed days and provide timely notification of denials to Health Net to facilitate claims adjudication.

Utilization Management Responsibilities

Dual risk is restricted to participating physician groups (PPGs) with a dual-risk capitation agreement with the plan for professional and hospital services that have successfully met the plan performance standards. These groups have comprehensive administrative systems and have demonstrated an ability to perform utilization and care management activities effectively. At least annually, Health Net performs standardized program reviews of these PPGs to assess performance. Refer to the discussions in the Provider Evaluation for Delegation section for more information about the standardized program reviews, including the use of the Delegation Oversight Interactive Tool (DOIT).

PPG Responsibilities

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

- Having an effective, comprehensive utilization management (UM) and care management (CM) program in place that includes a UM committee comprised of actively practicing providers.
- Performing prospective, concurrent and retrospective reviews of medical care consistent with Health Net's goals and objectives.
- Cooperating with Health Net on medical management of all out-of-area admissions.
- Providing valid and reliable encounter data in a timely manner as requested and complies with the UM program.
- Reporting and analysis, including, but not limited to, the following:
    - Bed days/1,000, admits/1,000, length of stay (semi-annually for commercial and quarterly for Medicare)
        - For Health Net membership
        - For all managed care membership
    - Mental health (not applicable to Medi-Cal)
        - Days/1,000

        - Admits/1,000
        - Length of stay
    - Adoption of UM criteria
    - Monitor quality and timeliness of UM decisions and notifications
    - Approval and denials
    - Communication with members
- Preparing action plans for any out-of-the-ordinary UM indicators.
- Identifying children with potential California Children's Services (CCS)-eligible conditions and making referrals to the appropriate CCS county programs (applicable to Medi-Cal only).
- Having a written UM program description and plan approved by Health Net. The program and plan are evaluated annually for effect on members and providers and are reviewed and approved by the governing body of the PPG with signature and minutes documenting the approval.
- Having specific written procedures for precertification, concurrent and retrospective reviews, and care management that is supervised by qualified medical professionals and physician consultants from the applicable specialties of medicine and surgery. Physicians used to assist in medical necessity determinations are certified by one of the American boards of medical specialties.
- Having a UM committee composed of providers that makes determinations regarding approval or denial of health care services to members.
- The PPG's UM program and policies and procedures specifically outline member and provider notification of medically necessary determinations, including for approvals and denials. The denial process is clearly outlined and includes an appeal process.
- The PPG denial policy and procedure and member letters include required regulatory statements that clearly indicate the reason for the denial, alternative treatment suggestions and how the member can appeal directly to Health Net.
- The PPG denial process includes required regulatory statements that inform participating providers (for example, physicians, inpatient facilities, and ancillary providers) that they may appeal directly to Health Net.
- The PPG uses standardized nationally recognized UM medical review criteria to ensure consistent medical necessity determinations and interrater reliability (IRR) for all individuals involved in the UM process.
- The PPG and PPG-hospital affiliates report encounter data monthly. Care management cases (shared risk only) are reported to the Medical Management staff at the point of identification. Dual-risk PPGs delegated to perform complex case management according to NCQA standards are assessed annually for compliance with those standards. Refer to the Care Management section in the Utilization Management section for additional information on criteria for referral to the care management program.
- The PPG assists in identification of coordination of benefits and third-party payer information (not applicable to Medi-Cal).
- The PPG participates with Health Net in meetings as scheduled.
- The PPG administers member coverage based on the member's Evidence of Coverage (EOC).
- Failure of the PPG to meet the under- and over-utilization standards results in development of a corrective action plan that is submitted to Health Net for review and approval.
- PPG representatives participate with Health Net medical management committees as requested.

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

Health Net Responsibilities

In a dual-risk relationship, Health Net is responsible for the following:

- Contracting with the PPG for delegated UM functions.
- Assigning a UM Compliance Auditor to conduct pre-contractual evaluations, annual evaluations, and perform oversight and monitoring of the PPG to evaluate the PPG's UM program using the Delegation Oversight Interactive Tool (DOIT), including a review of denial and appeal process, and assisting the PPG in complying with these policies, state and federal regulations and accreditation standards.
- During the pre-contractual assessment with the PPG, the UM compliance auditor validates the PPG UM program adheres to the plan utilization and care management delegation criteria.
- Review and approval of the PPG UM program and conducting an annual audit of the PPG using the Delegation Oversight Interactive Tool (DOIT), including a review of denial files. If the PPG is not able to maintain the required standard of medical management, the Delegation Oversight Committee (DOC) may recommend revocation of specific delegated activities.
- A provider engagement and network specialist (formally provider network administrator) and a regional medical director (RMD) acts as a liaison with the PPG to resolve all contractual, operational and ongoing service problems.
- Oversight and monitoring when the PPG is delegated to perform complex care management for its dual-risk membership.
- PPG performance is monitored to determine if members are receiving timely medical services.

Requirements for PPGs Utilization Management Process

Health care service plans (HCSPs) and participating physician groups (PPGs) to which utilization management (UM) functions are delegated are required to employ and designate a senior medical director with an unrestricted California license to be responsible for ensuring that the UM processes are in compliance with the statute.

The name and direct telephone number (or extension) of the health care professional making the decision to delay, deny or modify a request for authorization of payment of service must be included in the notification letter to the requesting provider.

Health care service plans and PPGs to which UM functions are delegated are required to maintain telephone access for providers to request authorization for payment of health care services.

Timeliness Requirements for UM Decision Making

The health care service plan and its PPGs to which utilization review (UR) functions have been delegated are required to comply with standards established by the Centers for Medicare & Medicaid Services (CMS), the Department of Health Care Services (DHCS) and the National Committee for Quality Assurance (NCQA).

For current standards, refer to the Industry Collaboration Effort (ICE) website at www.iceforhealth.org/library.asp to locate the Approved ICE Documents for the appropriate UM Timeliness Standards.

Disclosure of UM and UR Processes

Health care service plans (HCSPs) (or delegated participating physician groups (PPGs)) and disability insurers are required to disclose the UM and UR processes and criteria the plan and its delegated PPGs use to

authorize, modify, defer, or deny health care services when requested by health care providers, members or the public.

Disclosures must be accompanied with the following text in its entirety:

"The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."

Health care service plans and PPGs may charge reasonable fees for copying and postage costs and may make the information available electronically.

PPG Responsibilities for Referral Tracking

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

Participating physician groups (PPGs) delegated for utilization management (UM) functions are required to develop and implement policies and procedures for tracking whether Health Net members actually obtained services authorized pursuant to a referral.

In accordance with the California Department of Health Care Services (DHCS) requirements, Health Net requires PPGs to track member compliance with referrals within their network. PPGs may consider generating monthly reports on outstanding or expired referrals. These reports can be used at both the PPG and primary care physician (PCP) level to monitor completion and follow-up on referrals for specialty services.

Health Net's medical program managers (MPMs) monitor delegated PPGs for compliance with this responsibility as part of the PPG's annual UM audit and continuous oversight activities.

Delegation Oversight Interactive Tool

Participating Physician Groups (PPG)

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

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

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

Facility and Physician Additions, Changes and Deletions

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

This section includes information on requirements for adding or removing a participating provider.

Select any subject below:

Overview

Participating Physician Groups (PPG) | Ancillary | Hospitals

A participating provider that expands its capacity by adding new or satellite facilities or new participating physicians or other subcontracting providers must notify Health Net in writing at least 90 days before the addition. According to the terms of the Provider Participation Agreement (PPA), the participating provider agrees that Health Net has the right to determine whether the new or satellite facilities or the new participating physicians are acceptable to Health Net.

Addition of New Physicians, Providers or Facilities

Until Health Net approves new subcontracting providers (for example, primary care physicians (PCPs), specialists and ancillary providers), the providers are not allowed to provide covered services under the Health Net PPA. Health Net must be notified in writing at least 90 days before the addition.

Health Net is free to deny participation to any new subcontracting providers and is not obligated to state a cause or explain the denial of the addition or provide the facility, provider or subcontracting providers with any right to appeal or any other due process. Health Net's decision in these cases is final and binding.

In addition, hospitals, ancillary providers and participating physician groups (PPGs) are responsible for providing Health Net with copies of the standard agreements used for their subcontractors. Health Net reviews these standard agreements to ensure compliance with regulatory requirements[1] and directs the facility to make any changes required in order to meet the requirements. Health Net requires hospitals, ancillary providers and

PPGs to send sample forms to Health Net for review if they make any changes to their standard agreements or replace them with new standard agreements.

Hospitals, ancillary providers and PPGs must provide Health Net with a copy of the signature page for each subcontractor. Physicians or other subcontractors must be credentialed before they are added to Health Net's network. Hospitals, ancillary providers and PPGs must also provide Health Net a list of the names, locations and federal tax identification numbers (TINs) of all of its participating providers.

Hospitals, ancillary providers and PPGs are also responsible for informing Health Net when they cease to use a specific subcontractor or when they add a new subcontractor. Health Net periodically sends each hospital, ancillary provider and PPG a list of the physicians or subcontractors Health Net shows as active and under contract with the participating provider. Hospitals, ancillary providers and PPGs are required to review this list and notify Health Net of any additions or deletions. At least monthly, hospitals, ancillary providers and PPGs must provide Health Net with a list of additions, deletions and address changes, as well as a complete listing annually.

For PPGs only, the Active Physicians Listing is available monthly on the Health Net provider website as an administrative report. Select Provider Reports under Welcome. This report provides PPGs a means to review and revise their records on a monthly basis and communicate physician demographic changes and terminations to Health Net. Additionally, this listing is used by the Health Net Provider Network Management Department to validate PCP and specialist information with the PPG on a quarterly basis.

Hospitals, ancillary providers and PPGs must furnish Health Net copies of any amendments to a contract with a participating provider within 20 days of execution.

[1]Medicare Managed Care Manual, Chapter 11, Section 100.4.

Appeals and Grievances

Provider Type: Participating Physician Groups (PPG)

Health Net does not delegate member appeals or grievances, except for Molina. The Health Net State Health Programs Quality Improvement Health Equity Committee (QIHEC) reviews quarterly Medi-Cal appeals and grievance reports to assess emerging patterns of appeals and grievances, and to formulate potential plan policy/process changes and/or procedural improvements.

For more information on member appeals or grievances, refer to the discussions of Member Appeals and Grievances.

Outpatient Pharmacy Benefits and Services Carve Out

Health Net Medi-Cal pharmacy benefits and services transitioned from managed care to the State’s responsibility under the pharmacy benefit program known as Medi-Cal Rx. Appeals and grievances for these benefits and services are the responsibility of Medi-Cal Rx. Disputes regarding the denial of a referral or a prior authorization request should be directed to DHCS State Fair Hearing and not to Health Net. If Health Net receives a grievance related to these services, Health Net will redirect those grievances to Medi-Cal Rx contractor, Magellan Medicaid Administration, Inc. (Magellan), in a timely manner and in the manner outlined by DHCS. If Health Net receives an appeal related to these services, DHCS State Fair Hearing process is responsible. Health Net will redirect those appeals to DHCS State Fair Hearing.

Conditions of PCP Office Closures

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

Participating primary care physicians (PCPs) may close their practices to new members while remaining open to members of other insured or managed health care plans, provided certain conditions are met:

- The PCP must establish a certain numerical or percentage threshold beyond which they no longer accepts new members.
- The PCP may close their panel to new members once the threshold is met, provided that the number of members of the PCP exceeds the number of patients who are members of any other single insured or managed health care plan at the time the PCP wants to close their practice to plan members.
- Health Net has established a threshold in compliance with regulatory and accreditation requirements.

If a patient of the PCP, while a member of another health care plan, joins the plan, the PCP must continue to accept the member even if the PCP practice is closed to new plan members.

PCPs must provide the plan with any documentation or information reasonably requested to demonstrate to Health Net that the above conditions are being met prior to closing the practice to new members.

A PCP may close their practice to all new patients from all insurance or health plans at any time.

Facility and Physician Additions, Changes and Deletions | Facility Decertification Notification Requirement

Ancillary

Health Net is required to end contracts with network providers and subcontractors who have been decertified or whose participation has been revoked from the Medi-Cal and Medicare programs.

The California Department of Public Health (CDPH) is responsible for decertifying licensed long-term care (LTC) facilities. LTC facilities that receive a decertification notice from CDPH must take these steps:

1. Notify their Health Net Provider Network Management representative to begin the contract termination process.
2. Help with the transition planning for Health Net members in the LTC facility's care.

Affected LTC facilities

These requirements apply to any of these LTC facility types:

- Skilled nursing facilities (SNFs)
- Intermediate care facilities
- Congregate living health facilities
- Nursing facilities
- Pediatric day
- Respite facilities

Health Net's responsibilities

Upon notice from the LTC facility, Health Net:

- Ends its contract with the LTC facility within five business of the notice.
- Develops and submits a member transition plan to the DHCS.
- Suspends all payments for services provided after the effective date of the decertification notice.
- Informs all affected contracted providers and members of the decertified LTC facility.
- Coordinates care for members as required by federal and state law, and Health Net's contract with DHCS.

Immediate closure of LTC facilities by CDPH

In these cases, CDPH handles the transition of all affected members residing in the LTC facility. Health Net tracks the transition of members and coordinates care as needed.

Closure and Termination

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

Participating physician groups (PPGs) are required to notify the Health Net Regional Provider Network Management Department in writing at least 90 days in advance of the date that a subcontracting provider does the following:

- closes the medical practice
- terminates the relationship with the PPG

For Medi-Cal plans, Health Net must notify Medi-Cal members in writing within 15 calendar days of receipt of a primary care physician (PCP) termination or changes in PCP locations or after any unforeseen provider changes have been reported to Health Net. The notice to Medi-Cal members must be approved by the Department of Health Care Services (DHCS) prior to release, and is sent by U.S. mail, with instructions on selecting a new PCP.

Health Net may allow a member to continue using a terminated provider when:

- A member had been receiving care for an acute or chronic condition, in which case care by the terminated provider is covered for 90 days or longer, if necessary, for a safe transfer of the member.
- A member is pregnant, in which case care by the terminated provider is covered until postpartum services related to the delivery are completed or longer, if necessary, for a safe transfer of the member.

The terminated provider is subject to the same contractual terms and conditions imposed prior to termination until medical care to the member is completed. These terms and conditions include, but are not limited to:

- credentialing
- hospital privileging
- utilization review
- peer review
- compensation

Refer to the Transition of Care topic for more information.

PPG, Physician and Hospital Termination

In order to comply with the provider termination regulations of the Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC), participating hospitals, participating physician groups (PPGs) and physicians are required to notify Health Net's regional Provider Network Management Department, in writing, pursuant to the requirements of 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 Transition of Care Assistance discussion under the Utilization Management topic.

Member Notification for Specialist Termination

Participating Physician Groups (PPG)

Delegated participating physician groups (PPGs) must have a written policy regarding member notification when a specialist terminates their contract. The written policy must include the following elements:

- PPGs must notify the plan 90 days prior to a specialist terminating (or as stated in the PPG's Provider Participation Agreement (PPA)).
- PPGs must identify members who have regularly seen the terminating specialist or have an open authorization to receive services from the terminating specialist.
- Identified members must be notified by the PPG in writing and the notification must be made immediately upon notification of termination, but no later than 30 calendar days prior to the effective date of the specialist's termination.
- PPGs must help members transition to a new specialist within the PPG's network of participating providers.

If a member with an acute care condition has questions or concerns regarding the continuation of services from the terminating specialist, advise the member to call the Health Net Member Services Department, Health Net Medi-Cal Member Services Department, Community Health Plan of Imperial Valley Member Services Department or CalViva Health Member Services Department.

Templates for Only Medicare and DSNP Member Notifications

To notify Medicare and DSNP members when a specialist terminates, PPGs must use the applicable template in the table below approved by the Centers for Medicare & Medicaid Services.

Template	H-contract	Product
Medicare Provider Termination Notification Template-MA H0562	H0562	Medicare Advantage
Medicare Provider Termination Notification Template-DSNP H3561	H3561	Dual Special Needs Plans: • Wellcare Dual Align • Wellcare CalViva Dual Align • Wellcare Dual Liberty

Provider Online Demographic Data Verification

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

On a monthly basis, providers should validate that their demographic information is reflected correctly on the provider website under ProviderSearch. According to the terms of the Provider Participation Agreement (PPA), participating providers are required to provide a minimum of 30 days advance notice of any changes to their demographic information. If the change pertains to the status of accepting new patients or no longer accepting new patients, you must notify Health Net or the applicable PPG within five business days.

Providers directly contracting with Health Net must notify Health Net of changes to by completing the online form or by reaching out to your provider relations and contracting specialist (formally provider network administrator). The online form is available on the provider website. Providers must have privileges to update and submit changes online.

Providers contracting through a PPG must notify the PPG directly of changes, and the PPG notifies Health Net. PPGs must have policies in place that establish and implement processes to collect, maintain and submit their

provider demographic changes to Health Net on a real-time basis. Real-time is within 30 days, as recently defined by the Centers for Medicare & Medicaid Services (CMS).

If a provider sees patients at multiple locations, the provider should review address, phone number, fax number, and office hours for all locations to ensure data accuracy.

Demographic Information

Providers' demographic data information should include the following:

- Name
- Alternate name
- Address
- Telephone number
- Fax number
- License number
- National Provider Identifier
- Office hours

- Patient age ranges (lowest to highest) seen by provider
- Specialty
- Email address - used for members and is Health Insurance Portability and Accountability Act (HIPAA) compliant

- Practice website
- Hospital affiliation
- Languages other than English spoken by the physician
- Languages other than English spoken by the office staff

- Panel status - Accepting new patients, accepting existing patients, available by referral only, available only through a hospital or facility, not accepting new patients
- Handicap accessibility status for parking (P), exterior building (EB), interior building (IB), restroom (R), exam room (ER), and exam table/scale (T) - if accessibility is not yes to all, then indicate no

Provider Outreach Requirements

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

Health Net is required to contact directly contracting practitioners biannually, including physicians and other health professionals such as physical therapists (PTs), occupational therapists (OTs) and podiatrists; and annually contact PPGs, hospitals and ancillary providers to validate the accuracy of the information for each provider listed in Health Net's provider directories. The notification includes:

- The information Health Net has in its directories for the provider, including a list of networks and products in which the provider participates.
- A statement that the failure to respond to the notification may result in a delay of payment or reimbursement of a claim.

- Instructions on how the provider can update information including the option to use an online interface to submit verification or changes electronically which generates an acknowledgment from Health Net.
- A statement requiring an affirmative response from the provider acknowledging that the notification was received, and requiring the provider to confirm that the information in the directories is current and accurate or to provide an update to the information required to be in the directories, including whether the provider is accepting new patients for each applicable Health Net network or product. Note: this requirement does not apply to general acute care hospitals. If Health Net does not receive an affirmative response and confirmation from the provider that the information is current and accurate, or as an alternative, receive updated information from the provider within 30 business days, the following will occur:
    - Health Net takes no more than an additional 15 business days to verify whether the provider's information is correct or requires updates. Health Net documents the receipt and outcome of each attempt to verify the information.
    - If Health Net is unable to verify whether the provider's information is correct or requires updates, Health Net notifies the provider 10 business days prior to removal that the provider will be removed from provider directories. The provider is removed from the provider directories at the next required update of the provider directories after the 10 business-day notice period. A provider is not removed from the provider directories if they respond before the end of the 10 business-day notice period. This requirement does not apply to general acute care hospitals.

Health Net will sometimes work with an outside vendor (i.e., Symphony Provider Directory) to reach out to providers to validate practitioner participation and demographic data. Providers are required to respond to requests from Health Net, and/or may update changes as needed directly with Symphony.

Provider Status Change Notification Requirements

Providers are required to inform Health Net or the applicable PPG within five business days when either of the following occurs:

- The provider is not currently accepting new patients, when they had previously accepted new patients.
- The provider is currently accepting new patients, when they had previously not accepted new patients.

Additionally, if a provider who is not accepting new patients is contacted by a member or potential enrollee seeking to become a new patient, the provider is required to direct the member or potential enrollee to both Health Net for additional assistance in finding a provider and to the appropriate regulator listed below to report any inaccuracy with the provider directories.

Regulator	Contact Information	Line of Business
Department of Managed Health Care (DMHC)	1-888-466-2219 1-877-688-9891 (TDD) www.hmohelp.ca.gov	HMO, POS, HSP, Medi-Cal

Regulator	Contact Information	Line of Business
California Department of Insurance (CDI)	1-800-927-4357 www.insurance.ca.gov	EPO, PPO

PPGs must have policies in place that establish and implement processes to collect, maintain and submit provider demographic changes to Health Net within the required turnaround times.

Report of Inaccurate Information in Directories

When Health Net receives a report indicating that information listed in its provider directories is inaccurate by a potential enrollee, member, regulator or provider, Health Net promptly investigates the reported inaccuracy and, no later than 30 business days following receipt of the report, either verifies the accuracy of the information or updates the information in its provider directories, as applicable.

At a minimum, Health Net does the following:

1. Contacts the affected provider no later than five business days following receipt of the report.
2. Documents the receipt and outcome of each report, including the provider's name, location, and a description of Health Net's investigation, the outcome of the investigation, and any changes or updates made to the provider directories.
3. If changes to Health Net's directories are required as a result of the plan's investigation, the changes to the online provider directories must be made within the weekly turnaround time. For printed provider directories, changes must be made no later than the next required update or sooner if required by federal law or regulations.

Pursuant to Uniform Provider Directory Standards cited by Health and Safety Code (HSC) 1367.27(k) and Insurance Code 10133.15(k), Health Net will omit a provider, provider group or category of providers similarly situated from the directory if one of the below conditions is met.

- The provider is currently enrolled in the Safe at Home program.
- The provider fears for his or her safety or the safety of his or her family due to his or her affiliation with a health care service facility or due to his or her provision of health care services.
- A facility or any of its providers, employees, volunteers, or patients is or was the target of threats or acts of violence within one year of the date of this statement.
- Good cause or extraordinary circumstances (must provide detailed information on the cause or circumstances).

Providers must complete and sign the Directory Removal for At-Risk Providers form – Health Net (PDF), Directory Removal for At-Risk Providers form – Community Health Plan of Imperial Valley (PDF) or Directory Removal for At-Risk Providers form – CalViva Health (PDF) to be omitted from the directory.

Service and Quality Requirements

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

This section includes information on requirements for adding or removing a participating provider.

Select any subject below:

Access to Care and Availability Standards

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

Select appropriate county information below.

Amador, Calaveras, Inyo, Los Angeles, Mono, Sacramento, San Joaquin, Stanislaus, Tulare, Tuolumne

Health Net's appointment accessibility and provider availability policies, procedures and guidelines for providers and health care facilities providing primary care, specialty care (including seldom used or unusual specialty services), 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 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.

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 within reasonable timeframes. Additionally, Health Net and its participating providers are required to demonstrate that members have access to non-discriminatory and appropriate covered health care services within reasonable period of time appropriate for the nature of the

member's condition and consistent with good professional practice. This includes, but is not limited to, provider availability, waiting time and appointment access with established time-elapsed standards.

The following information delineates the medical appointment access standards, triage and/or screening access requirements, and telephonic access to health care services and the monitoring activities to ensure compliance:

Member Notification

Health Net members are notified annually, via member newsletters or the Evidences of Coverage (EOC), of time-elapsed appointment access standards, the availability of triage or screening services and how to obtain these services.

Primary Care Physician and Specialist Office Hours

As required by applicable federal and state statutes and regulations, primary care physician (PCP) and specialty care practitioners (SCP) office hours must be reasonable, convenient and sufficient to ensure that they do not discriminate against members and members are able to access care within established time-elapsed access standards. PCP and SCP office hours must be posted in the provider's office. Health Net requires a PCP practice to be open at least 20 hours per week and a SCP practice to be open at least 16 hours per week for members to schedule appointments within established appointment access standards. During evenings, weekends and holidays, or whenever the office is closed, an answering service or answering machine should be utilized to provide members with clear and simple instruction on after-hours access to medical care. Additionally, Medi-Cal participating providers must offer hours of operation to Medi-Cal members that are no less than the hours of operation offered to patients from other lines of business or to Medi-Cal fee-for-service (FFS) beneficiaries.

After-Hours Access Guidelines

As required by applicable statutes, Health Net's participating providers must ensure that, when medically necessary, they have medical services available and accessible to members 24 hours a day, 7 days a week, and PCPs are required to have appropriate 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 instructions about after-hours access to medical care (urgent/emergency medical care).

PCPs (or on-call physicians) should return phone calls and pages within 30 minutes and be available 24 hours a day, 7 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/or screening services 24 hours a day, 7 days a week through medical/nurse advice lines. Refer to the Triage and Screening Services/Advice Lines section below for further information.

Note: Although Health Net does not delegate triage and screening services, PCPs are still required to comply with these after-hours requirements since medically necessary services are required to be available and accessible 24 hours a day, 7 days a week.

After-Hours Script Template

In times of high stress, when members may have an urgent or emergent situation, it is important to provide clear messaging with call-back time frames and directions on how to access urgent and emergency care to prevent potential quality of care issues. Directing members to the appropriate level of care using simple and comprehensive instructions can improve the coordination and continuity of the member's care, health outcomes and satisfaction. Health Net has designed an after-hours script template that PPGs or physicians who have a centralized triage service or other answering service can use as a guide for staff answering the phone. For PPGs or physicians who use an automated answering system/answering machine, this template can be used as a script to advise members how to access care. The script includes basic information that members need to access after-hours care, and modifications can be made according to PPGs' and physicians' needs.

Health Net makes the script available in the following threshold languages:

- Arabic (PDF)
- Armenian (PDF)
- Chinese/Cantonese (PDF)
- English (PDF)
- Farsi (PDF)
- Hmong (PDF)
- Khmer (Cambodian) (PDF)
- Korean (PDF)
- Russian (PDF)
- Spanish (PDF)
- Tagalog (PDF)
- Vietnamese (PDF)

After-hours scripts are available in alternate formats and additional languages upon request request by calling the Customer Contact Center. Contact the Provider Network Management, Access & Availability Team for more information.

Answering Services

Providers are responsible for the answering service they use. If a member calls after hours or on a weekend for a possible medical emergency, the 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 phone 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 phone staff should have clear instructions about 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 phone 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 an authorization, which is binding and cannot be retracted.
- In the event of a hospitalization, the PPG or hospital must contact the Health Net Hospital Notification Unit within 24 hours or the next business day of the admission, including instances prior authorization has already been obtained.
- 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/Advice Lines

As defined in 28 CCR 1300.67.2.2(b)(5), Health Net provides 24-hour-a-day, 7 days a week triage or screening services by phone. 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 phone service for urgent/emergent instructions, medical condition assessment and advice. The Health Net Member Services Department coordinates member access to the service, if necessary.

The program allows California 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 phone 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 for Medi-Cal members through medical advice lines as follows:

- Triage and/or screening services/nurse advice help is available to members, 24 hours a day, 7 days a week through Health Net's Member Service Department phone line displayed on the back of the member's ID card. A representative connects the member to triage and/or screening services/nurse advice after verifying eligibility.

Facility Access for Persons with Disabilities

Health Net and its participating providers and practitioners do not discriminate against members who have physical or mental disabilities. Participating providers are required to provide reasonable access for members with disabilities in accordance with the Americans with Disabilities Act of 1990 (ADA). Access generally includes ramps, elevators, restroom equipment, designated parking spaces, and drinking fountain design.

Providers must reasonably accommodate members and ensure that programs and services are as accessible (including physical and geographic access) to members with disabilities as they are to members without disabilities. Providers must have written policies and procedures to ensure appropriate access, including ensuring physical, communication and programmatic barriers do not inhibit members with disabilities from obtaining all covered services.

Minor Consent Services

As defined in 42 CFR 2.14 (a) the term "minor" means a person who has not attained the age of majority specified in the applicable state law, or if no age of majority is specified in the applicable state law, age 18.

Under California state law, minor consent services are those covered services of a sensitive nature that minors do not need parental consent to access or obtain. The health care provider is not permitted to inform a parent or legal guardian without the minor's consent. Refer to Minors Consent section for more information.

Facility Site Review

Health Net provides PCPs with office policies and procedures to use as templates for the facility site reviews (FSRs). Refer to the Medi-Cal FSR PCP office management policy and procedure templates for more information. During Health Net's facility review process, a finding of any obvious physical barrier to accessibility for disabled members is noted. If any obvious physical barrier is found, Health Net discusses potential resolutions with the provider or PPG administrator. The provider indicates the resolutions on the facility site review (FSR) corrective action plan.

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 referrals for specialty care if the necessary services fall outside the scope of the PCP's practice. Exceptions to this process are:

- Emergency care (including emergency behavioral health care).
- Urgent care sought outside the service area, and under unusual or extraordinary circumstances provided in the service area when the participating medical provider is unavailable or inaccessible.
- 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 tests).
- Out-of-area renal dialysis services
- 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.
- Health Net is responsible to cover outpatient mental health services for members with mild to moderate mental health conditions not covered by the county mental health plan as specialty mental health services. Some of the services are provided by the PCP. Members may be eligible to self-refer to a behavioral health practitioner out-of-network through the mental health departments of members' counties of residence, depending on their Medi-Cal benefit coverage. Refer to Behavioral Health section for more information.
- Medi-Cal members may seek sensitive services, such as minor consent services, and family planning, sexually transmitted diseases and HIV testing and counseling services from qualified participating or out-of-network family planning providers, the local health department (LHD) and/or family planning clinics. Sensitive services for minors include sexual assault (including rape), drug or alcohol abuse, family planning, sexually transmitted infections, and behavioral health care.
- Medi-Cal members may access LHD clinics for immunizations.

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 the DMHC timely access regulations (28 CCR 1300.67.2.2) and to Health Net's Medical Records Documentation Standards policy and procedure (KK47-121230), when it is necessary for a provider or a member to reschedule an appointment, the appointment must be rescheduled promptly in a manner that is appropriate for the member's health care needs. Efforts to reschedule the appointment must ensure continuity of care; and be consistent with good professional practice and with the objectives of Health Net's access and availability policies and procedures.

Shortening or Extending Appointment Waiting Time

The applicable waiting time for a particular appointment may be shortened or extended by the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice. If the licensed applicable health care provider has determined to extend the appointment wait time, the provider must document in the member's record that a longer waiting time will not have a detrimental impact on the member's health, as well as the date and time of the appointment offered. The provider will notify the member of this decision, including an explanation of their right to file a grievance with Health Net. The record must be available to the Department of Health Care Services (DHCS) upon request.

Advanced Access

The PCP may demonstrate compliance with the established primary care time-elapsed access standards through the implementation of standards, policies, processes, and systems providing same or next business day appointments with a PCP, or other qualified health care provider, such as a nurse practitioner or physician assistant from the time an appointment is requested; and offers advance scheduling of appointments for a later date if the member prefers not to accept the appointment offered within the same or next business day.

Advance Scheduling

Preventive care services and periodic follow up care appointments, including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat health conditions and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice. For detailed standing referral information, refer to Operations Manuals > Referrals > Standing Referral to a Specialist > Regular Standing Referrals.

Shortage of Providers

If it is determined that there is a shortage of one or more types of participating providers including seldom used or unusual specialty services) in a Health Net service area, Health Net and its participating providers are responsible for ensuring members are seen within the appropriate time-elapsed appointment standards [28 CCR 1300.67.2.2(c)(7)(B)]. To comply with applicable laws and regulations, and ensure timely access to covered health care services, a provider or PPG operating in a service area that has a shortage of one or more types of providers and cannot provide an appointment within the required time frame must:

- For primary care services - Refer members to available and accessible participating providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the member's health care needs.
- For specialty services (including seldom used or unusual specialty care) - Refer members to available and accessible participating providers in neighboring service areas. If a specialist is not available in neighboring areas within the network, the participating provider must refer the member to, and arrange for the provision of, an out-of-network specialist, when medically necessary for the member's condition for as long as the provider or PPG is unable to provide timely access within the network.
- Member costs for medically necessary referrals for out-of-network providers must not exceed applicable copayments, coinsurance and deductibles.

Providing members with a list of potentially available out-of-network providers does not meet the requirement to arrange for medically necessary services from an out-of-network provider. To ensure members have access to services within geographic and timely access standards, Health Net and its participating providers are responsible to:

- Contact the out-of-network provider on behalf of the member to find out when appointments are available for medically necessary services.
- Schedule any initial and follow-up appointments for the member with an out-of-network provider.

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 Phone Assessment

Phone 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, including long-term support services (LTSS) providers, must ensure that services are provided in a culturally competent manner to all members, including those who have limited-English proficiency (LEP), limited reading skills, and those from diverse cultural and ethnic backgrounds. Refer to Language Assistance and Cultural Competency for more information.

Prior Authorization Processes

Health Net requires prior authorizations to be processed and completed in a manner that assures appointments for covered health care services are provided in a timely manner, appropriate to the member's condition and comply with the requirements of the time-elapsed appointment access standards. If the appointment type requires prior authorization, obtaining authorization must be completed within the time frame for that visit or service to be offered. For example, expedited utilization management (UM) review processes and appointment scheduling for urgent care appointments for services that require prior authorization, [28 CCR 1300.67.2.2(c)(5)(B)], more commonly known as urgent pre-service requests, must be conducted concurrently, or the prior authorization turnaround timeline must be shortened to allow sufficient time to communicate the outcome to the member and/or the referring provider and ensure an appointment is offered to the member within 96 hours of the request. Refer to the Prior Authorization section for further information. For additional information refer to Authorization and Referral Timelines.

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 phone access to measure performance, confirm compliance, and ensure the provider network is sufficient to provide appropriate accessibility, availability and continuity of care to Health Net members.

At least on a quarterly basis, the Plan will review reports from the Quality Improvement Department regarding Incidents of non-compliance resulting in substantial harm to an enrollee that are related to access. The Plan will address areas related to network non-compliance with the regional Provider Network Management teams. Corrective actions will be implemented as applicable.

PPGs are responsible to monitor data provided by Health Net regarding their provider adherence to the following standards as corrective actions may be required of providers that do not comply. Refer to the Corrective Action section below for further information.

Health Net's performance goals for access-related, time-elapsed provider criteria are available for providers' reference.

Health Net Medi-Cal 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 & Other) that require prior authorization	Appointment within 96 hours of request	70%
First prenatal visit (both PCP and SCP)	Appointment within 2 weeks of request	70%
Well-child visit	Appointment within 2 weeks of request	70%
Preventive health, physical exams and wellness checks with PCP	Appointment within 30 calendar days of request	70%
After-hours care (PCP)	Ability to contact on-call physician after hours within 30 minutes for urgent issues Appropriate after hours emergency instructions	90%

ACCESS MEASURE	STANDARD	PERFORMANCE GOAL
Non-urgent ancillary services for MRI/mammogram/physical therapy	Appointment within 15 business days of request	70%
In-office wait time for scheduled appointments (PCP and SCP)	Not to exceed 30 minutes	70%
Provider office phone callback during normal business hours	Provider callback within 1 business day	90%
Phone answer time at provider's office	Within 60 seconds	90%
Non-urgent appointment with a physician in a skilled nursing facility (SNF) or intermediate care facility (ICF)	Rural and Small Counties: Within 14 calendar days of request Medium Counties: Within 7 business days of request Large Counties: Within 5 business days of request	80%

Compliance is measured by results from the Provider Appointment Availability Survey (PAAS) and the Provider After-Hours Availability Surveys (PAHAS) conducted via phone by Health Net and the Consumer Assessment of Health Care Providers & Systems (CAHPS®[1]) survey.

[1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Health Net Medi-Cal Plans Appointment Access Standards - Behavioral Health

ACCESS MEASURE	STANDARD	PERFORMANCE GOAL
Urgent care[1]	Within 48 hours	90% or more of members with a clinical risk rating of urgent have access to urgent appointments within 48 hours

ACCESS MEASURE	STANDARD	PERFORMANCE GOAL
Non-life threatening emergency (NLTE)[1]	Within 6 hours	90% or more of members with a clinical risk rating of NLTE have access to an appointment within 6 hours
Access to care for life-threatening emergency[1]	Immediately	100% compliance with immediate referral to care
Rescheduled Appointments[2]	Appointment was scheduled to member's satisfaction	85% or more of members report their appointment was rescheduled to their satisfaction
Non-urgent appointments with behavioral health care physician (psychiatrist) for routine care[3]	Appointment within 15 business days of request	70%
Urgent care appointment with non-physician behavioral health care provider or behavioral health care physician (psychiatrist) that does not require prior authorization[3]	Appointment within 48 hours of request	70%
Urgent care appointment with non-physician behavioral health care provider or behavioral health care physician (psychiatrist) that requires prior authorization[3]	Appointment within 96 hours of request	70%
Non-urgent follow-up appointment with non-physician behavioral health care provider[3]	Within 10 business days of request	80%

[1]Assessed through care management software.

[2]Assessed through annual BH member experience survey (ECHO).

[3]Assessed through annual Provider Appointment Availability Survey (PAAS).

Corrective Action

Health Net investigates and implements corrective action when timely access to care as required by Health Net's Appointment Accessibility for Medi-Cal policy and procedure (CA.NM.05) are 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 of or more metrics are noted as being non-compliant:

- Appointment Access - PPGs that do not meet Health Net's 80% 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 with 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 phone 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 the standard meeting regulatory agency time frame compliance.

- 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 is to 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 the PNM and Contracting departments for further action.

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:

Geo Access and Provider Availability Standards*

Availability Standards	Performance Threshold
One PCP within 10 miles or 30 minutes from residence	100% or more of practitioner/provider network meet compliance rate
One hospital within 15 miles or 30 minutes from residence	100% or more of practitioner/provider network meet compliance rate
One ancillary care provider (lab, radiology or pharmacy) within 15 miles of 30 min from PCP (DMHC reporting purposes only)	90% or more of practitioner/provider network meet compliance rate
Specialist - Adult and Pediatric (standard determined by county as below)	Time and Distance Standard
Calaveras, Inyo, Mono and Tuolumne	60 miles or 90 minutes
Amador and Tulare	45 miles or 75 minutes
San Joaquin and Stanislaus	30 miles or 60 minutes
Los Angeles and Sacramento	15 miles or 30 minutes
DHCS Core Specialists (Adult and Pediatric)	Cardiology/Interventional Cardiology* Dermatology* Endocrinology* ENT/ Otolaryngology* Gastroenterology* General Surgery Hematology* HIV/AIDS Specialists/ Infectious Diseases* Nephrology* Neurology* Obstetrics/Gynecology (Adult Only)* Oncology* Ophthalmology* Orthopedic Surgery Physical

Availability Standards	Performance Threshold
	Medicine and Rehabilitation Psychiatry* Pulmonology* Non-physicians/Mental Health Providers* *Telehealth optional
Practitioner/Provider Availability Standards	Performance Threshold
Member to full-time equivalent (FTE) PCP ratio	2,000:1
Member to FTE physician	1,200:1
Member to Behavioral Health Provider ratio: • MD's/DO (Psychiatrists) • Psychologist • Masters Level practitioner	6,250:1 2,875:1 1,450:1
Percent PCPs open practice	85% of PCPs accepting new members
Percent SCPs open practice	85% of SCPs accepting new members

*Certain rural portions of the Plan service area may have access that differs from the standards based on lack of practitioner and hospital availability. Regulatory approval is required for areas that vary from within the standard.

Availability Corrective Action

Health Net collects and analyzes all data to identify opportunities for improvement, which is communicated to the appropriate quality committee or department to review for recommendations. Health Net implements plan-wide corrective actions based on its assessment. These results and applicable actions for improvement are communicated to practitioners, providers and PPGs through Health Net's Quality Improvement Committee or through the activities of Provider Network Management.

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Health Net's appointment accessibility and provider availability policies, procedures and guidelines for providers and health care facilities providing primary care, specialty care (including seldom used or unusual specialty services), 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 Department of Health Care Services (DHCS). The National Committee for Quality Assurance

(NCQA) monitors medical standards for access to, and availability of, care and sets behavioral health time-elapsed appointment access standards.

Note: Behavioral health and chemical dependency services are administered by Health Net.

Health Net and its participating providers are required to demonstrate that, throughout the geographic regions of Health Net's service area, a comprehensive range of primary, specialty, institutional, and ancillary care services are readily available and accessible, at reasonable times. Additionally, Health Net and its participating providers are required to demonstrate that members have access to non-discriminatory and appropriate covered health care services within reasonable period of time appropriate for the nature of the member's condition and consistent with good professional practices. This includes, but is not limited to, provider availability, waiting time and appointment access with established time-elapsed standards.

The following information delineates the medical appointment access standards, triage and/or screening access requirements, and telephonic access to health care services and the monitoring activities to ensure compliance:

Member Notification

Health Net members are notified annually, via member newsletters or the Evidence of Coverage (EOC), of time-elapsed appointment access standards, the availability of triage or screening services and how to obtain these services.

Primary Care Physician and Specialist Office Hours

As required by applicable federal and state statutes and regulations, primary care physician (PCP) and specialty care practitioners (SCP) office hours must be reasonable, convenient and sufficient to ensure that they do not discriminate against members and members are able to access care within established time-elapsed access standards. PCP and SCP office hours must be posted in the provider's office. Health Net requires a PCP practice to be open at least 20 hours per week and a SCP practice to be open at least 16 hours per week for members to schedule appointments within established appointment access standards. During evenings, weekends and holidays, or whenever the office is closed, an answering service or answering machine should be utilized to provide members with clear and simple instruction on after-hours access to medical care. Additionally, Medi-Cal participating providers must offer hours of operation to Medi-Cal members that are no less than the hours of operation offered to patients from other lines of business or to Medi-Cal fee-for-service (FFS) beneficiaries.

After-Hours Access Guidelines

As required by applicable statutes, Health Net's participating providers must ensure that, when medically necessary, they have medical services available and accessible to members 24 hours a day, seven days a week, and PCPs are required to have appropriate 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 instructions about after-hours access to medical care (urgent/emergency medical care).

PCPs (or on-call physicians) should 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/or screening services 24 hours a day, seven days a week through medical/nurse advice lines. Refer to the Triage and Screening Services/Advice Lines section below for further information.

Note: Although Health Net does not delegate triage and screening services, PCPs are still required to comply with these after-hours requirements since medically necessary services are required to be available and accessible 24 hours a day, seven days a week.

After-Hours Script Template

In times of high stress, when members may have an urgent or emergent situation, it is important to provide clear messaging with call-back time frames and directions on how to access urgent and emergency care to prevent potential quality of care issues. Directing members to the appropriate level of care using simple and comprehensive instructions can improve the coordination and continuity of the member's care, health outcomes and satisfaction. Health Net has designed an after-hours script template that PPGs or physicians who have a centralized triage service or other 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 to talk to when they need urgent medical advice.

Health Net makes the script available in the following threshold languages:

- English (PDF)
- Spanish (PDF)
- Hmong (PDF)

After-hours scripts are available in alternative format and in additional languages upon request. Contact the Provider Network Management, Access & Availability Team for more information.

Answering Services

Providers are responsible for the answering service they use. If a member calls after hours or on a weekend for a possible medical emergency, the 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 about 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 an authorization, which is binding and cannot be retracted.
- In the event of a hospitalization, the PPG or hospital must contact the Health Net 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/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 that 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 CalViva Health Medi-Cal Member Services Department coordinates member access to the service, if necessary.

The program allows California 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 self-care guidance, general health information, or recommend a visit to urgent care or the emergency room.

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 for Medi-Cal members through medical advice lines as follows:

- Triage and/or screening services/nurse advice help is available to members, 24 hours a day, seven days a week through Health Net's State Health Programs (SHP) Member Service Department telephone line displayed on the back of the member's ID card. A representative connects the member to triage and/or screening services/nurse advice after verifying eligibility

Facility Access for Persons with Disabilities

Health Net and its participating providers and practitioners do not discriminate against members who have physical or mental disabilities. Participating providers are required to provide reasonable access for members with disabilities in accordance with the Americans with Disabilities Act of 1990 (ADA). Access generally includes ramps, elevators, restroom equipment, designated parking spaces, and drinking fountain design.

Providers must reasonably accommodate members and ensure that programs and services are as accessible (including physical and geographic access) to members with disabilities as they are to members without disabilities. Providers must have written policies and procedures to ensure appropriate access, including ensuring physical, communication and programmatic barriers do not inhibit members with disabilities from obtaining all covered services.

Facility Site Review

Health Net provides PCPs with office policies and procedures to use as templates for the facility site reviews (FSRs). Refer to the Medi-Cal FSR PCP office management policy and procedure templates for more information. During Health Net's facility review process, a finding of any obvious physical barrier to accessibility for disabled members is noted. If any obvious physical barrier is found, Health Net discusses potential resolution with the provider or PPG administrator. The provider indicates the resolutions on the facility site review (FSR) corrective action plan.

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. Refer to Minor's Consent section for more information.

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 referrals for specialty care if the necessary services fall outside the scope of the PCP's practice. Exceptions to this process are:

- Emergency care (including emergency behavioral health care).
- Urgent care sought outside the service area, and under unusual or extraordinary circumstances provided in the service area when the participating medical provider is unavailable or inaccessible.
- 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 tests).
- Out-of-area renal dialysis services.
- 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.
- Behavioral health care is not covered by Health Net under its Medi-Cal managed care program. Accordingly, members may be eligible to self-refer to a behavioral health practitioner out-of-network through the mental health departments of members' counties of residence, depending on their Medi-Cal benefit coverage.
- Medi-Cal members may seek sensitive services, such as minor consent services, and family planning, sexually transmitted diseases and HIV testing and counseling services from qualified participating or out-of-network family planning providers, the local health department (LHD) and/or family planning clinics. Sensitive services for minors include sexual assault (including rape), drug or alcohol abuse, pregnancy, family planning, sexually transmitted diseases, and behavioral health care.
- Medi-Cal members may access LHD clinics for immunizations.

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 the DMHC timely access regulations (28 CCR 1300.67.2.2) and to Health Net's Medical Records Documentation Standards policy and procedure (KK47-121230), when it is necessary for a provider or a member to reschedule an appointment, the appointment must be rescheduled promptly in a manner that is appropriate for the member's health care needs. Efforts to reschedule the appointment must ensure continuity of care; and be consistent with good professional practice and with the objectives of Health Net's access and availability policies and procedures.

Shortening or Extending Appointment Waiting Time

The applicable waiting time for a particular appointment may be shortened or extended by the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice. If the licensed applicable health care provider has determined to extend the appointment wait time, the provider must document in the member's record that a longer waiting time will not have a detrimental impact on the member's health, as well as the date and time of the appointment offered. The provider will notify the member of this decision, including an explanation of their right to file a grievance with Health Net. The record must be available to the Department of Health Care Services (DHCS) upon request.

Advanced Access

The PCP may demonstrate compliance with the established primary care time-elapsed access standards through the implementation of standards, policies, processes, and systems providing same or next business day appointments with a PCP, or other qualified health care provider, such as a nurse practitioner or physician assistant from the time an appointment is requested; and offers advance scheduling of appointments for a later date if the member prefers not to accept the appointment offered within the same or next business day.

Advance Scheduling

Preventive care services and periodic follow-up care appointments, including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat health conditions and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice. For detailed standing referral information, refer to Operations Manuals > Referrals > Standing Referral to a Specialist > Regular Standing Referrals.

Shortage of Providers

If it is determined that there is a shortage of one or more types of participating providers (including seldom used or unusual specialty services) in a Health Net service area, Health Net and its participating providers are responsible for ensuring members are seen within the appropriate time-elapsed appointment standards [28 CCR 1300.67.2.2(c)(7)(B)]. To comply with applicable laws and regulations, and ensure timely access to covered health care services, a provider or PPG operating in a service area that has a shortage of one or more types of providers and cannot provide an appointment within the required time frame must:

- For primary care services - Refer members to available and accessible participating providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the member's health care needs.
- For specialty services (including seldom used or unusual specialty care) - Refer members to available and accessible participating providers in neighboring service areas. If a specialist is not

available in neighboring areas within the network, the participating provider must refer the member to, and arrange for the provision of, an out-of-network specialist, when medically necessary for the member's condition for as long as the provider or PPG is unable to provide timely access within the network.
- Member costs for medically necessary referrals for out-of-network providers must not exceed applicable copayments, coinsurance and deductibles.

Providing members with a list of potentially available out-of-network providers does not meet the requirement to arrange for medically necessary services from an out-of-network provider. To ensure members have access to services within geographic and timely access standards, Health Net and its participating providers are responsible to:

- Contact the out-of-network provider on behalf of the member to find out when appointments are available for medically necessary services.
- Schedule any initial and follow-up appointments for the member with an out-of-network provider.

These requirements do not prohibit Health Net or its delegated PPGs from accommodating a member's preference to wait for a later appointment from a specific participating provider. If a member prefers to wait for a later appointment, document it in the relevant record.

Emergency and Urgent Care Services

Emergency and urgent care services are available and accessible to members within Health Net's service area 24 hours a day, seven days a week.

Providing Emergency and Urgent Care Services in the PCP's Office

The physician, registered nurse (RN), or physician assistant (PA) on duty is responsible for evaluating emergency and urgent care members in the office and making the decision to further evaluate and treat, summon an ambulance for transport to the nearest emergency room, directly admit to the hospital, or refer to a same-day visit at another provider or urgent care facility.

Provider Telephone Assessment

Telephone assessment of a member's condition, and subsequent follow-up, may only be performed by licensed staff (physicians, RNs, and nurse practitioners (NPs)) and only in accordance with established standards of practice.

Telehealth

Telehealth services are subject to the requirements and conditions of the enrollee benefit plan and the contract entered into between Health Net and its participating providers. Prior to the delivery of health care via telehealth, the participating provider at the originating site must verbally inform the member that telehealth services may be used and obtain verbal consent from the member. The verbal consent must be documented in the member's medical record. To the extent that telehealth services are provided as described herein and as defined in Section 2290.5(a) of the Business & Professions Code, Section 1374.13 of the Health and Safety Code, and Sections 14132.72 and 14132.725 of the Welfare and Institutions Code, these telehealth services comply with the established appointment access standards.

Interpreter Services

In order to comply with applicable federal and state laws and regulations, Health Net requires providers to coordinate interpreter services with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment. If an appointment is rescheduled, it is very important to reschedule the interpreter for the time of the new appointment to ensure the member is provided with these services. Refer to Interpreter Services for more information.

Cultural Considerations

Health Net and its participating providers, including long-term support services (LTSS) providers, must ensure that services are provided in a culturally competent manner to all members, including those who have limited-English proficiency (LEP), have limited reading skills, and those from diverse cultural and ethnic backgrounds. Refer to Language Assistance and Cultural Competency for more information.

Prior Authorization Processes

Health Net requires prior authorizations to be processed and completed in a manner that assures appointments for covered health care services are provided in a timely manner, appropriate to the member's condition and comply with the requirements of the time-elapsed appointment access standards. If the appointment type requires prior authorization, obtaining authorization must be completed within the time frame for that visit or service to be offered. For example, expedited utilization management (UM) review processes and appointment scheduling for urgent care appointments for services that require prior authorization, [CCR T28 §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 further information. For more information refer to Authorization and Referral Timelines.

Determination Timeline for a Decision following a Deferral

- When additional information is received: If requested information is received, a decision must be made within five working days from the receipt of information, not to exceed 28 calendar days from the date of receipt of the original request.
- Decision when additional information received is incomplete or not received:

If the provider has not complied with the request for additional information, the Plan reviews the request with the information available and makes a determination within five working days of the expiration of the deferral notice, not to exceed 28 calendar days from receipt of the original request (Health & Safety Code 1367.01).

Quality Assurance

Health Net has a documented system for monitoring and evaluating practitioner/provider availability and accessibility of care. At least annually, Health Net monitors appointment access to care and provider availability standards through member and provider surveys. At least quarterly, Health Net reviews and evaluates the information available to Health Net regarding accessibility, availability, and continuity of care, through information obtained from appeals and grievances, triage or screening services, and customer service telephone access to measure performance, confirm compliance, and ensure the provider network is sufficient to provide appropriate accessibility, availability and continuity of care to Health Net members.

At least on a quarterly basis, the Plan will review reports from the Quality Improvement Department regarding Incidents of non-compliance resulting in substantial harm to an enrollee that are related to access. The Plan will

address areas related to network non-compliance with the regional Provider Network Management teams. Corrective actions will be implemented as applicable.

PPGs are responsible to monitor data provided by Health Net regarding their provider adherence to the following standards, as corrective actions may be required of providers that do not comply. Refer to the Corrective Action section below for further information.

Health Net's performance goals for access-related, time-elapsed provider criteria are available for providers' reference.

Medi-Cal 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 & Other) that require prior authorization	Appointment within 96 hours of request	70%
First prenatal visit (both PCP and SCP)	Appointment within 2 weeks of request	70%
Well-child visit	Appointment within 2 weeks of request	70%
Preventive health, physical exams and wellness checks with PCP	Appointment within 30 calendar days of request	70%

ACCESS MEASURE	STANDARD	PERFORMANCE GOAL
After-hours care (PCP)	Ability to contact on-call physician after hours within 30 minutes for urgent issues Appropriate after hours emergency instructions	90%
Non-urgent ancillary services for MRI/mammogram/physical therapy	Appointment within 15 business days of request	70%
In-office wait time for scheduled appointments (PCP and SCP)	Not to exceed 30 minutes	70%
Provider office telephone callback during normal business hours	Provider callback within 1 business day	90%
Phone answer time at provider's office	Within 60 seconds	90%
Non-urgent appointment with a physician in a skilled nursing facility (SNF) or intermediate care facility (ICF)	Rural and Small Counties: Within 14 calendar days of request Medium Counties: Within 7 business days of request Large Counties: Within 5 business days of request	80%

Compliance is measured by results from the Provider Appointment Availability Survey (PAAS) and the Provider After-Hours Availability Survey (PAHAS) conducted via telephone by Health Net and the Consumer Assessment of Health Care Providers & Systems (CAHPS®[1]) survey.

[1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Health Net Medi-Cal Plans Appointment Access Standards - Behavioral Health

ACCESS MEASURE	STANDARD	PERFORMANCE GOAL
Urgent care[1]	Within 48 hours	90% or more of members with a clinical risk rating of urgent have access to urgent appointments within 48 hours
Non-life threatening emergency (NLTE)[1]	Within 6 hours	90% or more of members with a clinical risk rating of NLTE have access to an appointment within 6 hours
Access to care for life-threatening emergency[1]	Immediately	100% compliance with immediate referral to care
Rescheduled Appointments[2]	Appointment was scheduled to member's satisfaction	85% or more of members report their appointment was rescheduled to their satisfaction
Non-urgent appointments with behavioral health care physician (psychiatrist) for routine care[3]	Appointment within 15 business days of request	70%
Urgent care appointment with non-physician behavioral health care provider or behavioral health care physician (psychiatrist) that does not require prior authorization[3]	Appointment within 48 hours of request	70%
Urgent care appointment with non-physician behavioral health care provider or behavioral health care physician (psychiatrist) that requires prior authorization[3]	Appointment within 96 hours of request	70%

ACCESS MEASURE	STANDARD	PERFORMANCE GOAL
Non-urgent follow-up appointment with non-physician behavioral health care provider[3]	Within 10 business days of request	80%

[1]Assessed through care management software.

[2]Assessed through annual BH member experience survey (ECHO).

[3]Assessed through annual Provider Appointment Availability Survey (PAAS).

Corrective Action

Health Net investigates and implements corrective action when timely access to care as required by Health Net's Appointment Accessibility for Medi-Cal policy and procedure (CA.NM.05) are 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 of or more metrics are noted as being non-compliant:

- 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 with 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 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 the standard meeting regulatory agency time frame compliance.
- The PPG is to return the IP within 30 calendar days.

CAP Follow-Up Process

- If the PPG fails to return a completed IP within the prescribed time frame, the Provider Network Management (PNM) Department is asked to intercede.
- PPGs demonstrating a pattern of noncompliance with access regulations and standards are subject to an in-office audit and may be referred to the PNM and Contracting departments for further action.

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:

Geo-Access and Provider Availability Standards*

Availability Standards	Performance Threshold
One PCP within 10 miles or 30 minutes from residence	100% or more of practitioner/provider network meet compliance rate
One hospital within 15 miles or 30 minutes from residence	100% or more of practitioner/provider network meet compliance rate
One ancillary care provider (lab, radiology, pharmacy, skilled nursing facility) within 15 miles or 30 minutes from residence	90% or more of practitioner/provider network meet compliance rate
Specialist - Adult and Pediatric	Time and Distance Standard
Fresno, Kings and Madera:	45 miles or 75 minutes
DHCS Core Specialists (Adult and Pediatric)	Cardiology/Interventional, Cardiology*, Dermatology*, Endocrinology*, ENT/ Otolaryngology*, Gastroenterology*, General Surgery Hematology*, HIV/AIDS Specialists/ Infectious Diseases*, Nephrology*, Neurology*, Obstetrics/Gynecology (Adult Only)*, Oncology*, Ophthalmology*, Orthopedic, Surgery, Physical Medicine and Rehabilitation Psychiatry*, Pulmonology*, Non-physicians/Mental Health Providers*, *Telehealth optional.
Practitioner/Provider Availability Standards	Performance Threshold

Availability Standards	Performance Threshold
Member to full-time equivalent (FTE) PCP ratio	2,000:1
Member to FTE physician	1,200:1
Member to Behavioral Health Provider ratio: • MD's/DO (Psychiatrists) • Psychologist • Masters Level practitioner	6,250:1 2,875:1 1,450:1
Percent PCPs open practice	85% of PCPs accepting new members
Percent SCPs open practice	85% of SCPs accepting new members
Members age 0-21 to Qualified Autism Service (QAS) Provider ratio	5000: 1
Members age 0-21 to QAS Professionals and Paraprofessionals ratio	5000: 2

*Certain rural portions of the Plan service area may have access that differs from the standards, based on lack of practitioner and hospital availability. Regulatory approval is required for areas that vary from within the standard.

Availability Corrective Action

Health Net collects and analyzes all data to identify opportunities for improvement, which is communicated to the appropriate quality committee or department to review for recommendations. Health Net implements plan-wide corrective actions based on its assessment. These results and applicable actions for improvement are communicated to practitioners, providers and PPGs through Health Net's Quality Improvement Committee or through the activities of Provider Network Management.

Community Health Plan of Imperial County

Health Net's appointment accessibility and provider availability policies, procedures and guidelines for providers and health care facilities providing primary care, specialty care (including seldom used or unusual specialty services), 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 Department of Health Care Services (DHCS). The National Committee for Quality Assurance (NCQA) monitors medical standards for access to, and availability of, care and sets behavioral health time-elapsed appointment access standards.

Note: Behavioral health and chemical dependency services are administered by Health Net.

Health Net and its participating providers are required to demonstrate that, throughout the geographic regions of Health Net's service area, a comprehensive range of primary, specialty, institutional, and ancillary care services are readily available and accessible, at reasonable times. Additionally, Health Net and its participating providers are required to demonstrate that members have access to non-discriminatory and appropriate covered health care services within reasonable period of time appropriate for the nature of the member's condition and consistent with good professional practices. This includes, but is not limited to, provider availability, waiting time and appointment access with established time-elapsed standards.

The following information delineates the medical appointment access standards, triage and/or screening access requirements, and telephonic access to health care services and the monitoring activities to ensure compliance:

Member Notification

Health Net members are notified annually, via member newsletters or the Evidence of Coverage (EOC), of time-elapsed appointment access standards, the availability of triage or screening services and how to obtain these services.

Primary Care Physician and Specialist Office Hours

As required by applicable federal and state statutes and regulations, primary care physician (PCP) and specialty care practitioners (SCP) office hours must be reasonable, convenient and sufficient to ensure that they do not discriminate against members and members are able to access care within established time-elapsed access standards. PCP and SCP office hours must be posted in the provider's office. Health Net requires a PCP practice to be open at least 20 hours per week and a SCP practice to be open at least 16 hours per week for members to schedule appointments within established appointment access standards. During evenings, weekends and holidays, or whenever the office is closed, an answering service or answering machine should be utilized to provide members with clear and simple instruction on after-hours access to medical care. Additionally, Medi-Cal participating providers must offer hours of operation to Medi-Cal members that are no less than the hours of operation offered to patients from other lines of business or to Medi-Cal fee-for-service (FFS) beneficiaries.

After-Hours Access Guidelines

As required by applicable statutes, Health Net's participating providers must ensure that, when medically necessary, they have medical services available and accessible to members 24 hours a day, 7 days a week, and PCPs are required to have appropriate 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 instructions about after-hours access to medical care (urgent/emergency medical care).

PCPs (or on-call physicians) should return telephone calls and pages within 30 minutes and be available 24 hours a day, 7 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/or screening services 24 hours a day, 7 days a week through medical/nurse advice lines. Refer to the Triage and Screening Services/Advice Lines section below for further information.

Note: Although Health Net does not delegate triage and screening services, PCPs are still required to comply with these after-hours requirements since medically necessary services are required to be available and accessible 24 hours a day, 7 days a week.

After-Hours Script Template

n times of high stress, when members may have an urgent or emergent situation, it is important to provide clear messaging with call-back time frames and directions on how to access urgent and emergency care to prevent potential quality of care issues. Directing members to the appropriate level of care using simple and comprehensive instructions can improve the coordination and continuity of the member's care, health outcomes and satisfaction. Health Net has designed an after-hours script template that PPGs or physicians who have a centralized triage service or other answering service can 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 to talk to when they need urgent medical advice.

Health Net makes the script available in the following threshold languages:

- English (PDF)
- Spanish (PDF)

After-hours scripts are available in alternate formats and additional languages upon request. Contact the Provider Network Management, Access & Availability Team for more information.

Answering Services

Providers are responsible for the answering service they use. If a member calls after hours or on a weekend for a possible medical emergency, the 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 about 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 an authorization, which is binding and cannot be retracted.
- In the event of a hospitalization, the PPG or hospital must contact the Health Net 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/Advice Lines

As defined in 28 CCR 1300.67.2.2(b)(5), Health Net provides 24-hours-a-day, 7-days-a-week triage or screening services by telephone. This program is a service that 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 Community Health Plan of Imperial Valley Member Services Department coordinates member access to the service, if necessary.

The program allows California 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 self-care guidance, general health information, or recommend a visit to urgent care of the emergency room.

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 for Medi-Cal members through medical advice lines as follows:

- Triage and/or screening services/nurse advice help is available to members, 24 hours a day, 7 days a week through Health Net's State Health Programs (SHP) Member Service Department telephone line displayed on the back of the member's ID card. A representative connects the member to triage and/or screening services/nurse advice after verifying eligibility.

Facility Access for Persons with Disabilities

Health Net and its participating providers and practitioners do not discriminate against members who have physical or mental disabilities. Participating providers are required to provide reasonable access for members with disabilities in accordance with the Americans with Disabilities Act of 1990 (ADA). Access generally includes ramps, elevators, restroom equipment, designated parking spaces, and drinking fountain design.

Providers must reasonably accommodate members and ensure that programs and services are as accessible (including physical and geographic access) to members with disabilities as they are to members without disabilities. Providers must have written policies and procedures to ensure appropriate access, including ensuring physical, communication and programmatic barriers do not inhibit members with disabilities from obtaining all covered services.

Facility Site Review

Health Net provides PCPs with office policies and procedures to use as templates for the facility site reviews (FSRs). Refer to the Medi-Cal FSR PCP office management policy and procedure templates for more information. During Health Net's facility review process, a finding of any obvious physical barrier to accessibility for disabled members is noted. If any obvious physical barrier is found, Health Net discusses potential resolution with the provider or PPG administrator. The provider indicates the resolutions on the facility site review (FSR) corrective action plan.

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. Refer to Minor’s Consent section for more information.

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 referrals for specialty care if the necessary services fall outside the scope of the PCP's practice. Exceptions to this process are:

- Emergency care (including emergency behavioral health care).
- Urgent care sought outside the service area, and under unusual or extraordinary circumstances provided in the service area when the participating medical provider is unavailable or inaccessible.
- 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 tests).
- Out-of-area renal dialysis services.
- 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.

- Behavioral health care is not covered by Health Net under its Medi-Cal managed care program. Accordingly, members may be eligible to self-refer to a behavioral health practitioner out-of-network through the mental health departments of members' counties of residence, depending on their Medi-Cal benefit coverage.
- Medi-Cal members may seek sensitive services, such as minor consent services, and family planning, sexually transmitted diseases and HIV testing and counseling services from qualified participating or out-of-network family planning providers, the local health department (LHD) and/or family planning clinics. Sensitive services for minors include sexual assault (including rape), drug or alcohol abuse, pregnancy, family planning, sexually transmitted infections, and behavioral health care.
- Medi-Cal members may access LHD clinics for immunizations.

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 the DMHC timely access regulations (28 CCR 1300.67.2.2) and to Health Net's Medical Records Documentation Standards policy and procedure (KK47-121230), when it is necessary for a provider or a member to reschedule an appointment, the appointment must be rescheduled promptly in a manner that is appropriate for the member's health care needs. Efforts to reschedule the appointment must ensure continuity of care; and be consistent with good professional practice and with the objectives of Health Net's access and availability policies and procedures.

Shortening or Extending Appointment Waiting Time

The applicable waiting time for a particular appointment may be shortened or extended by the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice. If the licensed applicable health care provider has determined to extend the appointment wait time, the provider must document in the member's record that a longer waiting time will not have a detrimental impact on the member's health, as well as the date and time of the appointment offered. The provider will notify the member of this decision, including an explanation of their right to file a grievance with Health Net. The record must be available to the Department of Health Care Services (DHCS) upon request.

Advanced Access

The PCP may demonstrate compliance with the established primary care time-elapsed access standards through the implementation of standards, policies, processes, and systems providing same or next business day appointments with a PCP, or other qualified health care provider, such as a nurse practitioner or physician

assistant from the time an appointment is requested; and offers advance scheduling of appointments for a later date if the member prefers not to accept the appointment offered within the same or next business day.

Advance Scheduling

Preventive care services and periodic follow-up care appointments, including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat health conditions and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice. For detailed standing referral information, refer to Operations Manuals > Referrals > Standing Referral to a Specialist > Regular Standing Referrals.

Shortage of Providers

If it is determined that there is a shortage of one or more types of participating providers (including seldom used or unusual specialty services) in a Health Net service area, Health Net and its participating providers are responsible for ensuring members are seen within the appropriate time-elapsed appointment standards [28 CCR 1300.67.2.2(c)(7)(B)]. To comply with applicable laws and regulations, and ensure timely access to covered health care services, a provider or PPG operating in a service area that has a shortage of one or more types of providers and cannot provide an appointment within the required time frame must:

- For primary care services - Refer members to available and accessible participating providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the member's health care needs.
- For specialty services (including seldom used or unusual specialty care) - Refer members to available and accessible participating providers in neighboring service areas. If a specialist is not available in neighboring areas within the network, the participating provider must refer the member to, and arrange for the provision of, an out-of-network specialist, when medically necessary for the member's condition for as long as the provider or PPG is unable to provide timely access within the network.
- Member costs for medically necessary referrals for out-of-network providers must not exceed applicable copayments, coinsurance and deductibles.

Providing members with a list of potentially available out-of-network providers does not meet the requirement to arrange for medically necessary services from an out-of-network provider. To ensure members have access to services within geographic and timely access standards, Health Net and its participating providers are responsible to:

- Contact the out-of-network provider on behalf of the member to find out when appointments are available for medically necessary services.
- Schedule any initial and follow-up appointments for the member with an out-of-network provider.

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.

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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.

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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.

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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.

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Telehealth services are subject to the requirements and conditions of the enrollee benefit plan and the contract entered into between Health Net and its participating providers. Prior to the delivery of health care via telehealth, the participating provider at the originating site must verbally inform the member that telehealth services may be used and obtain verbal consent from the member. The verbal consent must be documented in the member's medical record. To the extent that telehealth services are provided as described herein and as defined in Section 2290.5(a) of the Business & Professions Code, Section 1374.13 of the Health and Safety Code, and Sections 14132.72 and 14132.725 of the Welfare and Institutions Code, these telehealth services comply with the established appointment access standards.

Interpreter Services

In order to comply with applicable federal and state laws and regulations, Health Net requires providers to coordinate interpreter services with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment. If an appointment is rescheduled, it is very important to reschedule the interpreter for the time of the new appointment to ensure the member is provided with these services. Refer to Interpreter Services for more information.

Cultural Considerations

Health Net and its participating providers, including long-term support services (LTSS) providers, must ensure that services are provided in a culturally competent manner to all members, including those who have limited-English proficiency(LEP),limited reading skills, and those from diverse cultural and ethnic backgrounds. Refer to Language Assistance and Cultural Competency for more information.

Prior Authorization Processes

Health Net requires prior authorizations to be processed and completed in a manner that assures appointments for covered health care services are provided in a timely manner, appropriate to the member's condition and comply with the requirements of the time-elapsed appointment access standards. If the appointment type requires prior authorization, obtaining authorization must be completed within the time frame for that visit or service to be offered. For example, expedited utilization management (UM) review processes and appointment scheduling for urgent care appointments for services that require prior authorization, [CCR T28 §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 further information. For additional information refer to Authorization and referral Timelines.

Determination timeline for a decision following a deferral

- When additional information is received: If requested information is received, a decision must be made within five working days from the receipt of information, not to exceed 28 calendar days from the date of receipt of the original request.
- Decision when additional information received is incomplete or not received:

If the provider has not complied with the request for additional information, the Plan reviews the request with the information available and makes a determination within five working days of the expiration of the deferral notice, not to exceed 28 calendar days from receipt of the original request (Health & Safety Code 1367.01).

Expedited Authorization (Pre-Service) - Deferral Needed

An initial decision may be deferred for 14 calendar days from the date of receipt of the original request if the referring provider, treating provider, or triaging health professional has determined and noted in the relevant record that a longer waiting time will not have detrimental impact on the health of the enrollee," in accordance with Section 1367.03(a)(5)(H), and:

- Additional clinical information is required.
- Requires consultation by an expert reviewer.
- Additional examination or tests are to be performed.

Written Notification, Notice of Action – Deferral: Written notification is sent to the member and requesting provider within the initial 72 hours from receipt of the original request, or as soon as the Plan becomes aware that it will not meet the timeframe, whichever occurs first, and:

- Specify the additional information requested; requesting only that information that is reasonably necessary to make a decision.
- Provide the anticipated date of decision.

- Advise the requesting provider that:

“In accordance with Section 1367.03(a)(5)(H):

- If this delay to obtain additional information and resulting delay *will* have a detrimental impact on the health of the member, you *must* contact the Plan.
- If this delay will *not* have a detrimental impact on the health of the member, you *must* document this in the member record.”

Determination timeline for a decision following a deferral

- When additional information is received: If requested information is received, a decision must be made within five working days from the receipt of information, not to exceed 28 calendar days from the date of receipt of the original request.
- Decision when additional information received is incomplete or not received.

If the provider has not complied with the request for additional information, the Plan reviews the request with the information available and makes a determination within five working days of the expiration of the deferral notice, not to exceed 28 calendar days from receipt of the original request (Health & Safety Code 1367.01).

Quality Assurance

Health Net has a documented system for monitoring and evaluating practitioner/provider availability and accessibility of care. At least annually, Health Net monitors appointment access to care and provider availability standards through member and provider surveys. At least quarterly, Health Net reviews and evaluates the information available to Health Net regarding accessibility, availability, and continuity of care, through information obtained from appeals and grievances, triage or screening services, and customer service telephone access to measure performance, confirm compliance, and ensure the provider network is sufficient to provide appropriate accessibility, availability and continuity of care to Health Net members.

At least on a quarterly basis, the Plan will review reports from the Quality Improvement Department regarding Incidents of non-compliance resulting in substantial harm to an enrollee that are related to access. The Plan will address areas related to network non-compliance with the regional Provider Network Management teams. Corrective actions will be implemented as applicable.

PPGs are responsible to monitor data provided by Health Net regarding their provider adherence to the following standards, as corrective actions may be required of providers that do not comply. Refer to the Corrective Action section below for further information.

Health Net's performance goals for access-related, time-elapsed provider criteria are available for providers' reference.

Medi-Cal 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%

ACCESS MEASURE	STANDARD	PERFORMANCE GOAL
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 & Other) that require prior authorization	Appointment within 96 hours of request	70%
First prenatal visit (both PCP and SCP)	Appointment within 2 weeks of request	70%
Well-child visit	Appointment within 2 weeks of request	70%
Preventive health, physical exams and wellness checks with PCP	Appointment within 30 calendar days of request	70%
After-hours care (PCP)	Ability to contact on-call physician after hours within 30 minutes for urgent issues Appropriate after hours emergency instructions	90%
Non-urgent ancillary services for MRI/ mammogram/physical therapy	Appointment within 15 business days of request	70%
In-office wait time for scheduled appointments (PCP and SCP)	Not to exceed 30 minutes	70%
Provider office telephone callback during normal business hours	Provider callback within 1 business day	90%
Phone answer time at provider's office	Within 60 seconds	90%
Non-urgent appointment with a physician in a skilled nursing facility (SNF) or intermediate care facility (ICF)	Rural and Small Counties: Within 14 calendar days of request	80%

ACCESS MEASURE	STANDARD	PERFORMANCE GOAL
	Medium Counties: Within 7 business days of request Large Counties: Within 5 business days of request	

Compliance is measured by results from the Provider Appointment Availability Survey (PAAS) and the Provider After-Hours Availability Survey (PAHAS) conducted via telephone by Health Net and the Consumer Assessment of Health Care Providers & Systems (CAHPS®1) survey.

1 CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Health Net Medi-Cal Plans Appointment Access Standards - Behavioral Health

ACCESS MEASURE	STANDARD	PERFORMANCE GOAL
Urgent care1	Within 48 hours	90% or more of members with a clinical risk rating of urgent have access to urgent appointments within 48 hours
Non-life threatening emergency (NLTE)1	Within 6 hours	90% or more of members with a clinical risk rating of NLTE have access to an appointment within 6 hours
Access to care for life-threatening emergency1	Immediately	100% compliance with immediate referral to care
Rescheduled Appointments2	Appointment was scheduled to member's satisfaction	85% or more of members report their appointment was rescheduled to their satisfaction
Non-urgent appointments with behavioral health care physician (psychiatrist) for routine care3	Appointment within 15 business days of request	70%
Urgent care appointment with non-physician behavioral health care provider or behavioral	Appointment within 48 hours of request	70%

ACCESS MEASURE	STANDARD	PERFORMANCE GOAL
health care physician (psychiatrist) that does not require prior authorization3		
Urgent care appointment with non-physician behavioral health care provider or behavioral health care physician (psychiatrist) that requires prior authorization3	Appointment within 96 hours of request	70%
Non-urgent follow-up appointment with non-physician behavioral health care provider3	Within 10 business days of request	80%

1Assessed through care management software.

2Assessed through annual BH member experience survey (ECHO).

3Assessed through annual Provider Appointment Availability Survey (PAAS).

Corrective Action

Health Net investigates and implements corrective action when timely access to care as required by Health Net's Appointment Accessibility for Medi-Cal policy and procedure (CA.NM.05) are 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 of or more metrics are noted as being non-compliant:

- 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 with 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 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 the standard meeting regulatory agency time frame compliance.
- The PPG is to return the IP within 30 calendar days.

CAP Follow-Up Process

- If the PPG fails to return a completed IP within the prescribed time frame, the Provider Network Management (PNM) Department is asked to intercede.
- PPGs demonstrating a pattern of noncompliance with access regulations and standards are subject to an in-office audit and may be referred to the PNM and Contracting departments for further action.

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:

Geo-Access and Provider Availability Standards*

Availability Standards	Performance Threshold
Imperial	60 miles or 90 minutes
DHCS Core Specialists (Adult and Pediatric)	Cardiology/Interventional Cardiology*, Dermatology*, Endocrinology*, ENT/Otolaryngology*, Gastroenterology*, General Surgery, Hematology*, HIV/AIDS Specialists/Infectious Diseases*, Nephrology*, Neurology*, Obstetrics/Gynecology (Adult Only)*, Oncology*, Ophthalmology*, Orthopedic Surgery, Physical Medicine and Rehabilitation, Psychiatry*, Pulmonology*, Non-physicians/Mental Health Providers* *Telehealth optional
Practitioner/Provider Availability Standards	Performance Threshold

Availability Standards	Performance Threshold
Member to full-time equivalent (FTE) PCP ratio	2,000:1
Member to FTE physician	1,200:1
Member to Behavioral Health Provider ratio: • MD's/DO (Psychiatrists) • Psychologist • Masters Level practitioner	6,250:1 2,875:1 1,450:1
Percent PCPs open practice	85% of PCPs accepting new members
Percent SCPs open practice	85% of SCPs accepting new members
Members age 0-21 to Qualified Autism Service (QAS) Provider ratio	5000: 1
Members age 0-21 to QAS Professionals and Paraprofessionals ratio	5000: 2

*Certain rural portions of the Plan service area may have access that differs from the standards, based on lack of practitioner and hospital availability. Regulatory approval is required for areas that vary from within the standard.

Availability Corrective Action

Health Net collects and analyzes all data to identify opportunities for improvement, which is communicated to the appropriate quality committee or department to review for recommendations. Health Net implements plan-wide corrective actions based on its assessment. These results and applicable actions for improvement are communicated to practitioners, providers and PPGs through Health Net's Quality Improvement Committee or through the activities of Provider Network Management.

Threshold Languages

Any non-English language that meets the following criteria for Medi-Cal eligibles within a county is designated as a threshold language. As Medi-Cal is an entitlement program, the criteria is based on those that may be eligible for services not those that are enrolled in the plan. Currently, Health Net has a total of 11 non-English languages that are required for translation.

- 3,000 within one county or five percent (5%), whichever is lower
- 1,000 within one zip code
- 1,500 within two contiguous zip codes

Per DHCS, “Threshold Standard Languages ≥3,000 per language or ≥5% of the Medi-Cal Population that speak the language per county. Concentration Standard Languages ≥1,000 per zip code or ≥1,500 per two contiguous.”

All members whose primary language has been identified as a threshold language by the Department of Health Care Services (DHCS) and Health Net receive written and oral information in that language. Health Net monitors member access to information and services in threshold languages through a variety of ways, including primary care site certification.

Amador

In Amador County, there are no non-English threshold languages.

Calaveras

In Calaveras County, there are no non-English threshold languages.

Fresno

In Fresno County, the threshold languages are Spanish and Hmong.

Imperial

In Imperial County, the threshold language is Spanish

Inyo

In Inyo County, the threshold language is Spanish.

Kings and Madera

In Kings and Madera counties, the threshold language is Spanish.

Los Angeles

In Los Angeles County, the threshold languages are Arabic, Armenian, Cambodian (Khmer), Chinese, Farsi, Korean, Russian, Spanish, Tagalog, and Vietnamese.

Mono

In Mono County, the threshold language is Spanish.

Sacramento

In Sacramento County, the threshold languages are Arabic, Chinese, Farsi, Hmong, Russian, Spanish, and Vietnamese.

San Joaquin

In San Joaquin County, the threshold language is Spanish.

Stanislaus

In Stanislaus County, the threshold language is Spanish.

Tulare

In Tulare County, the threshold language is Spanish.

Tuolumne

In Tuolumne County, there are no non-English threshold languages.

Open Clinical Dialogue

Participating Physician Groups (PPG) | Hospitals

The Provider Participation Agreements (PPAs) include a statement that providers can communicate freely with members regarding their medical conditions and treatment alternatives, including medication treatment options, regardless of coverage limitations. Providers' contracts and subcontracts are required to include this provision.

Additionally, Health Net may not prohibit or otherwise restrict a health care professional, acting within the lawful scope of practice, from advising, or advocating on behalf of, an individual who is a patient and enrolled under a Health Net plan.

Claims Denials

Participating Physician Groups (PPG) | Hospitals

The Delegation Oversight auditors review claim denial by delegated entities to ensure that notification letters to providers comply with accuracy and timeliness requirements. Providers may not send a denial notice to a member as they are provider denials only..

Claim Audit Check Cashing Requirement

Health Net conducts audits to ensure 70% of checks mailed by the delegated entity to their participating and non-participating providers are cleared within 14 calendar days from the date the check was mailed. Check mailing is monitored to validate that checks are being mailed timely.

Claims Payment Requirements

Participating Physician Groups (PPG)

Accurate and timely processing and payment of claims is monitored via the participating physician group's (PPG's) monthly claims timeliness report and is verified by routine and targeted audits conducted by the Health Net Delegation Oversight staff.

PPGs are required to:

- Process 90 percent of Medi-Cal clean claims within 30 calendar days of receipt
- Process 95 percent of all Medi-Cal claims within 45 business days of receipt
- Pay 15 percent interest or $15 per annum, whichever is greater, on late paid claims for emergency services rendered in the United States
- Pay 15 percent interest on late paid claims and include an additional payment of $10 if the interest is not paid within five business days of the date of claim payment
- Issue payment within 10 business days for claims identified during an audit as underpaid or denied incorrectly

Timely Claims Processing Requirements

When a member seeks medical attention from a PPG, it is important that the PPG attempts to determine eligibility with Health Net and enrollment in the PPG before providing care. If the PPG does not follow the required steps for verification of eligibility and enrollment, Health Net does not accept financial responsibility for any services performed.

All Medi-Cal claims must be processed in accordance with these requirements:

- Process 90 percent of Medi-Cal clean claims within 30 calendar days of receipt
- Process 100 percent of all Medi-Cal claims within 45 business days of receipt
- The payer is required to notify the provider in writing of contested claims
- The payer is required to notify the provider in writing of contested claims within 45 days

Providers are asked to produce an action plan if the volume of encounters not processed within 30 calendar days without satisfactory notification to the provider is not in compliance with Health Net's standards. Providers may be sanctioned if continued non-compliance is demonstrated. Sanctions can include freezing new enrollment and can ultimately result in termination of the provider's contract.

Health Net is required to submit encounter information to the Department of Health Care Services (DHCS) within 90 days following the month in which the service was provided. To meet this requirement, providers need to submit this information to Health Net within 60 days of the date of service. This allows Health Net 30 days to process the information prior to submission to DHCS.

Claims must be submitted within six months of the last date of the month during which services were rendered. Health Net denies claims submitted beyond this period.

If providers accidentally bill Electronic Data System (EDS), EDS denies the claim and sends the claim back to the provider with a notice instructing the provider to bill the correct carrier. EDS does not forward the claim to Health Net. It is the provider's responsibility to bill the correct payer.

Claims Universe Report

PPGs are required to report all family planning and sensitive service claims that were paid or denied to non-participating providers during the regular scheduled claims audit. To ensure Health Net PPGs comply with this requirement, PPGs must submit a Claims Universe Report for the quarter being audited. The report may cover the same time period as the claims timeliness audit. The report should include:

- Member name
- Member identification (ID) number
- Provider name
- Check date
- Check mail date
- Check number and amount paid
- Claim number
- Date of service
- CPT and ICD-10 codes
- Service(s) billed amount
- Place of service
- Signed informed consent form (if required for specific service)

Authorization and Referral Timelines

Participating Physician Groups (PPG)

According to the utilization management (UM) standards, all participating physician groups (PPGs) are required to:

- Approve, modify or deny and process all routine authorization requests within 5 working days of the date of receipt of all information necessary to render a decision.
- Approve or deny and process all urgent requests for authorization within 72 hours after the receipt of the request for service.
- If additional clinical information is required, the member and practitioner must be notified in writing within the applicable regulatory time frame of the extension.
- Communicate the decision to the member and practitioner within the applicable regulatory timeframe from the date of the original receipt of the request.

The regulatory time frames begin when the delegated PPG receives a request for prior authorization. If the PPG's UM department receives a request for prior authorization of services and it is determined to be the plan's responsibility, the PPG must immediately forward the request to the plan as the regulatory time frames begin at the time of the original request. The Medicare Advantage Informational Letter to Member or Provider/ Physician carve-out letter (PDF) serves to advise the member that the PPG's utilization management entity received a prior authorization request for which the PPG is not delegated to conduct a prior authorization review and notifies the member that the request has been forwarded to the plan (no Medi-Cal carve-out letter is available at this time). PPGs use the Medicare Advantage Information Letter for Cal MediConnect members. The regulatory time frame for the prior authorization review does not reset or stop when this letter is issued.

For additional information, refer to:

- Utilization Management Timeliness Standards - Medi-Cal (PDF)
- Utilization Management Timeliness Standards - Medicare (PDF)

Continued Access to Non-Participating Providers for SPD Members

Participating Physician Groups (PPG) | Hospitals

Health Net requires all subcontracting health plans, delegated participating physician groups (PPGs) and capitated hospitals to adhere to the Procedures for SPD Members Requesting Services from Non-Participating Providers (see section below). Health Net subcontractors must arrange for medically necessary services for newly enrolled Seniors and Persons with Disabilities (SPD) members to be provided by non-participating providers when the SPD member requests such services. This applies to Medi-Cal members enrolled in Health Net's Medi-Cal plan directly from the Medi-Cal FFS program beginning June 1, 2011, and who are in one of the following aid codes:

- Disabled (Medi-Cal only - Not Medicare eligible): 20, 24, 26, 2E, 2H, 36, 60, 64, 66, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V
- Aged (Medi-Cal only - Not Medicare eligible): 10, 14, 16, 1E, 1H

SPD members who request continued access to existing non-participating providers may be treated by the non-participating provider for medically necessary services for up to 12 months from the date of the member's enrollment in Health Net, if there are no quality-of-care issues involving the provider. If an SPD member agrees to transition to a participating provider earlier than the 12-month transition period, the PPG is encouraged to work with the member and transition him or her to a participating provider.

Health Net's subcontractors - a Medi-Cal capitated PPG, a Medi-Cal capitated hospital or Molina Healthcare - must pay non-participating providers providing covered services for SPD members under the terms and conditions of the guidelines and requirements in the above procedure at the higher of the subcontractor's Medi-Cal contracting rate, or the Medi-Cal fee-for-service (FFS) provider rate. Health Net's subcontractors may require non-participating providers to agree in writing to contractual terms and conditions, including, but not limited to, prior authorization, hospital privileging, utilization review, case management, and quality performance requirements.

Additional Terms and Conditions of Coverage

Following are additional terms and conditions of coverage for continuation of care by a non-participating provider:

- A newly enrolled SPD member has an ongoing relationship with the requested provider
  - The requested provider was not terminated from participation with Health Net or its subcontractor for a medical discipline reason, fraud or crime
  - The requested provider is not excluded, suspended or terminated from participation in the Medicare or Medi-Cal and Medicaid programs
  - Services to be rendered by the provider are covered services

Procedures for SPD Members Requesting Services from Non-Participating Providers

Health Net Responsibilities

Health Net follows these steps to notify subcontractors of newly enrolled Seniors and Persons with Disabilities (SPD) members who request to continue to obtain medically necessary care and services from a non-participating provider during their 12-month transition period following enrollment with Health Net:

- The SPD member or the member's representative calls or writes Health Net's Medi-Cal Member Services Department , Community Health Plan of Imperial Valley Member Services Department or CalViva Health's Member Services to request that the SPD member continue to be treated by a non-participating provider.
- Health Net's Medi-Cal Member Services Department verifies, to the extent possible, with the SPD member that he or she has an ongoing relationship with the requested provider and forwards the completed Transition of Care/Continuation of Care Request Form for response to either:
  - Health Net's Medi-Cal Health Care Services Department
  - Molina Healthcare's medical director when the SPD member is assigned to Molina

For the purposes of these guidelines and requirements, references to medical director are meant to include the member's designated case manager

- The Health Net Medi-Cal Health Care Services Department representative reviews the fee-for-service (FFS) utilization data provided by Department of Health Care Services (DHCS) to verify claims were paid under the FFS Medi-Cal program to the requested non-participating provider. If the requested non-participating provider does not appear in the FFS utilization data, the representative contacts the requested provider to obtain visit history for the SPD member. The representative then forwards the completed form to the member's assigned PPG medical director

Subcontractor Responsibilities

- Upon receipt of the completed Transition of Care/Continuation of Care Request Form, the applicable PPG or Molina medical director or designee determines whether the SPD member qualifies for coverage of continuation of care by the non-participating provider. This includes confirming that there are no quality-of-care issues involving the non-participating provider and whether the non-participating provider is willing to provide the continuation of care at the higher of the subcontractor's Medi-Cal contracting rate or the Medi-Cal FFS provider rates. If the non-participating provider does not agree to these or other permissible terms, then Health Net is not required to provide the new SPD member with continued access to covered services offered by the non-participating provider
- If the applicable PPG or Molina medical director or designee determines that the SPD member does not qualify for continued access to a non-participating provider in accordance with this policy, the medical director or designee:
  - Arranges for a participating provider to provide for the SPD member's care
  - Informs the SPD member of the determination in a timely manner appropriate for the SPD member's clinical condition, not to exceed five business of the member's request
- If the applicable PPG or Molina medical director or designee determines that the SPD member qualifies for continued access to a non-participating provider in accordance with this policy, and the non-participating provider agrees on a rate and to comply with any of the subcontractor's other contractual requirements, the medical director or designee:
  - Authorizes coverage for continuation of care by the non-participating provider
  - Informs the SPD member of the determination in a timely manner appropriate for the SPD member's clinical condition, not to exceed five business of the member's request
- Subcontractors are required to track the number of continuation of care requests that are approved and the number that are denied, along with the reason that they are denied

Eligibility and Data Entry Requirements

Participating Physician Groups (PPG) | Hospitals

All participating physician groups (PPGs) and hospitals are required to enter the following into the PPG's or hospital's system:

- Eligibility and primary care physician (PCP) assignment information within two business days after receipt.
- New member information that is not yet on eligibility or capitation reports upon verification of eligibility.
- PCP changes requested by the member within two business days of receipt of requested change.

Quality Improvement Problem Resolution

Participating Physician Groups (PPG) | Hospitals

Under the plan's quality improvement (QI) standards, all participating physician groups (PPGs) and hospitals are required to:

- Initiate research, on quality-of-care problems identified by clinical staff.
- Provide feedback and information on the issue so that a determination can be made.
- Participate in the QI corrective action process, as applicable.

Public Programs

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

Select any subject below:

- AIDS Waiver Program
- Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment
- California Children's Services
- DDS-Administered Home and Community Based Services (HCBS) Waiver
- Early Start Program
- EPSDT / Medi-Cal for Kids & Teens Services
- Home and Community Based Waiver
- Local Education Agency Services
- Long-Term Services and Supports
- Mental Health
- Regional Center Coordination
- Sexually Transmitted Infections (STIs)
- Tuberculosis Detection and Treatment
- WIC

Medi-Cal Waiver Program (formerly AIDS Waiver Program)

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

The Medi-Cal Waiver Program (MCWP), formerly known as the AIDS Waiver, provides comprehensive case management and direct care services to persons living with HIV/AIDS as an alternative to nursing facility care or hospitalization. Case management is participant centered and provided using a team-based approach by a registered nurse and social work case manager. Case managers work with the participant, their primary care provider, family, caregivers, and other service providers to determine and deliver needed services to participants who choose to live in a home setting rather than an institution. The goals of the MCWP are to:

- Assist participants with disease management, preventing HIV transmission, stabilizing overall health, improving quality of life, and avoiding costly institutional care;
- Increase coordination among service providers and eliminate duplication of services;

- Transition participants to more appropriate programs as their medical and psychosocial status improves, thus freeing MCWP resources for those in most need; and,
- Enhance utilization of the program by underserved populations.

Clients eligible for the program must be Medi-Cal recipients: whose health status qualifies them for nursing facility care or hospitalization, in an “Aid Code" with full benefits and not enrolled in the Program of All-Inclusive Care for the Elderly (PACE); have a written diagnosis of HIV disease or AIDS with current signs, symptoms, or disabilities related to HIV disease or treatment; adults who are certified by the nurse case manager to be at the nursing facility level of care and score 60 or less using the Cognitive and Functional Ability Scale assessment tool, children under 13 years of age who are certified by the nurse case manager as HIV/AIDS symptomatic; and individuals with a health status that is consistent with in-home services and who have a home setting that is safe for both the client and service providers.

Care Management

The California Department of Public Health's (CDPH's) Medi-Cal Waiver Program agencies provide services only in non-institutional settings. The home is the most common place of service. The CDPH contracting agencies are responsible for administering the program, providing nurse care management, and authorizing payment to Medi-Cal Waiver Program services subcontractors.

The CDPH's Office of AIDS contracts with agencies throughout California to administer the Medi-Cal Waiver Program and provide nurse care management services. These agencies subcontract with licensed providers for program services.

CDPH's Medi-Cal Waiver Program care management team locates, coordinates and monitors services for enrollees. This includes developing a written service plan and assessing the service requirements and medical condition of the enrollee. Medi-Cal Waiver Program care management is performed by a team that includes a program nurse care manager, social worker or foster-child case-worker (if needed), attending physician, and member.

The CDPH's Medi-Cal Waiver Program care manager may authorize Medi-Cal FFS in-home skilled nursing care, attendant care, homemaker care, psychosocial counseling, equipment and minor physical adaptations to the home, Medi-Cal supplement for infants and children in foster care, non-emergency medical transportation, non-medical transportation, nutrition counseling, nutritional supplements, and home-delivered meals.

Eligibility

Members must meet the California Department of Public Health's (CDPH's) Medi-Cal Waiver Program eligibility requirements to participate through Health Net. Managed care members are not required to disenroll from Health Net in order to enroll in the Medi-Cal fee-for-service (FFS) Medi-Cal Waiver Program. To qualify, members with AIDS or symptomatic HIV disease must meet the California Department of Public Health's CDPH's criteria:

1. be Medi-Cal enrolled
2. have a written diagnosis of HIV disease or AIDS with current signs, symptoms, or disability related to the HIV disease or treatment
3. adults who are certified by the CDPH nurse case manager to be at the nursing facility level of care and score 60 or less on the cognitive and functional ability scale assessment tool

4. children under age13 who are identified by the CDPH nurse case manager as HIV/AIDS symptomatic (Note: Children who are HIV-positive must be referred to the California Children's Services (CCS) program.)
5. individuals with health status consistent with in-home services and who have home settings safe for both members and service providers
6. have exhausted other coverage, such as private health insurance for health care benefits similar to those available under the Medi-Cal Waiver Program prior to use of Medi-Cal Waiver Program services
7. must not be simultaneously enrolled in Medi-Cal hospice, but may be simultaneously enrolled in Medicare hospice
8. must not be simultaneously enrolled in the AIDS Case Management program
9. must not simultaneously receive case management services or use State Targeted Case Management Services program funds to supplement the Medi-Cal Waiver Program (MCWP)
10. must have an attending primary care physician (PCP) willing to accept full professional responsibility for the recipient's medical care

Members eligible for the CDPH Medi-Cal Waiver Program may remain enrolled in both Health Net's Two-Plan Model and Geographic Model managed care plans. Members accepted into the CDPH Medi-Cal Waiver Program are not required to disenroll from their Heath Net managed care Medi-Cal plans.

Excluded Managed-care Medications for HIV and AIDS

These medications are covered through the Medi-Cal Rx program. Providers bill the state directly for these medications under Medi-Cal Rx.

Problem Resolution

Disputes that arise between the Medi-Cal Waiver Program and Health Net or a participating provider are resolved by Health Net's Public Programs Specialists. During a dispute, the provider and the Health Net Health Services staff continue to manage the member's medical care.

Referral and Coordination of Care

The primary care physician (PCP), Health Net Health Care Services staff or both inform eligible members about the California Department of Public Health's Medi-Cal Waiver Program.

If the member believes he or she is eligible and requests program referral, the type of supportive care needed is identified and the Health Net Health Care Services or Public Program's staff initiates a referral.

The California Department of Public Health's Office of AIDS conducts the assessment of the member based on the CDPH's Medi-Cal Waiver Program criteria for enrollment eligibility.

With the member's consent, the PCP or the Health Net Health Care Services staff, if requested, forwards any available relevant medical documentation to the program, including the member's medical history, lab results and an outline of the therapeutic regimen, if a copy is in the plan's possession.

For members who elect to remain enrolled in both the plan and Medi-Cal Waiver Program, the Health Net Health Care Services staff concurrently institutes a care management plan and coordinates with the member's PCP.

The member's PCP and Health Net Health Care Services staff are responsible for developing a primary care management plan that covers all medically necessary treatment and meets the health care needs of the member diagnosed with AIDS. They are responsible for coordinating and authorizing pharmacy, inpatient services, outpatient services, infusion services, laboratory services, specialty referrals, durable medical equipment (DME), preventive care services, and respiratory care services.

If the member elects to disenroll from the plan, the Health Net Health Care Services staff contacts the Health Net Medi-Cal Member Services Department, Community Health Plan of Imperial Valley Member Services Department or CalViva Health Medi-Cal Member Services Department (for Fresno, Kings and Madera counties) to initiate the disenrollment. The Health Net Health Care Services staff is responsible for authorization of services and coordination of the member's medical care until the member enters the Medi-Cal Waiver program.

Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment

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

Alcohol and drug treatment services are excluded from Health Net's coverage responsibilities under Health Net's Medi-Cal managed care contract. These services are overseen by the state of California.

Health Net, its affiliated health plans and subcontracting providers are available to coordinate referrals for members requiring substance use treatment and services. Members receiving services under this program remain enrolled in Health Net. Participating primary care physicians (PCPs) are responsible for maintaining continuity of care for the member.

Alcohol Misuse Screening and Behavioral Counseling

Alcohol and drug treatment services are excluded from Health Net's coverage responsibilities under Health Net's Medi-Cal managed care contract. These services are administered by Counties and overseen by the state of California.

Health Net, its affiliated health plans and subcontracting providers are available to coordinate referrals for members requiring substance use treatment and services. Members receiving services under this program remain enrolled in Health Net. Participating primary care physicians (PCPs) are responsible for maintaining continuity of care for the member. Additionally, participating providers must maintain documentation of Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) services provided to members.

When a member transfers from one PCP to another, the receiving PCP must attempt to obtain the member's prior medical records, including those pertaining to the provision of preventive services. Member medical records must include the following:

- The service provided (e.g., screen and brief intervention).
- The name of the screening instrument and the score on the screening instrument (unless the screening tool is embedded in the electronic health record).
- The name of the assessment instrument (when indicated) and the score on the assessment (unless the screening tool is embedded in the electronic health record). and
- If and where a referral to an alcohol use disorder (or substance use disorders program was made.

Alcohol Misuse Screening and Behavioral Counseling

Consistent with U.S. Preventive Services Task Force (USPSTF) Grade A or B recommendations, AAP/Bright Futures, and the Medi-Cal Provider Manual, Managed Care Plans (MCPs) must provide alcohol and drug SABIRT services for members 11 years of age and older, including pregnant women. These services may be provided by providers within their scope of practice, including, but not limited to, physicians, physician assistants, nurse practitioners, certified nurse midwives, licensed midwives, licensed clinical social workers, licensed professional clinical counselors, psychologists and licensed marriage and family therapists.

Screening

Alcohol and drug use screening must be conducted using validated screening tools. Validated screening tools include, but are not limited to:

- Alcohol use disorders identification test (AUDIT).
- Alcohol use disorders identification test (Audit-C).
- Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) for non-pregnant adolescents.
- Cut down-annoyed-guilty-eye-opener adapted to include drugs (CAGE-AID).
- Drug abuse screening test (DAST-10).
- Drug abuse screening test (DAST-20).
- Michigan alcoholism screening test geriatric (MAST-G) alcohol screening for geriatric population.
- National institute on drug abuse (NIDA) quick screen for adults.
- The single NIDA quick screen alcohol-related questions can be used for alcohol use screening.
- NIDA-modified alcohol, smoking and substance involvement screening test (NM-ASSIST).
- Parents, partners, past and present (4Ps) for pregnant women and adolescents.
- Tobacco alcohol, prescription medication, and other substances (TAPS).

Brief Assessment

When a screening is positive, validated assessment tools should be used to determine if

alcohol use disorder (AUD) or substance use disorder (SUD) is present. Validated alcohol and drug assessment tools may be used without first using validated screening tools. Validated assessment tools include, but are not limited to:

- NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test (NM-ASSIST)
- Drug Abuse Screening Test (DAST)-20
- Alcohol Use Disorders Identification Test (AUDIT)

Brief Interventions and Referral to Treatment

For members with brief assessments that reveal unhealthy alcohol use, brief misuse counseling should be offered. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, must be offered to members whose brief assessment demonstrates probable AUD or SUD. Alcohol and/or drug brief interventions include alcohol misuse counseling and counseling a member regarding additional treatment options, referrals, or services. Brief interventions must include the following:

- Provide feedback to the patient regarding screening and assessment results;
- Discuss negative consequences that have occurred and the overall severity of
- the problem;
- Support the patient in making behavioral changes; and
- Discuss and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated.

Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care

The USPSTF recommends that clinicians screen adults ages 18 or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.

The following HCPCS codes may be used to bill for these services:

- G0442 - annual alcohol misuse screening, 15 minutes
- G0443 - brief face-to-face behavioral counseling for alcohol misuse, 15 minutes

Code G0442 is limited to one screening per year, any provider, unless otherwise medically necessary. Code G0443 may be billed on the same day as code G0442. Code G0443 is limited to three sessions per recipient per year, any provider, unless otherwise medically necessary.

Treatment Referral

Providers are responsible for referring members who meet criteria for alcohol and drug disorders to a county drug program for services. These services are not covered by Health Net. A list of county contacts for local substance use disorder treatment information and referrals is available on the DHCS website, under Referral to Treatment.

Documentation Requirements

Member medical records must include the following:

- The service provided (e.g., screen and brief intervention);
- The name of the screening instrument and the score on the screening instrument
- (unless the screening tool is embedded in the electronic health record);
- The name of the assessment instrument (when indicated) and the score on the
- assessment (unless the screening tool is embedded in the electronic health record); and
- If and where a referral to an AUD or SUD program was made.

PCPs must maintain documentation of SABIRT services provided to members. When a member transfers from one PCP to another, the receiving PCP must attempt to obtain the member's prior medical records, including those pertaining to the provision of preventive services.

Continuity of Care

Participating providers are responsible for providing services in a manner that ensures coordinated and continuous care to all members needing alcohol and drug treatment services, including timely referrals.

On receipt of a specific written request from the member, the primary care physician (PCP) must transfer requested summaries of the member's records to the substance abuse practitioner or program and to any organization where future care will be rendered. Any transfer of member medical records and other information must be done in a manner consistent with appropriate confidentiality standards.

A member receiving services under the Health Net Alcohol and Drug Treatment program remains enrolled with Health Net. The PCP and Health Net Health Services staff retain the responsibility for maintaining continuity of care for the member. The PCP is responsible for the coordination of the members care with the Alcohol and Drug Treatment program case managers and Health Net Health Services staff. The PCP monitors the member to ensure that follow-up care is provided as necessary.

Criteria for Referral

A number of screening instruments are available to the primary care physician (PCP) to assist in detecting substance use. Refer to samples of the Drug Use Questionnaire (PDF), Red Flags for Alcohol or Drug Abuse (PDF), T-Ace (PDF), and TWEAK Test (PDF).

Criteria for Admission to a Partial Hospital Program

A member is a candidate for admission in a partial hospital program for treatment of substance use if all the following criteria are met:

- A clearly documented pattern of substance use or dependence that meets current DSM criteria and is severe enough to interfere with social and occupational functioning and causes significant impairment in activities of daily living.
- The member is medically stable enough that the criteria for inpatient detoxification services are not met.

- The member requires up to eight hours of structured treatment per day in order to obtain the most benefit from coordinated services, such as individual, group or family therapy, education, or medical supervision.
- The member's living situation and social support system are sufficiently stable to allow for treatment in this care setting.
- There is evidence of sufficient motivation for successful participation in treatment in this care setting.
- The member has demonstrated, or there is reason to believe, that he or shee can avoid the use of substances between treatment sessions based on an assessment of such factors as intensity of cravings, impulse control, judgment, and pattern of use.

Criteria for Admission to a Residential Facility

A member is a candidate for referral for admission to a residential facility for the treatment of substance use if all the following are present:

- A clearly documented pattern of substance use or dependence that meets the current DSM criteria and is severe enough to interfere markedly with social and occupational functioning and cause significant impairment in activities of daily living.
- The member is medically stable enough that the criteria for inpatient detoxification services are not met.
- There is clearly documented evidence of the failure of partial hospital or structured outpatient treatment for substance use or dependence meeting the current DSM criteria.
- The member's living situation is severely impaired as a result of inadequate or unstable support systems, including the work environment, that may jeopardize successful outpatient treatment.
- There is significant risk of relapse if the member is treated in a less restrictive care setting related to severely impaired impulse control or a co-morbid disorder.
- Pregnant and postpartum women are eligible to receive substance use services through certified perinatal programs. Women are eligible during the term of pregnancy and for a period of up to 60 days after delivery.

Criteria for Admission to a Structured Outpatient Program

A member is a candidate for referral for admission to a structured outpatient program for the treatment of substance use if all the following are present:

- A clearly documented pattern of substance use or dependence that meets the current DSM criteria and is severe enough to interfere with social and occupational functioning and cause significant impairment in activities of daily living.
- The member is medically stable enough that the criteria for inpatient detoxification services are not met.
- The member requires up to four hours of structured treatment per day in order to obtain the most benefit from coordinated services, such as individual, group or family therapy, education, or medical supervision.
- The member's living situation and social support system are sufficiently stable to allow for structured outpatient treatment at this level of care.

- There is evidence of sufficient motivation for successful participation in treatment at this level of care.
- The member has demonstrated, or there is reason to believe, that he or she can avoid the use of substances between treatment sessions based on an assessment of factors such as intensity of cravings, impulse control, judgment, and pattern of use.

Criteria for Inpatient Detoxification

A member is a candidate for acute inpatient detoxification if symptoms are present that suggest that the failure to use this level of treatment would be life threatening or cause permanent impairment once substance use has stopped. All of the following must be present:

- Fluids and medication to modify or prevent withdrawal complications that threaten life or bodily functions
- 24-hour nursing care with close and frequent observation and monitoring of vital signs
- Medical therapy, which is supervised and re-evaluated daily by the attending physician in order to stabilize the member's physical condition
- At least two of the following symptoms of substance withdrawal:
  - tachycardia
  - hypertension
  - diaphoresis
  - significant increase or decrease in psychomotor activity
  - tremor
  - significantly disturbed sleep patterns
  - nausea or vomiting
  - clouding of consciousness with reduced capacity to shift, focus and sustain attention

Referral Documentation

Participating providers are responsible for performing all preliminary testing and procedures necessary to develop a diagnosis. Referrals to Drug Medi-Cal (D/MC) or Fee-for-Service Medi-Cal (FFS/MC) programs must include the appropriate medical records supporting the diagnosis and additional documentation. The referring provider must obtain a signed release from the member prior to making the referral.

The final decision on the acceptance of a member for FFS/MC or D/MC services (authorization of the referral) rests solely with the county alcohol and drug program.

Treatment Services

The alcohol and drug treatment services covered by the Drug Medi-Cal (D/MC) program include:

- Outpatient heroin detoxification services.
- Outpatient methadone maintenance services.
- Outpatient drug-free treatment services.
- Day care habilitative services.
- Perinatal residential substance use services.

Voluntary Inpatient Detoxification

Voluntary inpatient detoxification (VID) is a Medi-Cal fee-for-service (FFS) benefit. VID services are excluded from Health Net's coverage responsibilities and are the responsibility of the Medi-Cal FFS program. Health Net members receiving VID services remain enrolled with Health Net and primary care physicians (PCPs) remain responsible for coordinating ongoing care and services unrelated to VID.

Participating providers must refer members to a VID provider in a general acute care hospital. VID services require authorization. It is the VID provider's responsibility to submit the Treatment Authorization Request (TAR) to the local Medi-Cal field office for approval.

Health Net Medi-Cal members who meet medical necessity criteria may receive VID services in a general acute care hospital. To receive VID services, a member must have one or more of the following:

- Delirium tremens with any combination of the below clinical manifestations with cessation or reduced intake of alcohol or sedative:
  - hallucinations
  - disorientation
  - tachycardia
  - hypertension
  - fever
  - agitation
  - diaphoresis
- A score greater than 15 on the Clinical Institute Withdrawal Assessment of Alcohol Scale, revised (CIWA-Ar) form.
- Alcohol or sedative withdrawal with CIWA score greater than 8 and one or more of the following high risk factors:
  - multiple substance abuse
  - history of delirium tremens
  - unable to receive the necessary medical assessment, monitoring and treatment in a setting with a lower level of care
  - medical comorbidities that make detoxification in an outpatient setting unsafe
  - history of failed outpatient treatment
  - psychiatric comorbidities
  - pregnancy
  - history of seizure disorder or withdrawal seizures
- Complication of opioid withdrawal that cannot be adequately managed in the outpatient setting due to the following:
  - persistent vomiting and diarrhea from opioid withdrawal
  - dehydration and electrolyte imbalance that cannot be managed in a setting with a lower level of care

California Children's Services

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

The California Children's Services (CCS) program provides specialized medical care, rehabilitation services, and case management to children with medical or surgical conditions who meet program eligibility requirements. CCS services are delivered by paneled providers and approved tertiary medical centers in local communities who meet CCS program requirements.

CCS services are carved-out under the Medi-Cal managed care program, but the member remains enrolled with Health Net or its subcontracting health plans for the purpose of receiving primary care and services unrelated to the CCS condition. The responsibility for paying for treatment services for the CCS-eligible condition of the child enrolled in managed care rests with the CCS program rather than the health plan.

It is essential that physicians identify children with CCS-eligible conditions and arrange for their timely referral to the county CCS program. The primary care physician (PCP) provides a complete baseline health assessment and diagnostic evaluations sufficient to ascertain evidence or suspicion of a CCS-eligible condition. The PCP remains responsible for the complete health care of the member until CCS program eligibility is determined.

Once CCS eligibility has been established, the CCS program assumes case management responsibilities, including prior authorization of, and payment for, all services related to the CCS-eligible condition. The PCP remains responsible for providing primary care services to the member, including coordination with CCS and specialists to ensure continuity of care.

CCS does not pay for services provided before the date of referral, even though the child may have a CCS-eligible condition, except for children with full-scope Medi-Cal and emergency services or services rendered after hours. For Medi-Cal retroactive payment, services must have been provided by a CCS-paneled provider in a CCS-approved facility. Referrals for emergency or after-hours care must be made to the county CCS program on the next business day and must include documentation substantiating necessity for emergency or urgent care.

For more information, select any subject below:

Billing Inpatient Services for Members with CCS-Eligible Conditions

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

Inpatient services at private hospitals and non-designated public hospitals for Medi-Cal members who have California Children's Services (CCS)-eligible conditions are reimbursed using diagnosis-related group (DRG) methodology, which reimburses hospitals for the member's entire stay, with payments based on acuity and not length of stay.

Inpatient services at designated public hospitals (DPHs) are reimbursed based on the applicable DPH Medi-Cal inpatient interim per diem rate.

Billing policies

1. For days of service during an inpatient hospital stay, the following benefits apply for services provided to Plan Medi-Cal members with a CCS-eligible condition: If the member is admitted to the hospital for a CCS-eligible condition, the entire stay will require a CCS SAR from the date of admission and is to be billed by the hospital to Medi-Cal Fee For Service (FFS), regardless of whether any services provided during that stay are Medi-Cal covered services. NOTE: The hospital will receive one payment for the entire stay based on Medi-Cal's FFS DRG for that stay. Hospitals are disallowed from billing the Plan (APL16-008).
2. If the member is admitted to the hospital for a non-CCS-eligible condition, and subsequently receives services during the stay for a CCS-eligible condition, the entire stay will require a CCS SAR from the date of admission and is to be billed to Medi-Cal FFS. The full stay is to be billed to Medi-Cal FFS. NOTE: DHCS advises that a SAR will be authorized back to the day of admission. The hospital will receive one payment for the entire stay based on the Medi-Cal FFS DRG for that stay. Hospitals are disallowed from billing the Plan (APL 16-008).
3. When a member's stay includes delivery and well-baby coverage, the entire claim is the responsibility of the Plan. If, during the stay, a CCS-eligible condition is identified, the entire stay for the baby will require a CCS SAR from the date of admission and is to be billed to Medi-Cal FFS. The Plan is not to be billed for the baby's CCS-eligible condition stay. In this case, the hospital will receive two payments: one (1) for the delivery and well-baby stay from the Plan, and one (1) for the baby under the Medi-Cal FFS DRG.

CCS Application and Service Agreement Forms

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

A signed Application to Determine CCS Program Eligibility (PDF) on file with the California Children's Services (CCS) program provides a legal right to appeal if services are denied by the CCS program.

CCS and Health Net strongly recommend that the CCS application and service agreement be completed to ensure that the member receives CCS program benefits. If the application is on file with CCS, the member may continue to receive services through CCS even if the member loses plan eligibility.

CCS Eligibility Determination

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

On referral, the California Children's Services (CCS) program determines whether there is an eligible condition, whether the family is financially eligible, and whether the child is a resident of the county in which the member has applied for services. If eligibility for the program is established, the client, parent or legal guardian signs a CCS program agreement.

Financial eligibility requirements are assumed to be satisfied for Health Net's Medi-Cal members.

CCS Service Authorization Request (SAR)

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

California Children's Services (CCS) sends an authorization to the CCS-paneled provider indicating that the provider may deliver the services approved for treatment of the CCS-eligible condition. The provider is reimbursed at a fee-for-service (FFS) rate. A separate service authorization request (SAR) (PDF) must be obtained by the hospital and provider for each hospitalization.

CCS Program Agreement

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

The California Children's Services (CCS) program agreement is a consent form that indicates the family's willingness to abide by CCS program policies and procedures and offers recipients the full range of CCS program benefits.

CCS Program Eligibility

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

The California Children's Services (CCS) program is open to a member who:

- Are under age 21.
- Have a physical limitation or disease that is covered by CCS.
- Are residents of California and apply in the county of residence.

- Have a family income of either:
  - Less than $40,000 reported as adjusted gross income on the state tax form.
  - More than $40,000 reported as adjusted gross income on the state tax form, but out-of-pocket costs of care for the CCS-eligible condition are expected to exceed 20 percent of the family's adjusted gross income.

Problem Resolution

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

County California Children's Services (CCS) program staff determine medical eligibility, limit authorization to CCS-paneled providers, review proposed treatment plans to determine necessity, and authorize services. Problems that arise involving the CCS program, Health Net, the participating physician group (PPG), and the primary care physician (PCP) are resolved by Health Net's public programs administrators. During any problem periods, the Health Net Health Services staff and the PCP or specialty physician continue to coordinate the medical care of the member.

The Health Net public programs administrators produce monthly CCS Reconciliation Reports to assist in tracking CCS referrals and active cases for coordination. They also meet routinely with CCS liaisons to identify and resolve areas of procedural concern on a local level and exchange client and provider listings and program and policy updates. The public programs administrators also collaborate with the local CCS programs to provide educational opportunities to participating providers.

Program Components

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

Diagnosis and Treatment Program

The Diagnosis and Treatment Program provides medically necessary care and case management for infants, children and adolescents meeting program eligibility requirements. This care is delivered by California Children's Services (CCS)-paneled providers who meet program standards in tertiary care medical centers and in local communities.

High-Risk Infant Follow-Up Program

The High-Risk Infant Follow-up (HRIF) program provides outpatient services to infants who meet the CCS medical eligibility criteria for CCS-approved neonatal intensive care unit (NICU), or had a CCS-eligible medical condition during their stay in a CCS approved NICU, even if they were never CCS clients during their NICU stay. These services include comprehensive history and physical examination, including neurological and

developmental assessment, ophthalmological and audiological evaluations, and family psychosocial and home assessment, including coordination of HRIF services during the first three years of life.

HIV Children's Screening Program

The Department of Health Care Services (DHCS) Office of AIDS provides funding for the California Children's Services (CCS) HIV Children's Screening Program. CCS issues authorization to a CCS-approved Infectious Disease Immunology Disease Special Care Center (IDID SCC) for outpatient diagnostic services for infants and children under age of 21 who are at risk for HIV infection. Authorizations for diagnostic services are not to exceed six months.

Medical Therapy Program

Local California Children's Services (CCS) programs deliver Medical Therapy Program (MTP) services to children with cerebral palsy and other neuromuscular conditions. MTP provides medically necessary physical therapy (PT), occupational therapy (OT) and medical therapy conference (MTC) services to children who are medically eligible for the program. A medical therapy unit (MTU) team performs examinations and prescribes PT, OT, durable medical equipment (DME), and any other necessary medical interventions required to treat the child's CCS-eligible diagnosis. MTUs are located at select public schools as part of an interagency agreement with the California Department of Education.

Newborn and Infant Hearing Screening Program

The Newborn and Infant Hearing Screening Program offers hearing screening to all infants delivered in California Children's Services (CCS)-approved hospitals and CCS-approved neonatal intensive care units (NICUs) prior to the infant's discharge. Infants identified through the Newborn and Infant Hearing Screening Program who need diagnostic or treatment services are referred for health care and support services. Infants eligible for the CCS program are referred to CCS-approved Communication Disorder Centers for audiological services.

Orthodontic Screening Program

Orthodontic services are a benefit of the California Children's Services (CCS) program for children with severe malocclusion if evaluated by CCS-paneled orthodontists and determined to be medically eligible for orthodontic services as defined by CCS.

Referral to CCS

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

The California Children's Services (CCS) program accepts referrals for eligibility determination from any source (for example, specialist, teacher or parents). Providers may use the California Children's Services Referral form (PDF). Completed forms may be submitted via mail or fax to CCS. Los Angeles (LA) county also requires the LA County CCS Fax Cover Sheet (PDF) when submitting a CCS referral.

A new referral may be sent on a CCS-GHPP SAR (PDF) form or in a letter including all of the following information:

- Member's name.
- Member's date of birth.
- Name, address and phone number of the parent or legal guardian.
- Medical condition.
- Description of services/procedures being requested.
- Name of CCS-paneled provider and phone number.
- Name, address and phone number of the referral source.

Primary care physicians (PCPs), specialists and participating physicians group (PPG) staff must refer potentially eligible children to CCS within 24 hours of identification and inform the parent or legal guardian. Hospitals must refer potentially eligible children to CCS within 24 hours of inpatient admission and inform the parent or legal guardian of the referral to the CCS program.

Referrals to CCS must include:

- Completed CCS SAR form or letter with required information.
- Medical history with sufficient medical information to ascertain the evidence or suspicion of a CCS-eligible condition.
- Recent medical records pertaining to eligible diagnosis or condition.
- Description of services being requested.
- Name of CCS-paneled provider who will perform the requested services (if known).
- Name and phone number of the referral source.
- Completed CCS Application for Service form (if available at the physician's office at the time of referral).

Providers referring a member that has an existing case with CCS should make a new referral using the Established CCS-GHPP Client SAR (PDF). If the member has a closed case, providers should make a new referral using the New Referral CCS/GHPP Client Service Authorization Request (SAR) (ca.gov)

The following are examples of the type of medical documentation that should be included with the CCS referral for some various diagnoses:

- Cerebral palsy - Detailed medical reports documenting the findings from a complete physical and neurological exam.
- HIV infection - Laboratory test results.
- Lead poisoning - Documentation confirming a blood level of 20 micrograms per deciliter or above.
- Scoliosis - X-ray reports showing a curvature of the spine greater than 20 degrees.

On receipt of a referral, the county CCS program sends a CCS program application and service agreement to the family.

Request for Services

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

The California Children's Services (CCS) program reviews the request for services and determines medical necessity. All services, except emergency and after-hour services, require prior authorization (PDF). If treatment for the CCS-eligible condition or for an associated complication is found to be medically necessary, the CCS program issues an authorization.

Tracking and Coordination of Care

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

Participating providers are required to develop a procedure for tracking California Children's Services (CCS) program referrals and submit a monthly report to the Health Net Delegation Oversight Department. Health Net is available to work with participating providers and care managers to facilitate referrals to CCS and continuity of care as needed.

CCS Eligible Conditions

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

Medical conditions referred to California Children's Services (CCS) are subject to review under the CCS Medical Eligibility Regulations, CCR Title 22, Sections 41800-41872. The categorical summaries of eligible conditions in these materials are merely guides for participating providers to use in identifying potential CCS-eligible conditions.

Accidents, Poisonings, Violence, and Immunization Reactions

California Children's Services (CCS) applicants with at least one of the following conditions are medically eligible for participation in the CCS program:

- Injuries to organ systems or organs that, if left untreated, are likely to result in permanent physical disability, permanent loss of function, severe disfigurement, or death.
- Fractures of the spine, pelvis or femur.
- Skull fractures that, if left untreated, would result in central nervous system complications or severe disfigurement.

- All other fractures that require open reduction or internal fixation or that involve the joints or growth plates.
- Burns, when at least one of the following is present:
  - Second- and third-degree burns to more than 10 percent of the body surface area in children younger than age 10.
  - Second- and third-degree burns to more than 20 percent of the body surface area in children older than age 10.
  - Third-degree burns to more than five percent of the body surface area for any age group.
  - Burns involving signs or symptoms of inhalation injury or causing respiratory distress
  - Second- or third-degree burns to the face, ear, mouth and throat, genitalia, perineum, major joints, hands, or feet.
  - Electrical injury or burns, including burns caused by lightning.
- Presence of a foreign body when the object, if not surgically removed, would result in death or a permanent limitation or compromise of a body function.
- Ingestion of drugs or poisons that result in life-threatening events and require inpatient hospital treatment.
- Lead poisoning, defined as a confirmed blood level of 20 micrograms per deciliter or above.
- Poisonous snake bites that require complex medical management and that may result in severe disfigurement, permanent disability or death.
- Other envenomation, such spider bites, that require complex medical management and that may result in severe disfigurement, permanent disability or death.
- Severe adverse reactions to an immunization requiring extensive medical care.

Congenital Anomalies

California Children's Services (CCS) applicants with congenital anomalies are medically eligible for participation in the CCS program when the congenital anomaly is amenable to cure, correction or amelioration and one of the following:

- Anomaly limits or compromises a body function based on a combination of factors, such as its size, type and location.
- Anomaly is severely disfiguring.

The following conditions are not medically eligible for the CCS program when the application for eligibility is based solely on their presence:

- Inguinal and umbilical hernia.
- Hydrocele.
- Unilateral undescended testicle.

Diseases of Blood and Blood-Forming Organs

California Children's Services (CCS) applicants with at least one of the following conditions are medically eligible for participation in the CCS program:

- Anemias due to abnormal production of red cells or hemoglobin.
- Anemias resulting solely from a nutritional deficiency, such as inadequate intake of iron, folic acid or Vitamin B-12 are eligible only when they present life-threatening complications.

- Hemolytic anemia, such as congenital spherocytosis, sickle cell disease, thalassemia, and erythroblastosis fetalis.
- Hemolytic anemias resulting from infection are eligible only when they present with life-threatening complications.
- Pancytopenia, such as congenital and acquired aplastic anemia.
- Disorders of leukocytes, such as acquired and congenital neutropenia and chronic granulomatous disease.
- Hemorrhagic diseases due to:
  - Coagulation disorders, such as hemophilia and von Willebrand disease.
  - Disorders of platelets that are life-threatening.
- Other disorders of blood and blood-forming organs that are life-threatening, such as polycythemia, hypersplenism and hypercoagulable states.

Diseases of the Circulatory System

California Children's Services (CCS) applicants with at least one of the following conditions are medically eligible for participation in the CCS program:

- Diseases of the endocardium, myocardium or pericardium.
- Cardiac dysrhythmias requiring medical or surgical intervention.
- Diseases of blood vessels, such as embolism, thrombosis, aneurysms, and periarteritis.
- Cerebral and subarachnoid hemorrhage.
- Chronic diseases of the lymphatic system.
- Primary hypertension that requires medication to control.
- Congenital anomalies of the circulatory system that meet the criteria of Congenital Anomalies.

Diseases of the Digestive System

California Children's Services (CCS) applicants with at least one of the following conditions are medically eligible for participation in the CCS program:

- Diseases of the liver, including:
  - Acute liver failure.
  - Chronic liver disease.
- Disorders of the gastrointestinal tract, including:
  - Chronic inflammatory diseases requiring complex ongoing medical management or surgical intervention, such as pancreatitis, peptic ulcer, ulcerative colitis, regional enteritis, diverticulitis, and cholecystitis.
  - Chronic intestinal failure.
- Gastroesophageal reflux when:
  - It is part of or complicates the management of a CCS-eligible condition.
  - It is an isolated condition with complications such as esophageal stricture or chronic aspiration pneumonia.
- Congenital anomalies of the digestive system that meet the criteria under Congenital Anomalies.

Diseases of the Ear and Mastoid Process

California Children's Services (CCS) applicants are eligible for participation in the CCS program for diagnostic services to determine the presence of a hearing loss when one of the following occurs:

- The applicant fails two pure tone audiometric hearing screening tests performed at least six weeks apart at levels not to exceed 25 decibels and at the minimum number of frequencies of 1,000, 2,000 and 4,000 hertz.
    - If this test is performed by an audiologist or otolaryngologist, only one exam is required for eligibility for diagnostic testing.
- The applicant fails to have normal auditory brain stem-evoked response.
- The applicant fails to have otoacoustic emission or behavioral responses to auditory stimuli as determined by two tests performed at least six weeks apart.
    - If this test is performed by an audiologist or otolaryngologist, only one exam is required for eligibility for diagnostic testing.
- The applicant fails to pass hearing screening provided through the Newborn and Infant Hearing Screening, Tracking and Intervention Program.
- The applicant exhibits symptoms that may indicate a hearing loss, such as poor speech for age or delay in age-specific behavioral milestones.
- The applicant has documentation of one of the risk factors associated with a sensorineural hearing or conductive hearing loss, such as:
    - A family history of congenital or childhood onset of hearing impairment.
    - Congenital infection known or suspected to be associated with hearing loss.
    - Craniofacial anomalies.
    - Hyperbilirubinemia at a level exceeding the indication for an exchange transfusion.
    - Ototoxic medications used for more than five days.
    - Bacterial meningitis.
- The applicant has severe depression at birth, defined as one of the following:
    - Apgar score of three or less.
    - Failure to initiate spontaneous respirations by ten minutes of age.
    - Hypotonia persisting to two hours of age.
- The applicant fails prolonged mechanical ventilation for the duration of at least 10 days.
- There is a finding of a syndrome known to be associated with hearing loss.

CCS applicants are eligible for participating in the CCS program for treatment services when one of the following is present:

- There is a hearing loss present, as defined by the following criteria:
    - Children over age five, a pure tone audiometric loss of 30 decibels or greater at two or more frequencies in the same ear tested at 500,1,000, 2,000, 3,000, 4,000, 6,000, and 8,000 hertz or a loss of 40 decibels or greater at any one frequency between and including 500 through 8,000 hertz.
    - Children ages three to five, a pure tone audiometric loss of 30 decibels or greater at any frequency tested at 500, 1,000, 2,000, 3,000, 4,000, 6,000, and 8,000 hertz.
    - In children unable to complete a pure tone audiometric test and whose auditory brain stem evoked response, or otoacoustic emission, or behavioral responses to auditory stimuli indicate hearing loss of 30 decibels or greater.
- Perforation of the tympanic membrane that requires tympanoplasty.
- Mastoiditis.
- Cholesteatoma.
- Congenital infection known or suspected to be associated with hearing loss.
- Craniofacial anomalies.

- Congenital anomalies of the ear and mastoid process that meet the criteria for Congenital Anomalies.

Diseases of the Eye

California Children's Services (CCS) applicants with at least one of the following eye conditions are medically eligible for participation in the CCS program:

- Strabismus, when surgery is required, and either until fusion is obtained or a visibly abnormal deformity is corrected.
- Infections that produce permanent visual impairment or blindness, such as keratitis and choroditis.
- Infections that require repeated ophthalmological treatment or surgery, such as chronic dacryocystitis.
- Other diseases that can lead to permanent visual impairment, such as:
  - Cataract.
  - Glaucoma.
  - Retinal detachment.
  - Optic atrophy or hypoplasia.
  - Optic neuritis.
  - Lens dislocation.
  - Retinopathy of prematurity.
  - Persistent hyperplastic primary vitreous.
  - Ptosis.
- Congenital anomalies of the eye that meet the criteria under Congenital Anomalies.

Diseases of the Genitourinary System

California Children's Services (CCS) applicants with at least one of the following conditions are medically eligible for participation in the CCS program:

- Acute glomerulonephritis in the presence of acute renal failure, malignant hypertension or congestive heart failure.
- Chronic glomerulonephritis, chronic nephrosis or chronic nephrotic syndrome.
- Chronic renal insufficiency.
- Obstructive uropathies.
- Vesicoureteral reflux, grade II or higher.
- Renal calculus.
- Congenital anomalies of the genitourinary tract that meet the criteria under Congenital Anomalies.

Diseases of the Musculoskeletal System and Connective Tissue

California Children's Services (CCS) applicants with at least one of the following conditions are medically eligible for participation in the CCS program:

- Acute and chronic suppurative infections of the joint.
- Chronic, progressive or recurrent inflammatory disease of the connective tissue or joints, such as rheumatoid arthritis, inflammatory polyarthropathy, lupus erythematosus, dermatomyositis, and scleroderma.
- Chronic, progressive or degenerative diseases of the muscles and fascia, such as myasthenias, myotonias, dystrophies, and atrophies that lead to atrophy, weakness, contracture and deformity, and motor disability.
- Intervertebral disc herniation.
- Scoliosis with a curvature of 20 degrees or greater.
- Other diseases of the bones and joints, except fractures, resulting in limitation of normal function and requiring surgery, complex customized bracing, or more than two castings.
- Congenital anomalies of the musculoskeletal system or connective tissue that meet the criteria under Congenital Anomalies.

Minor orthopedic conditions, such as tibial torsion, femoral anteversion, knock knees, pigeon toes, and flat feet that only require special shoes, splints or simple bracing, are not eligible.

Diseases of the Nervous System

California Children's Services (CCS) applicants with at least one of the following conditions are medically eligible for participation in the CCS program:

- Noninfectious diseases of the central and peripheral nervous system that produce a neurological impairment that is life threatening or disabling.
- Cerebral palsy, a non-progressive motor disorder with onset in early childhood resulting from a non-progressive lesion in the brain manifested by the presence of one or more of the following:
    - Rigidity or spasticity.
    - Hypotonia, with normal or increased deep tendon reflexes, and exaggeration of or persistence of primitive reflexes beyond the normal range.
    - Involuntary movements that are described as athetoid, choreoid or dystonic.
    - Ataxia, manifested incoordination of voluntary movement, dysdiadochokinesia, intention tremor, reeling or shaking of trunk and head, staggering or stumbling, and broad-based gait.
- Seizure disorder when either of the following occurs:
    - It is secondary to a CCS-eligible condition.
    - It is of unknown origin and one of the following exists:
        - The frequency or duration of the seizures requires more than four changes in dosage or type of medications in the 12 months preceding the initial or subsequent determination of medical eligibility.
        - The frequency or duration of the seizures requires three or more types of seizure medications each day.
        - The frequency or duration of the seizures requires at least monthly medical office visits for assessment of the applicant's clinical status and periodic blood tests for medication levels or presence of blood dyscrasia.
        - The applicant has an episode of status epilepticus, in which case medical eligibility extends for one year following that event.
- Congenital anomalies of the nervous system that meet the criteria under Congenital Anomalies.

When the eligibility criteria listed above have not been present for at least one year, eligibility ceases.

Diseases of the Respiratory System

California Children's Services (CCS) applicants with at least one of the chronic conditions of the respiratory tract, such as the following conditions, are eligible for participation in the CCS program:

- Chronic pulmonary infections, such as abscess or bronchiectasis.
- Cystic fibrosis.
- Chronic lung disease (CLD) of infancy, such as bronchopulmonary dysplasia (BPD), when one or more of the following criteria are met:
    - History of care in a neonatal intensive care unit that includes all of the following:
        - Mechanical ventilation for more than six days.
        - Concentration of oxygen greater than 60 percent for more than four of the days of ventilation.
        - Need for supplemental oxygen for more than 30 days.
    - Presence of at least one of the following in an infant:
        - Radiographic changes characteristic of CLD, such as hyperinflation, areas of radiolucency, and areas of radio density due to peribronchial thickening or patchy atelectasis.
        - Impaired pulmonary function, as manifested by one or more of the following during a stable phase: increased airway resistance, increased residual capacity, decreased dynamic compliance, arterial CO
        - Cardiovascular sequelae, such as pulmonary or systemic hypertension or right or left ventricular hypertrophy.
- Asthma, when it has produced CLD.
- Chronic disorders of the lung that are the result of chemical injury, metabolic disorders, genetic defects, or immunologic disorders other than asthma.
- Respiratory failure requiring ventilatory assistance.
- Hyaline membrane disease.
- Congenital anomalies of the respiratory system that meets the criteria under Congenital Anomalies.

Diseases of the Skin and Subcutaneous Tissues

California Children's Services (CCS) applicants with at least one of the following conditions are medically eligible for participation in the CCS program:

- Persistent or progressive diseases of the skin or subcutaneous tissue, such as pemphigus and epidermolysis bullosa, which:
    - Are disabling or life-threatening.
    - Require multidisciplinary management.
- Scars when surgery is required and at least one of the following criteria is met:
    - There is limitation of or loss of mobility of a major joint, such as the ankle, knee, hip, wrist, elbow, or shoulder.
    - They are disabling or severely disfiguring.
- Congenital anomalies of the skin or subcutaneous tissue that meet the criteria under Congenital Anomalies.

Endocrine, Nutritional, and Metabolic Diseases and Immune Disorders

California Children's Services (CCS) applicants with at least one of the following conditions are medically eligible for participation in the CCS program:

- Diseases of the pituitary, thyroid, parathyroid, thymus, and adrenal glands.
- Growth hormone deficiency (eligible without qualifiers).
- Diseases of the ovaries or testicles in which there is delayed onset of puberty, primary amenorrhea after the age of 15, sexual development prior to the age of eight, feminization of a male, or virilization of a female.
- Diseases of the pancreas resulting in pancreatic dysfunction.
- Diabetes mellitus (eligible without qualifiers).
- Diseases due to congenital or acquired immunologic deficiency manifested by life-threatening infections, as determined from medical information about the applicant's clinical course and laboratory studies.
- Inborn errors of metabolism, such as phenylketonuria, homocystinuria, galactosemia, glycogen storage disease, and maple syrup urine disease.
- Cystic fibrosis.

Infectious Diseases

California Children's Services (CCS) applicants diagnosed with at least one of the following are medically eligible for participation in the CCS program:

- Infections of the bone, such as osteomyelitis and periostitis.
- Infections of the eye when the infection, if left untreated, may result in permanent visual impairment or blindness.
- Infections of the central nervous system producing a neurological impairment that results in physical disability requiring surgery or rehabilitation services to regain or improve function, such as movement or speech, which was limited or lost as a result of the infection.
- Infections acquired in utero and for which medically necessary postnatal treatment is required, such as toxoplasmosis, cytomegalovirus infection, rubella, herpes simplex, and syphilis.
- HIV, when confirmed by laboratory tests.

Medical Eligibility for Care in a NICU

The following criteria are used to determine California Children's Services (CCS) medical eligibility for admission into a CCS-approved neonatal intensive care unit (NICU).

An infant is medically eligible for care in a CCS-approved NICU when one of the following conditions are met:

- There is the presence of a CCS-eligible medical condition.
- One of the following services is required (medical eligibility continues only for the duration needed to deliver the service):

- Positive pressure ventilatory assistance that is invasive or non-invasive; the latter includes, but is not limited to, continuous positive airway pressure (CPAP) by nasal prongs, nasal cannula or face mask.
- Supplemental oxygen concentration by hood of greater than or equal to 40 percent.
- Maintenance of an umbilical arterial catheter or peripheral arterial catheter for medically necessary indications including, but not limited to, monitoring blood pressure, sampling of blood for monitoring blood gases, and exchange transfusions.
- Maintenance of an umbilical venous catheter or other central venous catheter for medically necessary indications including, but not limited to, pressure monitoring, cardiovascular drug infusions, hypertonic solutions, and exchange transfusions.
- Maintenance of a peripheral line for intravenous pharmacologic support of the cardiovascular system.
- Central or peripheral hyperalimentation.
- Chest tube.

- Two of the following services are required (medical eligibility continues only for the duration needed to deliver the services):
  - Supplemental inspired oxygen.
  - Maintenance of a peripheral intravenous line for administration of fluids, blood, blood products, or medications other than those agents used in support of the cardiovascular system.
  - Pharmacologic treatment for apnea or bradycardia episodes.
  - Tube feedings.

Medical eligibility for CCS ceases when the infant does not have a CCS-eligible condition or no longer meets the criteria defined above.

Medical Therapy Program

There are two separate groups of children served in the California Children's Services (CCS) Medical Therapy Program.

CCS applicants with one of the following conditions are medically eligible for participation in the Medical Therapy Program:

- Cerebral palsy as specified in Diseases of the Nervous System section above.
- Neuromuscular conditions that produce muscle weakness and atrophy, such as poliomyelitus, myasthenias and muscular dystrophies.
- Chronic musculoskeletal and connective tissue diseases or deformities, such as osteogenesis imperfecta, arthrogryposis, rheumatoid arthritis, amputations, and contractures resulting from burns.
- Other conditions manifesting the findings listed in Diseases of the Nervous System, such as ataxias, degenerative neurological disease or other intracranial processes.

CCS applicants under age three are eligible when two or more of the following neurological findings are present:

- Exaggerations of or persistence of primitive reflexes beyond the normal age (corrected for prematurity).
- Increased deep tendon reflexes that are 3+ or greater.

- Abnormal posturing as characterized by the arms, legs, head, or trunk turned or twisted into abnormal position.
- Hypotonicity, with normal or increased deep tendon reflexes, in infants under one year of age (infants one year of age or older must meet criteria described in Diseases of the Nervous System).
- Asymmetry of neurological motor findings of trunk or extremities.

Mental Disorders and Mental Retardation

California Children's Services (CCS) applicants with a mental disorder, whose application is based on that disorder, are not medically eligible for the CCS program. CCS applicants with mental retardation, whose application is based on that condition, are not medically eligible for the CCS program.

CCS applicants with a mental disorder or mental retardation may be eligible only when the mental disorder is associated with or complicates an existing CCS-eligible condition.

Neoplasms

California Children's Services (CCS) applicants with at least one of the following conditions are medically eligible for participation in the CCS program:

- All malignant neoplasms, including leukemia.
- A benign neoplasm when either of the following is present:
  - The neoplasm is physically disabling or severely disfiguring.
  - The neoplasm is located contiguous to or within a vital organ or body part, and its continued growth or lack of treatment would limit or eliminate the function of the organ or body part or lead to the death of the applicant.

DDS-Administered Home and Community Based Services (HCBS) Waiver

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

The primary goal of the Department of Developmental Services' (DDS)-administered Home and Community Based Services (HCBS) Waiver Program is to ensure consumer choice of waiver services and consumer satisfaction, and to provide safeguards necessary to ensure the health and safety of each consumer in the program. The DDS administered HCBS waiver program includes an array of services designed to support those with developmental disabilities in either a home or community-based setting as an alternative to care in a care facility for the developmentally disabled.

The DDS-administered HCBS waiver program is available to developmentally disabled persons regardless of their age. A developmental disability is defined as a disability that originates before an individual attains the age of 18, continues, or can be expected to continue indefinitely, and constitutes a substantial disability for that individual.

As of January 1, 2024, the Plan provides all Medically Necessary Covered Services for members residing in or obtaining care in an ICF/DD Home, including home services, professional services, ancillary services, and transportation services. The Plan ensures members in need of ICF/DD Home services, as determined through the IPP and Regional Center authorization, are authorized using the Certification for Special Treatment Program Services form HS 231. The Plan must receive a copy of the Certification for Special Treatment Program Services form HS 231 as a prerequisite to providing coverage of ICF/DD Home services.

Coordination of HCBS Services

Once Health Net determines a member may meet the requirements for participation in the Department of Development Services (DDS)-administered Home and Community-Based Services (HCBS) waiver program, Health Net initiates a referral. A regional center service coordinator is assigned to coordinate the waiver services. Receipt of DDS-administered HCBS services do not require a member to be disenrolled from the plan. The primary care physician (PCP) continues to provide all medically necessary covered services and coordinates the member's care. Health Net is responsible for coordinating with the regional center care manager and the PCP in the development of the member's individual service plan and individual education plan.

If the member is currently receiving services through the DDS program, Health Net coordinates services with the PCP and regional center service coordinator as needed.

If the member does not meet the criteria for the waiver program or if placement is unavailable, Health Net's PCP continues to manage the care and provide all covered medically necessary services to the member.

DDS-Administered HCBS Waiver Programs

The Department of Developmental Services (DDS) has administrative responsibility for the state's five developmental centers and 21 regional centers. DDS oversees the regional centers and administers the Home and Community Based Services (HCBS) waiver program. The DDS-administered HCBS waiver program provides specialized services in the member’s family home.

The regional center service coordinator is responsible for determining the DDS administered HCBS waiver setting that is best for the eligible developmental disabled member. Although the regional centers provide overall care management, they are not responsible for direct medical services. During the member's participation in the DDS-administered HCBS waiver program, a Health Net participating primary care physician (PCP) continues to provide all primary care and other medically necessary services.

Eligibility

To be eligible for Regional Center services, an individual must have a developmental disability that originates before 18 years of age, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. As defined by the director of DDS, in consultation with the Superintendent of Public Instruction, this term includes intellectual disability, cerebral palsy, epilepsy, and autism. This term also includes disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability but shall not include other handicapping conditions that are solely physical in nature.

Problem Resolution

Regional center staff determines eligibility and are responsible for overall care management. Problems that arise between the regional center and Health Net or the primary care physician (PCP) are resolved by Health Net's public programs administrators. Health Net's care manager continues to coordinate and authorize all immediate health care needs for the member in collaboration with the PCP or specialty provider until the matter is resolved.

Referrals to HCBS

Health Net coordinates referrals to the regional center when notified of a member with a potential need for supportive care and facilitates medical records from the member's primary care physician (PCP) for the Department of Developmental Services (DDS) administered Home and Community-Based Services (HCBS) waiver program.

Regional centers are nonprofit private corporations that contract with DDS to provide or coordinate the services and supports for individuals with developmental disabilities. They have offices throughout California to provide local resources to help find and access the many services available to these individuals and their families.

Early Start Program

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

California's Department of Developmental Services' (DDS) Early Start program provides early intervention services to infants and toddlers (from birth to 36 months) who have a developmental delay in one or more of the following areas: cognitive, physical and motor development, including vision and hearing; communication, social or emotional development or adaptive development; and those who are determined to have a significant difference between the expected level of development for their age and their current level of functioning. Health Net identifies children under age of three who may be eligible to receive services from the DDS Early Start program and refers them accordingly.

Coordination of Care

Health Net assists primary care physicians (PCPs) and families with referrals of identified children under age three who may be eligible to receive services from the Department of Developmental Services (DDS) Early Start program. Assistance may include contacting the local Regional Center administrative staff or the local Early Start Program by telephone or letter, or following up with the family, PCP or regional center to ensure the referral is complete and services are accessed.

Once the referral has been made, the PCP:

- Provides medically necessary covered diagnostic, preventive and treatment services identified in the individual family plan developed by the Early Start program.

- Consult and provide appropriate reports to the Early Start program intervention team
- Continues case management with assistance from the Health Net Medi-Cal Health Services Department when necessary

Identification of Conditions

Primary care physicians (PCPs) need to identify infants and toddlers (from birth to 36 months) who may benefit from services provided by the Department of Developmental Services (DDS) Early Start program. These children may have the following risk conditions:

- Significant developmental delay in one or more of these areas:
  - Cognitive
  - Physical and motor
  - Communication
  - Emotional and social
  - Adaptive
- Established risk conditions expected to result in developmental delay, including:
  - Chromosomal disorders
  - Inborn errors of metabolism
  - Neurological disorders
  - Visual or hearing impairments
  - Family history of developmental delay

  When determining the need to make a referral to the DDS Early Start program for intervention services, consider:

- Stability of the infant's or toddler's medical condition
- Readiness of the infant and family to benefit from services
- Need for additional assessments to document developmental delay or disability

PCP Responsibilities

Primary care physicians (PCPs) identify infants and toddlers (from birth to 36 months) who are at risk or suspected of having a developmental disability or delay through health screenings and assessments, including:

- Initial comprehensive physical evaluation for congenital abnormalities and/or treatable medical conditions.
- Developmental screening using EPSDT/Medi-Cal for Kids & Teens and/or American Academy of Pediatrics (AAP) standards. PCP also arranges for the provision of medically necessary Behavioral Health Treatment (BHT) services even without a diagnosis of Autism Spectrum Disorder (ASD). Health Net Behavioral Health Services provides the BHT services.
- Diagnosis and, if possible, etiology

PCPs are responsible for referring infants and toddlers identified as needing early intervention services to the local DDS Early Start program (administered by either the local Regional Center, education agency, or other designated agency) within two business days of determination of need. PCPs provide or arrange for all medically necessary covered services, including preventive care, referral for specialty or subspecialty consultation, and therapy services necessary to correct or ameliorate identified conditions.

Eligible infants and toddlers and their families may receive service coordination and developmental services from the local Regional Center or education agency, depending on the condition. PCPs participate or consult with staff of the local Regional Center or local education agency (LEA) in the development of the Individual Family Service Plan (IFSP).

Problem Resolution

If Health Net or a participating provider disagrees with the recommendation of the Early Start program staff, Health Net's public programs administrators are responsible for problem resolution. The Health Net Medi-Cal Health Services Department continues to coordinate and authorize all immediate covered health care needs for the member in collaboration with the primary care physician (PCP) until the matter is resolved.

Public Programs Coordination

Health Net's public programs administrators are available to participate in the community Local Interagency Coordination Areas (LICA). Health Net's public programs administrators work with the Regional Centers to enhance collaboration and coordination.

Referral Coordination with California Children Services

In situations where a child is eligible for both California Children's Services (CCS) and the Department of Developmental Services' (DDS) Early Start program, the primary referral is to CCS if diagnosis or treatment for a CCS-eligible condition is the primary concern. The primary care physician (PCP) must notify CCS and the local Regional Center simultaneously if both medical and DDS Early Start program intervention services are indicated.

Referrals to Early Start Programs

Referrals to the local Department of Developmental Services (DDS) Early Start program are made through the local Regional Centers.

Federal law requires that primary care physicians (PCPs) refer children under age three identified as potentially requiring developmental intervention services for evaluation within two business days of determining the need for services. Health Net may provide either written or telephone referrals to the local Regional Center, education agency, or other locally designated agency.

Providers must provide the following services and information to the DDS Early Start program with each referral:

- Initial physical evaluations
    - A comprehensive physical examination and assessment for congenital abnormalities and treatable medical conditions

- A review of the mother's prenatal and perinatal course to identify biomedical or environmental risks
- Follow-up of newborn screening tests to assure normal values or initiate treatment

- Developmental screening
  - Provide developmental and behavioral assessment using Early and Periodic Screening, Diagnosis, and Treatment (EPSDT/Medi-Cal for Kids & Teens; American Academy of Pediatrics (AAP) standards; or a combination). Detection of hearing or visual sensory deficits or early developmental problems are of significant interest
- Primary preventive and pediatric care, referrals for special consultations, and therapy services
  - Periodic, comprehensive physical examinations
  - Anticipatory parental guidance (for example, health education and injury prevention advice)
  - Immunizations, lead screening and hematocrit
  - Monitoring of nutrition status
- Diagnosis and, if possible, etiology
  - Complete family history, including prenatal course and genetic pedigree
  - Comprehensive medical evaluation to determine underlying causes (including genetic conditions) and any chromosome or metabolic tests performed

EPSDT / Medi-Cal for Kids & Teens Services

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

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/Medi-Cal for Kids & Teens services for Medi-Cal members under age 21 are based upon members' identified health care needs. Diagnostic and treatment services are provided to treat, correct or ameliorate any physical or behavioral conditions by the appropriate provider or organization. The EPSDT/Medi-Cal for Kids & Teens program allows for periodic medically necessary screening and appropriate preventive, mental health, developmental, vision, hearing, dental and specialty services. For Medi-Cal members under age 21, dental screening or assessment must be performed at every periodic assessment. EPSDT/Medi-Cal for Kids & Teens services include case management and targeted case management services designed to assist children in gaining access to necessary medical, social, education and other services, such as pediatric day health center services, cochlear implant and transportation services.

The Health Net Medi-Cal Health Services staff or delegated participating physician group (PPG) coordinates with primary care physicians (PCPs) to identify children under age 21 who would benefit from these services and assists with appointment scheduling. Health Net determines medical necessity of most EPSDT/Medi-Cal for Kids & Teens services according to criteria established by the Department of Health Care Services (DHCS). When EPSDT/Medi-Cal for Kids & Teens services are provided for the California Children's Services (CCS) program, or are specialty mental health services (which are carved-out from Health Net's coverage responsibilities), Health Net does not determine medical necessity.

The Health Net Medi-Cal Health Services staff or delegated PPG ensures that members under age 21 who qualify for EPSDT/Medi-Cal for Kids & Teens services are referred to an EPSDT/Medi-Cal for Kids & Teens services provider or to an entity that provides EPSDT/Medi-Cal for Kids & Teens services. If these referred providers render EPSDT/Medi-Cal for Kids & Teens care management services, the care manager and Health Net medical director or delegated PPG medical director determine medical necessity. If EPSDT/Medi-Cal for

Kids & Teens care management services are not available from these referred providers, the health plan or delegated PPG arranges and pays for EPSDT/Medi-Cal for Kids & Teens services.

According to Department of Health Care Services (DHCS) All Plan Letter(APL) 19-010: Medi-Cal managed care health plans (MCPs) and delegated PPGs are to provide all medically necessary Medi-Cal covered services while EPSDT/Medi-Cal for Kids & Teens program eligibility is pending. The EPSDT/Medi-Cal for Kids & Teens benefit is more robust than the Medi-Cal benefit package required for adults and states may not impose limits on EPSDT/Medi-Cal for Kids & Teens services and must cover services listed in Section 1905(a) of the Social Security Act (SSA) regardless of whether or not they have been approved under a state plan amendment. Health Net or delegated PPG shall determine the medical necessity of EPSDT/Medi-Cal for Kids & Teens services using the criteria established in 42 USC Section 1396d(r) and W & I Code Section 14132(v).

Care Coordination

Health Net's Medi-Cal Health Services staff or delegated participating physician group (PPG) works with Health Net public programs administrators to monitor the appropriate use of local government organizations, including regional centers, that provide Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/Medi-Cal for Kids & Teens services. The Health Net Medi-Cal Health Services staff or delegated PPG coordinates with the member's primary care physician (PCP) to monitor that referrals are made to the proper agencies and programs. Following review and authorization from a Health Net medical director or delegated PPG medical director, Health Net Medi-Cal Health Services staff or the PPG coordinates services with the PCP.

If EPSDT/Medi-Cal for Kids & Teens services are not available through a local government agency or organization, Health Net's Medi-Cal Health Services staff or delegated PPG issues letters of authorization and negotiated claims payment instruction to EPSDT/Medi-Cal for Kids & Teens services providers and continues to provide care coordination services, including assistance in scheduling appointments, arranging non-medical transportation and non-emergency medical transportation to and from medical appointments, and updating the care management plan. Health Net must ensure that appropriate EPSDT/Medi-Cal for Kids & Teens services are initiated in a timely manner, as soon as possible but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for a follow-up. California Children's Services is (CCS) is excluded from covered services.

Documentation

The member's medical record must reflect the following for Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/Medi-Cal for Kids & Teens care management services:

- Member and family education regarding EPSDT/Medi-Cal for Kids & Teens services
- Referral to EPSDT/Medi-Cal for Kids & Teens care management services
- Reason for referral
- Member or family response to referral
- Subsequent case management plan

Problem Resolution

Health Net's public programs administrators resolve disputes that arise regarding responsibility for necessary Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/Medi-Cal for Kids & Teens services. The

Health Net Medi-Cal Health Services staff or delegated PPG continues to coordinate and authorize all immediate health care needs in collaboration with the primary care physician (PCP) until the matter is resolved.

Referrals

Los Angeles County

In most cases, primary care physicians (PCPs) identify members in need of Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/Medi-Cal for Kids & Teens services as part of regular health screening visits. It is also possible that the need for services is identified by the member, the member's parents or other family, or by an encounter with another health professional. Providers must direct all referrals for EPSDT/Medi-Cal for Kids & Teens services to the Health Net Medi-Cal Health Services staff or delegated PPG, and the affiliated health plans' utilization management (UM) departments for prior authorization.

The Health Net Medi-Cal Health Services staff and Health Net Medi-Cal medical directors or delegated PPG medical directors review the request and determine medical necessity for EPSDT/Medi-Cal for Kids & Teens supplemental services.

All Other Counties

In most cases, primary care physicians (PCPs) identify members in need of Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/Medi-Cal for Kids & Teens services as part of regular health screening visits. The need for services may also be identified by the member, the member's parents or other family, or by an encounter with another health care provider. Providers must direct all referrals for EPSDT/Medi-Cal for Kids & Teens services to the Health Net Medi-Cal Health Services staff or delegated PPG.

The Health Net Medi-Cal Health Services staff and Health Net's Medi-Cal medical directors or delegated PPG medical directors review requests and determine medical necessity for EPSDT/Medi-Cal for Kids & Teens services.

Referral Coordination

PCPs and delegated PPGs are responsible for referring EPSDT/Medi-Cal for Kids & Teens-eligible members identified as needing behavioral health therapy (BHT) services, regardless of diagnosis to Health Net Behavioral Health Services for assessment and referral to a mental health provider. Health Net Behavioral Health Services and delegated PPGs coordinate the management of behavioral health benefits of Medi-Cal members. BHT services may include, but are not limited to:

- Applied behavioral analysis.
- Individual or family training.
- Client/parent support behavioral intervention training.
- Adaptive skills trainer by a qualified BHT provider.

Private Duty Nursing Case Management Requirements

The following describes the health plan's responsibilities related to case management/care coordination services for private duty nursing (PDN) services that have been approved for Medi-Cal members under age 21 pursuant to the EPSDT benefit. The health plan, with assistance from participating provider groups (PPGs) delegated to provide utilization management for such members, is responsible for case management requirements.

Prior authorization

PDN services are nursing services provided in a member's home by a registered nurse (RN) or licensed vocational nurse (LVN) for a member who requires more individual and continuous care than what would be available from a visiting nurse.[1]

Submit prior authorization requests for PDN services as indicated:

Providers participating through PPGs

Providers participating through a PPG must contact their PPG, follow the PPG's prior authorization process and use the PPG's forms.

Direct Network providers

Direct Network providers must request prior authorization by completing a Request for Prior Authorization form and faxing it to the health plan Health Care Services Department at 1-800-743-1655. Providers must submit clinically relevant information for medical necessity review with the prior authorization request. The form is available in the Provider Library at providerlibrary.healthnetcalifornia.com under *Forms and References.*

For CCS-eligible conditions

When PDN services support a California Children's Services- (CCS-) eligible medical condition, the provider must submit a Service Authorization Request (SAR) with clinical documentation to the local CCS program office. CCS will authorize a SAR for the requested services if medical necessity criteria are met.

Requirements

- PDN services require an authorization for all members under age 21.
    - If the PPG is delegated for utilization management, the PPG is responsible for completing the authorization.
    - If the PPG's member is receiving PDN services through CCS, CCS is responsible for the authorization.
    - Whoever completes the authorization must document all efforts to locate and collaborate with providers of PDN services and with other entities, such as CCS.
- All members under 21 receiving PDN services must be case-managed.
- Providers must submit a referral to the health plan's Case Management Department for members under 21 receiving PDN services approved by the PPG, and for their members receiving PDN services through CCS or another entity.
- Providers can submit a referral to the health plan's Case Management Department by completing and submitting the case management referral form via email to CASHP.ACM.CMA@healthnet.com or by fax to 1-866-581-0540. The form is available in the Provider Library at providerlibrary.healthnetcalifornia.com under *Forms and References.*

Department of Health Care Services (DHCS) All Plan Letter (APL) 20-012 outlines the requirements.

The health plan and PPGs delegated for utilization management are contractually obligated to provide case management/care coordination services to members. Specifically, for Medi-Cal eligible members under age 21 who have had PDN services approved, managed care health plans are required to provide case management/ care coordination, as set forth in the health plan contract, and to arrange for all approved PDN services, whether or not the health plan is financially responsible for the PDN services.[2]

PDN case management/care coordination responsibilities

When an eligible member under age 21 is approved for PDN services and requests that the health plan or delegated PPG provide case management services for those PDN services, the health plan or delegated PPG's obligations include, but are not limited to:

- Providing the member with information about the number of PDN hours the member is approved to receive;
- Contacting enrolled home health agencies and enrolled individual nurse providers to seek approved PDN services on behalf of the member;
- Identifying potentially eligible home health agencies and individual nurse providers and assisting them with navigating the process of enrolling to become a Medi-Cal provider; and
- Working with enrolled home health agencies and enrolled individual nurse providers to jointly provide PDN services to the member.

Note, members approved for PDN services by delegated PPGs are identified via the delegated PPG's monthly utilization management Authorization Request (AR) source data log submission. Fifteen days post log submission, the list of approved members is provided to the health plan's Case Management Department to monitor care coordination.

Members may choose not to use all approved PDN service hours, and health plans and delegated PPGs are permitted to respect the member's choice. The member's record must document instances when a member chooses not to use approved PDN services.

Compliant policies and procedures

Health plans and delegated PPGs are required to issue new or revised policies and procedures that comply with the requirements of APL 20-012. Health plans must submit copies of the new or updated policies and procedures to their Managed Care Operations Division Contract Manager for review and approval. Delegated PPGs' policies and procedures must meet APL 20-012 requirements and either be submitted to the health plan or be made available to the health plan upon request. Such policies and procedures must be consistent with the section below about monitoring and oversight of delegated PPGs.

Notice to members

The health plan or delegated PPG is required to issue a notice to every member under the age of 21 for whom it has currently authorized PDN services on or before July 31, 2020. The notice must:

1. Explain that the health plan or delegated PPG has primary responsibility for case management of PDN services.
2. Describe the case management services available to the member in connection with PDN services, as set forth above.
3. Explain how to access those services.
4. Include a statement that the member may:

- Utilize the health plan's existing grievance and appeal procedures to address difficulties in receiving PDN services or their dissatisfaction with their case management services;
- File a Medi-Cal fair hearing as provided by law; or
- Email DHCS directly at EPSDT@dhcs.ca.gov.

5. Include a statement that if the member has questions about their legal rights regarding PDN services, they may contact Disability Rights California at 1-888-852-9241.

Monitoring and oversight

DHCS will audit health plan compliance with the PDN services case management policy outlined in APL 20-012 and the case management requirements set forth in the health plan's contract with DHCS. If the health plan fails to comply with the requirements of the APL or the case management requirements in the health plan's contract, DHCS may require a corrective action plan and/or assess monetary penalties as provided for in the health plan contract and any applicable state or federal statutes and regulations.

Monitoring and oversight of delegated PPGs

The health plan's Delegation Oversight Department will monitor and evaluate your compliance to all requirements through the health plan's annual compliance audit in the following areas:

- Review of EPSDT policies and procedures including:
  - Approval of services that are medically necessary for EPSDT eligible members.
  - Communicating the approval duration/number of approved services/hours if applicable.
  - Assisting the health plan Case Management Department with case management and care coordination services for EPSDT members regardless of financial responsibility for services approved. If the PPG was not the entity to approve the services, the PPG is still required to assist with the provision of case management services as needed or requested by the member.
  - Refer members for whom PDN services have been approved or for whom the PPG is aware have been approved by another entity (such as CCS) to the health plan's Case Management Department to monitor care coordination.
- Review of procedures for assisting the health plan's Case Management Department with requests for PDN services including:
  - Validation that the home health agency/provider of PDN services is enrolled as a Medi-Cal provider.
  - Assisting the health plan Case Management Department with contacting home health agencies and enrolled individual nurse providers on the member's behalf.
  - Arranging for all PDN service hours, as needed or requested by the member.
  - Documentation of all attempts to identify PDN services for the member and the member's refusal to use all PDN hours approved.
- Evidence that the PPG is actively assisting the health plan to increase the network of private duty nursing services by:
  - Assisting eligible home health agencies/individual providers to enroll as Medi-Cal providers.
  - Assisting the health plan Case Management Department with leveraging home health agencies and individual nurse providers (in combination if needed) to meet members' needs.
- Additional activities as identified

[1] For more information, refer to Department of Health Care Services (DHCS) All Plan Letter (APL) 20-012.

[2] Acceptance of available PDN services is at the member's discretion. Members are not required to use all approved PDN service hours.

Home and Community Based Waiver

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

The Home and Community-Based Services (HCBS) Waiver program offers an array of services designed to support an individual in his or her home as an alternative to care in a licensed health care facility. These waivers include the In-Home Medical Care Waiver and the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Medi-Cal for Kids & Teens Services benefit. EPSDT shift nursing is a benefit for members under the age of 21. Medical management of chronically ill Medi-Cal members, including those with catastrophic illnesses, those who are dependent on life-sustaining equipment and those at risk of life-threatening occurrences, requires close coordination between Health Net and the HCBS Waiver program. By providing in-home care, this program seeks to ensure that the medical needs of physically and mentally disabled Medi-Cal members are met.

Coordination of Care

Services provided under the HCBA Waiver program are not covered under the Plan's Managed Medi-Cal Contracts (Two-Plan and Geographic Models). The Plan maintains procedures for identifying members who may be eligible for the HCBA waiver and facilitates the referrals of these members. The Plan endeavors to monitor and ensure the coordination of services with the HCBA Waiver and to provide all medically necessary covered services to its Medi-Cal members.

Eligibility

To qualify for potential enrollment into the HCBA waiver, members must meet the following criteria:

- Must have full-scope Medi-Cal eligibility
- Physically disabled (no age limit)
- This waiver will serve Medi-Cal beneficiaries, who in the absence of this waiver, and as a matter of medical necessity, would require care in an inpatient nursing facility (NF) providing the following types of care:

1. Nursing Facility (NF) B level of care
2. NF A level of care
3. NF Level B Pediatric Services
4. NF Subacute Services
5. NF Pediatric Subacute Services

The Health Net Population Health Department monitors and reviews all inpatient stays for proper use and to identify members who may benefit from Home and Community Based Services (HCBS) Waiver programs.

HCBS Waiver Services Available

The HCBA Waiver provides care management services to persons at risk or nursing home or institutional placement. The care management services are provided by a multidisciplinary Care Management Team (CMT) comprised of a nurse and social worker. The CMT coordinates Waiver and State Plan services (such as medical, behavioral health, In-Home Supportive Services) and arranges for other long-term services and supports available in the local community. Care management and Waiver services are provided in the participant's community-based residence. This residence can be privately owned, secured through a tenant lease arrangement, or the residence of a participant's family member.

Requests for waiver services can come from Medi-Cal providers, associated agencies, Medi-Cal beneficiaries, families, friends, or advocates. Upon receipt of the request for HCBA Waiver services, Waiver Agency staff will mail or email an HCBA Waiver Application Packet to the individual. Assessment for the HCBA waiver services begins after the Waiver Agency receives a completed HCBA Waiver Application.

Referrals to HCBS

The primary care physician (PCP) needs to inform the member, guardian or authorized representative about the availability of in-home care alternatives.

On consent of the member, guardian or authorized representative, the Health Net Medi-Cal Population Health Department coordinates with the inpatient facility discharge planner and care manager to refer the member to a licensed and Medi-Cal-certified home health care agency for evaluation. The home health agency care managers evaluate the member's health care needs and whether they can be met in the member's home.

Local Education Agency Services

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

The Local Education Agency (LEA) provides certain health care assessment services via school programs. LEA services may include:

- Targeted case management
- Physical and mental health evaluation
- Education and psychosocial assessments
- Health and nutrition education
- Developmental assessments
- Behavioral Health screenings and treatment services
- Behavioral Health wellness programs and services

Primary care physicians (PCPs) are encouraged to inform members of these services; however, members may obtain services without a referral from their PCPs. PCPs should, whenever possible, coordinate needed medical services with LEA providers to promote continuity of care and ensure proper and timely follow-up. LEA medical services may include:

- Physical and occupational therapy
- Speech pathology and audiology
- Psychology and counseling
- Nursing services

- School health aide services
- Medical transportation
- Behavioral Health screenings and treatment
- Behavioral Health wellness programs and services

PCPs may be asked to support LEAs with the following:

- Written prescriptions for specific LEA services
- Medical evaluations or records on request
- Referrals for appropriate and necessary medical services
- Medically necessary services when school is not in session

On request, the PCP may authorize LEA providers to provide other services on a case-by-case basis.

Long-Term Services and Supports

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

This section contains member benefit and provider information on long-term services and supports (LTSS) available to Health Net Medi-Cal eligible members in California. LTSS encompasses a variety of services and supports to help members live independently.

Select any subject below:

- Community-Based Adult Services
- In-Home Supportive Services
- Multipurpose Senior Services Program (MSSP) Waiver

Community-Based Adult Services

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

The Community-Based Adult Services (CBAS) program is a community-based day care program designed to provide a variety of health, therapeutic and social services to eligible Medi-Cal members ages 18 and older. CBAS services are delivered based on need and an established care plan, offering a bundle of services during a service day. The number of days per week that members receive services is based on medical criteria and is incorporated into a Health Net-approved care plan. Services include, but are not limited to:

- skilled nursing care
- social services
- personal care
- physical, occupational and speech therapy
- family and caregiver training and support
- meals
- mental health services

- transportation to and from the CBAS center

Members who may benefit from CBAS are those with multiple complex chronic medical, cognitive or psychological conditions and functional limitations who require regular health monitoring, skilled nursing and therapeutic intervention, and social supports to maintain function in the community and prevent avoidable emergency department or hospital admissions, or short-or long-term nursing facility admission.

CBAS is a Medi-Cal managed care benefit, and covered services are Health Net's financial responsibility. CBAS program eligibility does not affect dual-eligible (Medicare and Medi-Cal) members' Medicare coverage, Social Security benefits or the Medicare physicians they visit outside a CBAS center.

Coordination of Care

The Health Net Health Services staff and subcontractors are available to coordinate care with the member's primary care physician (PCP), the community-based adult services (CBAS) center and the multidisciplinary team. PCPs continue to provide medically necessary care and must be available to consult with the CBAS center's staff as needed.

Eligibility

Medi-Cal members who have a physical, mental or social impairment occurring after age 18, and who may benefit from community-based adult services (CBAS), may be eligible. Eligible members must meet one of the following criteria:

- Needs are significant enough to meet nursing facility level of care A (NF-A) or above
- A moderate to severe cognitive disability, including moderate to severe Alzheimer's or other dementia
- A developmental disability
- A mild to moderate cognitive disability, including Alzheimer's or dementia and needed assistance or supervision with two of the following:
    - bathing
    - dressing
    - self-feeding
    - toileting
    - ambulation
    - transferring
    - medication management
    - hygiene
- A chronic mental illness or brain injury and needed assistance or supervision with two of the following:
    - bathing
    - dressing
    - self-feeding
    - toileting
    - ambulation
    - transferring
    - medication management, or need assistance or supervision with one needed from the above list and one of the following:

- hygiene
- money management
- accessing resources
- meal preparation
- transportation

- A reasonable expectation that preventive services will maintain or improve the present level of function (for example, in cases of brain injury due to trauma or infection)
- A high potential for further deterioration and probable institutionalization if CBAS is not available (for example, in cases of brain tumors or HIV-related dementia)

Problem Resolution

If a participating provider disagrees with the community-based adult services (CBAS) center staff's recommendation concerning provision of services, Health Net's public programs administrators can assist with dispute resolution. Refer to the Provider Appeals and Dispute Resolution overview topic for more information about the provider appeals and dispute resolution process.

Referral Process

Participating providers, case managers, registered nurses, and licensed social workers who believe a member may benefit from the Community-Based Adult Services (CBAS) program must request a face-to-face assessment by submitting the request on the Health Net provider portal. To submit a request for an assessment, go to the enrollee's profile and select *Assessments* . Click *Fill Out Now!* next to CBAS Treatment Request to initiate a face-to-face assessment and arrange for transportation to and from the center for assessment.

Health Net completes an initial face-to-face assessment using the CBAS Eligibility Determination Tool (CEDT) to determine eligibility for CBAS. Once eligibility is validated, Health Net notifies the CBAS center to complete the evaluation of service needs and develop an Individual Plan of Care (IPC). The CBAS center submits the evaluation and IPC, signed by all appropriate team members, to Health Net for authorization or notification of services and number of days per week. Refer to the Eligibility section above for more information about CBAS eligibility.

Prior authorization or notification is required for CBAS. Refer to Prior Authorization Requirements for additional information. For more information on how to submit a prior authorization request or notification, refer to Prior Authorization Requirements.

In-Home Supportive Services

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

The In-Home Supportive Services (IHSS) program provides in-home care to seniors and persons with disabilities (SPD) allowing them to remain safely in their homes with as much independence as possible. IHSS include, but are not limited to:

- domestic and related services (housecleaning, meal preparation and clean up, laundry, and grocery shopping)
- personal care services (bathing, dressing, grooming)
- paramedical services (wound care, catheter care, injections)
- family and caregiver training
- accompaniment to medical appointments
- protective supervision for the mentally impaired

Members who may benefit from IHSS are those with complex chronic medical, cognitive or psychological conditions and functional limitations who require regular health monitoring and social supports to maintain function in the community and prevent avoidable emergency department or hospital admissions, or short- or long-term nursing facility admission.

Members have the right to hire, fire and supervise the work of IHSS personnel rendering services to them.

IHSS, is not a managed care benefit, and services are carved out to county departments of social services.

Eligibility

To qualify for enrollment in the In-Home Supportive Services (IHSS) program, Medi-Cal members must meet all of the following criteria:

- Be a resident of California and United States citizen and live in their own home.
- Be age 65 or older, legally blind or disabled.
- Current Supplemental Security Income/State Supplementary Payment (SSI/SSP) recipient or be eligible to receive SSI/SSP.
- Be able to obtain a Health Care Certification form (SOC 873) from a licensed health care professional that indicates inability to independently perform some activity of daily living, and without IHSS, would be at risk of placement in out-of-home care.

Problem Resolution

Health Net public programs administrators provide information and assist in the referral of members who have complaints, grievances or appeals related In-Home Supportive Services (IHSS), to the grievance and appeal process established by the California Department of Social Services (CDSS) and local county agencies responsible for IHSS.

Referral Process

Participating providers, case managers, community-based organizations, and family members who believe a member may benefit from in-home supportive services (IHSS) can contact the Health Net Member Services Department to coordinate referrals for members needing IHSS assessments. Members potentially eligible for IHSS may also be identified through emergency room/urgent care usage, inpatient admissions, authorizations, claims, and encounter data. For additional assistance or to obtain county-specific information, providers can also contact the Health Net Public Programs Department.

Providers must supply the completed health care certification form (SOC 873) required by the IHSS program in order to have a referral processed. If the referral comes from a source other than the member's provider, the IHSS social worker mails the SOC 873 to the member to have his or her PCP complete and return the form in order to complete the referral.

Health Net PCPs and other providers continue to render medically necessary care while the member participates in the IHSS program.

Multipurpose Senior Services Program (MSSP) Waiver

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

The Multipurpose Senior Services Program (MSSP) provides social and health care case management services for members ages 65 and older who wish to remain in their homes and communities. The goal of the program is to use available community services to prevent or delay institutionalization. The services must be provided at a cost lower than that of a skilled nursing facility (SNF). MSSP services include, but are not limited to:

- environmental accessibility adaptations
- personal emergency response systems (PERSs) and communication devices
- care management
- personal care services (bathing, dressing, grooming)
- respite care (in- and out-of-home)
- adult day care, support center and health care
- housing assistance and minor home repair
- chore services
- income maintenance counseling
- mental health services
- transportation services
- protective supervision
- meal services
- communication services (translation or interpreter)

MSSP is provided by licensed MSSP sites. MSSP is not a managed care benefit.

Eligibility

To qualify for the Multipurpose Senior Services Program (MSSP), Medi-Cal members must meet all of the following criteria:

- Be age 65 or older.
- Certifiable for placement in a skilled nursing facility (SNF).
- Live in a county with an MSSP site and be within the site's service area.
- Be appropriate for care management services.

- Able to be served within MSSP's cost limitations.

MSSP is provided by licensed MSSP sites. MSSP is not a managed care benefit.

Problem Resolution

If a participating provider disagrees with the Multipurpose Senior Services Program (MSSP) decision or recommendation concerning the provision of MSSP services, Health Net's public programs administrators can assist with resolution.

Referral Process

Members who are potentially eligible for the Multipurpose Senior Services Program (MSSP) may be identified through a variety of sources, including the member's primary care physician (PCP) or specialist, community-based organizations, inpatient admissions (concurrent review), or claims and encounter data. Members may also apply for MSSP directly by calling the Department of Public Services (DPSS) in Los Angeles County or the Health Net Public Programs Department.

With the member's consent, Health Net provides case management information required by the MSSP. A team of health and social service professionals determine the member's eligibility for MSSP participation. The team's assessment determines the member's medical diagnosis, physical disabilities, functional abilities, psychological status, and social and physical environment. Health Net case managers continue to provide needed care coordination with the member's PCP and other community agencies pending MSSP waitlist activity.

Health Net's PCPs and other providers continue to render medically necessary care while the member participates in the MSSP.

Mental Health

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

Health Net Medi-Cal members obtain the following mental health services through Health Net:

- Non-specialty mental health services (NSMHS):
  - Mental health evaluation and treatment, including individual, group and family psychotherapy.
  - Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.
  - Outpatient services for purposes of monitoring drug therapy.
  - Psychiatric consultation.
  - Outpatient laboratory, drugs, supplies and supplements.
- Medications for Addiction Treatment (MAT), also known as medication-assisted treatment provided in primary care, inpatient hospital, emergency departments, and other contracted medical settings.
- Emergency services necessary to stabilize the member.

Members do not need to contact their primary care physician (PCP), participating physician group (PPG) or attending physician to request a referral for mental health care services. Health Net members may obtain these services directly through Health Net's extensive behavioral health network by calling the member services telephone number listed on their identification card (ID). Participating providers may also contact Behavioral Health Provider Services for assistance with mental health services referrals.

Prior authorization is not required for initial assessment for outpatient behavioral health services.

PCPs may refer members to marriage and family therapists, social workers, professional counselors, psychologists, and psychiatrists for services, as follows:

- Marriage and family therapists, social workers, professional counselors, and psychologists can:
  - Diagnose, treat and consult for the management of mild to moderate emotional problems for which the PCP or member feels the need for consultation.
  - Evaluate cases for which a member would benefit from psychotherapy in addition to psychotherapeutic medication.
  - Conduct psychological testing for clarification of diagnosis to establish a treatment plan (psychologists).
- Psychiatrists can:
  - Diagnose, treat and recommend a medication regimen in difficult or complex cases, including cases of depression that do not respond to a 60-day trial of selective serotonin re-uptake inhibitor (SSRI) medications or other antidepressants.
  - Evaluate cases in which members report feeling suicidal or homicidal, severe anxiety states, clear somatoform disorders, schizophrenic disorders where Clozaril® or risperidone is being considered, and bipolar disorder where lithium, carbamazepine or valproic acid may be needed.

  PCPs are responsible for coordinating referrals for members requiring specialty or inpatient mental health services to county mental health plans (CMHPs) in Fresno, Kern, Kings, Los Angeles, Madera, Sacramento, San Diego, San Joaquin, Stanislaus, Tulare. PCPs retain responsibility for coordination of ongoing care for co-existing medical and mental health needs and provision of medically necessary medications.

The Mental Health Services Division (MHSD) oversees CMHPs and each county is required to provide access to specialty mental health services for Medi-Cal members. Refer to the MHSD Medical Necessity Criteria document for additional information about criteria for specialty mental health services.

Excluded Psychotherapeutic Medications

Refer to the Medi-Cal Rx program for psychotherapeutic medications excluded. These medications are covered through the Medi-Cal fee-for-service (FFS) or Medi-Cal Rx program. Providers must bill the state directly for these medications.

Health Net Responsibilities

Health Net is responsible to:

- Monitor appropriate referral of members by primary care physicians (PCPs) through audits (specific services may be considered Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental services for members under age 21).
- Monitor the availability of coordination of care services when indicated and requested by the PCP or mental health care provider.
- Provide medically necessary emergency room (ER) professional services and medical transportation services for emergency medical conditions. This includes facility charges for ER visits that do not result in a psychiatric admission and all laboratory and radiology services necessary for the diagnosis, monitoring or treatment of a member's mental health condition.
    - Transportation for non-emergency conditions is not covered unless prior authorized. ER services for non-emergency medical conditions, services after stabilization, or an emergency medical condition require authorization.

MHSD Medical Necessity Criteria

The following Mental Health Services Division (MHSD) medical necessity criteria for specialty mental health services are the responsibility of the county mental health plan (CMHP).

Diagnosis - The member must have one of the following DSM IV-included diagnoses, which indicates the focus of the intervention provided:

Medical Necessary Criteria

Included diagnosis	Excluded diagnosis*
• Pervasive developmental disorders (autistic disorder excluded) • Attention deficit and disruptive behavior disorders • Feeding and eating disorders of infancy or early childhood • Elimination disorders • Other disorders of infancy, early childhood or adolescence • Schizophrenia and other psychotic disorders • Mood disorders • Anxiety disorders • Somatoform disorders • Factitious disorders • Dissociative disorders • Paraphilias • Gender identity disorder • Eating disorders • Impulse-control disorders not classified elsewhere	• Mental retardation • Learning disorders • Motor skills disorders • Communication disorders • Autistic disorders (other pervasive developmental disorders included) • Tic disorders • Delirium, dementia and amnestic and other cognitive disorders • Mental disorders due to a general medical condition • Substance-related disorders** • Sexual dysfunctions • Sleep disorders • Antisocial personality disorders • Other conditions that may be a focus of clinical attention (medication-induced movement disorders included)

Included diagnosis	Excluded diagnosis*
• Adjustment disorders • Personality disorders (antisocial personality disorder excluded) • Medication-induced movement disorders	

*A beneficiary may receive services for an included diagnosis even if an excluded diagnosis is present.

**Early and Periodic Screening, Diagnosis and Treatment (EPSDT) beneficiaries with an included diagnosis and a substance-related disorder may receive specialty mental health services directed at the substance use component. The intervention must be consistent with, and necessary to the attainment of, the specialty mental health treatment goals.

Impairment - Member must have one of the following as a result of an included mental disorder:

- A significant impairment in an important area of life functioning
- A probability of significant deterioration in an important area of life functioning

Children also qualify if there is a probability the child will not progress developmentally as individually appropriate. Children covered under EPSDT qualify if they have a mental disorder that can be corrected or ameliorated.

Intervention related - All three of the following must apply:

- The focus of proposed intervention is to address the condition identified in the impairment criteria identified above.
- It is expected the beneficiary will benefit from the proposed intervention by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning, or for children, it is probable the child will progress developmentally as individually appropriate (or if covered by EPSDT can be corrected or ameliorated).
- The condition would not be responsive to physical health care-based treatment.

PCP Responsibilities and Referrals to Behavioral Health Providers

Primary care physicians (PCPs) provide outpatient mental health services within the scope of their practice. The PCP is responsible for identifying and treating, or making a specialty medical referral for, the member's general medical conditions that cause or exacerbate psychological symptoms.

If members require mental health services for mild to moderate conditions, PCPs may refer members to Health Net for assessment and referral to a mental health provider. PCPs must continue to:

- Make available all necessary medical records and documentation relating to the diagnosis and care of the mental health condition that resulted in a referral.
- Ensure the appropriate documentation is included in the member's medical record.
- Respond to requests to coordinate non-specialty mental health conditions and services with specialists.

Examples of mental health services generally considered appropriate to be provided by the PCP are:

- Complete physical and mental status examinations and extended psychosocial and developmental histories when indicated by psychiatric or somatic presentations (fatigue, anorexia, overeating, headaches, pains, digestive problems, altered sleep problems, and acquired sexual problems).
- Diagnosis of physical disorders with behavioral manifestation.
- Maintenance medication management after stabilization by a psychiatrist or, if longer-term psychotherapy continues, with a non-physician therapist.
- Diagnosis and case management of child, elder and dependent adult abuse and domestic violence victims.
- Coordination of psychological assessments to rule out:
    - General medical conditions as a cause of psychological symptoms.
    - Mental or substance-related disorders caused by a general medical condition.

PPG Responsibilities

Participating physician groups (PPGs) are responsible for providing the initial health history and physical assessment of members admitted to the psychiatric ward of a general acute care hospital or to a freestanding licensed psychiatric inpatient hospital.

Problem Resolution

Health Net's public programs administrators resolve disputes that arise between the county mental health plan (CMHP) and Health Net or the primary care physician (PCP). During the dispute period, the Health Net Medi-Cal Health Services Department and the PCP or specialty provider continue to coordinate the care of the member until the matter is resolved.

Referral Process to Specialty Mental Health

The need for referral for specialty mental health services is determined by the primary care physician's (PCP's) evaluation of the member's medical history, psychosocial history, current state of health, and any request for such services from either the member or the member's family. Once the determination has been made to refer the member for specialty mental health services, PCPs may do one of the following based on the member's level of mental health impairment:

- For members with mild to moderate impairment, providers may contact Behavioral Health Provider Services for assistance.
- For Health Net members assigned to Molina with mild to moderate impairment, refer to the Molina Behavioral Health Services Line.
- For all Medi-Cal members with a severe level of impairment, refer to the county mental health plan (CMHP) for specialty mental health services (SMHS). Providers may also refer directly to the CMHP.

Refer to the Mental Health Services Division (MHSD) Medical Necessity Criteria in the section above for included and excluded diagnoses and information on when to refer to the CMHP.

Members may self-refer for behavioral health services by calling the member services phone number listed on their identification card (ID). Health Net members assigned to Molina may also self-refer by calling the member services phone number listed on their ID card.

Specialty Mental Health Services

Specialty mental health services covered by county mental health plans (CMHPs) include:

- Outpatient services
  - Mental health services, including assessments, plan development, therapy and rehabilitation
  - Medication support
  - Day treatment services and day rehabilitation
  - Crisis intervention and stabilization
  - Targeted case management
  - Therapeutic behavior services
- Residential services
  - Adult residential treatment services
  - Crisis residential treatment services
- Inpatient services
  - Acute psychiatric inpatient hospital services
  - Psychiatric inpatient hospital professional services
  - Psychiatric health facility services

  Refer to the Mental Health Services Division (MHSD) Medical Necessity Criteria discussion above for additional information.

No Wrong Door Policy for Mental Health Services

This policy allows members who directly access a treatment provider to receive an assessment and mental health services, and to have that provider reimbursed for those services by their contracted plan, even if the member is transferred to the other delivery system due to their level of impairment and mental health needs. In certain situations, members may receive coordinated, non-duplicative services in multiple delivery systems, such as when a member has an ongoing therapeutic relationship with a therapist or psychiatrist in one delivery system while requiring medically necessary services in the other.

Health Net provides or arranges for the provision of the following:

- Non-specialty mental health services (NSMHS):
  - Mental health evaluation and treatment, including individual, group and family psychotherapy.
  - Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.
  - Outpatient services for purposes of monitoring drug therapy.
  - Psychiatric consultation.
  - Outpatient laboratory, drugs, supplies and supplements.
- Medications for Addiction Treatment (MAT), also known as medication-assisted treatment provided in primary care, inpatient hospital, emergency departments, and other contracted medical settings.
- Emergency services necessary to stabilize the member.

NSMHS listed above applies to the following populations:

- Members ages 21 and older with mild to moderate distress, or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders.
- Members under age 21, to the extent they are eligible for services through the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, regardless of the level of distress or impairment, or the presence of a diagnosis.
- Members of any age with potential mental health disorders not yet diagnosed.

Consistent with W&I Code section 14184.402(f), clinically appropriate NSMHS are covered by Health Net even when:

1. **Services provided during the assessment period prior to a determination of a diagnosis, during the assessment period or prior to determination of whether NSMHS criteria are met.** Health Net and county mental health plan (MHPs) will not deny or disallow reimbursement for NSMHS provided during the assessment process described above if the assessment determines that the member does not meet the criteria for NSMHS or meets the criteria for SMHS.
2. **Services not included in an individual treatment plan.**
3. **The member has a co-occurring mental health condition and substance use disorder (SUD)**. Health Net and CMHP will not deny or disallow reimbursement for NSMHS provided to a member who meets NSMHS criteria on the basis of the member having a co-occurring SUD, when all other Medi-Cal and service requirements are met. Similarly, Health Net covers clinically appropriate SUD services delivered by Health Net providers (e.g., alcohol and drug screening, assessment, brief interventions, and referral to treatment; MAT) whether or not the member has a co-occurring mental health condition. Drug Medi-Cal (DMC) and Drug Medi-Cal Organized Delivery System (DMC-ODS) counties cover clinically appropriate DMC/DMC-ODS services delivered by DMC/DMC-ODS providers, respectively, whether or not the member has a co-occurring mental health condition.
4. **Concurrent NSMHS and SMHS.** Members may concurrently receive NSMHS from a Health Net provider and SMHS via a CMHP provider when the services are clinically appropriate, coordinated and not duplicative. When a member meets criteria for both NSMHS and SMHS, the member should receive services based on the individual clinical need and established therapeutic relationships. Health Net and CMHP will not deny or disallow reimbursement for NSMHS provided to a member on the basis of the member also meeting SMHS criteria and/or also receiving SMHS services.

Any concurrent NSMHS and SMHS for adults and children under ages 21, will be coordinated between Health Net and the local CMHP to ensure member choice. Health Net will coordinate with local CMHP to facilitate care transitions and guide referrals for members receiving NSMHS to transition to a SMHS provider and vice versa, ensuring that the referral loop is closed, and the new provider accepts the care of the member. Such decisions should be made via a patient-centered shared decision-making process.

- Members with established therapeutic relationships with a Health Net provider may continue receiving NSMHS from the Health Net provider (billed to Health Net), even if the member simultaneously receives SMHS from a CMHP provider (billed to the CMHP), as long as the services are coordinated between the delivery systems and are non-duplicative (e.g., a member may only receive psychiatry services in one network, not both networks; a member may only access individual therapy in one network, not both networks).
- Members with established therapeutic relationships with a CMHP provider may continue receiving SMHS from the CMHP provider (billed to the CMHP), even if the member simultaneously receives NSMHS from a Health Net provider (billed to Health Net), as long as the services are coordinated between these delivery systems and are non-duplicative.

Screening and transition of care tools

Per APL 22-028, DHCS developed the following standardized adult and youth (under age 21) screening and transition of care tools for Medi-Cal managed care plans (MCPs) and county mental health plans to use:

- Screening tools to determine the most appropriate Medi-Cal mental health delivery system referral for members who are not currently receiving mental health services when they contact the MCP or county mental health plan seeking mental health services.
- Transition of care tool to ensure Medi-Cal members receive timely and coordinated care when completing a transition of services to the other delivery system or when adding a service from the other delivery system to their existing mental health treatment.

Sexually Transmitted Infections (STIs)

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

Diagnosis and treatment of sexually transmitted infections (STIs) is available to Health Net Medi-Cal members without prior authorization under Health Net's contract with the Department of Health Care Services (DHCS). Members may choose any qualified provider, in- or out-of-network, including local health departments (LHDs) and family planning clinics, for care of an STI episode without prior authorization. STI services include education, prevention, screening, counseling, diagnosis, and treatment.

Out-of-network services provided by LHDs and family planning providers are limited to the following:

- One office visit per disease episode for the purpose of:
    1. Diagnosis and treatment of vaginal discharge and urethral discharge
    2. Those STIs that are amenable to immediate diagnosis and treatment, and this includes syphilis, gonorrhea, chlamydia, herpes simplex, chancroid, trichomoniasis, human papilloma virus, non-gonococcal urethritis, lymphogranuloma venereum and granuloma inguinale and
    3. Evaluation and treatment of pelvic inflammatory disease.

Additional visits require prior authorization and may require that the member be referred back to his or her primary care physician (PCP) for any additional medically necessary follow-up or treatment.

For community providers other than LHD and family planning providers, out-of-network services are limited to one office visit per disease episode (follow-up care must be obtained by an in-network provider).

Member Education

Member education on sexually transmitted infections (STIs) includes disease-specific material, the right to out-of-network treatment, health assessment for risk factors, and the method for obtaining preventive services. Members are advised of these services in the Evidence of Coverage (EOC).

The Health Net Health Education Department sends STI health education information to providers on request.

Nonparticipating Providers

Health Net requests that nonparticipating providers contact the Health Net Medi-Cal Member Services Department to verify eligibility and benefits and to obtain billing instructions for Medi-Cal members. The nonparticipating provider is given the name of the member's primary care physician (PCP) to arrange for follow-up services. Nonparticipating providers may also use either an EDS Point of Service (POS) device or the Automated Eligibility Verification System (AEVS) by telephone to confirm eligibility. If the nonparticipating provider contacts the PCP directly, the PCP is responsible for coordinating the member's care with the non-participating provider.

If the nonparticipating provider requests care management services, the request is forwarded to the Health Net Medi-Cal Health Services Department. The Health Net Medi-Cal Health Services Department arranges for any necessary follow-up care and coordinates the care with the member's PCP.

PCP Responsibilities

Primary care physicians (PCPs) are responsible for primary treatment of sexually transmitted infections (STIs). The PCP may perform the service or may refer members to local health department (LHD) clinics, participating specialists, or on request of the member, out-of-network providers.

PCPs are responsible for reporting incidences of STIs to the LHD within specific time frames. Refer to the Communicable Diseases Reporting discussion under the Compliance and Regulations topic for a list of reportable STIs, reporting requirements and the Confidentiality Morbidity Report form (PDF).

When reporting to the LHD, the following information must be included:

- Member demographics (name, age, address, home telephone, date of birth, gender, ethnicity, and marital status)
- Locating information (employer, work address and telephone number)
- Disease information (diagnosed date of onset, symptoms, laboratory results, and prescribed medications)

Plan PCPs shall screen for chlamydia in all sexually active women 24 years or younger and women 25 years or older who are at increased risk for infection, in accordance with the U.S. Preventive Services Task Force (USPSTF) recommendations. Follow up for positive results must be documented in the medical record.

If the member refuses to have the chlamydia screening performed, unsuccessful attempts and refusals to screen must be documented in the member's medical record by the PCP.

PCPs should document any preventive care and health education counseling provided at the time of a routine exam for all members with high-risk behaviors for STIs.

Access to STI services by minors, including confidentiality and monitoring of STI services, is a covered benefit. Refer to the Access to Sensitive Services discussion under the Benefits topic for additional information.

Reimbursement

Participating providers must bill Health Net, or the capitated participating physician group (PPG), in accordance with their *Provider Participation Agreement (PPA)* .

Individually participating providers who provide sexually transmitted infection (STI) services are reimbursed at the allowable Medi-Cal fee-for-service (FFS) rate determined by the Department of Health Care Services (DHCS), if a specific rate has not been included in the *PPA* .

Denials of STI services (for example, member ineligibility under the Medi-Cal program) are sent to the provider of service to protect the member's privacy.

Plan Medi-Cal providers may submit appeals to the Provider Disputes Department for any unresolved claims issue. The procedure is outlined for providers in the Plan's Medi-Cal Provider Manual.

Members may submit appeals to the Plan's Medi-Cal Member Appeals and Grievance Department for any unresolved claims issue. The procedure is outlined for Members in the Evidence of Coverage document. Any questions or issues should be referred to the Plan's Medi-Cal Customer Contact Center.

Tuberculosis Detection and Treatment

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

Tuberculosis (TB) screening, diagnosis, treatment, and follow-up are covered services for Medi-Cal members. Health Net and its participating providers, provide TB care and treatment in compliance with the guidelines recommended by the American Thoracic Society and the Centers for Disease Control and Prevention.

Health Net coordinates with local health departments (LHDs) in the provision of LHD's Direct Observation Therapy (DOT) program.

Early diagnosis, immediate reporting to LHDs and effective TB treatment are critical to interrupting continued transmission of TB. Physicians must report known or suspected cases to the LHD TB Control program office within one working day of identification (17 CCR 2505).

Care Management

Primary care physicians (PCPs) are instructed to notify the Health Net Medi-Cal Health Services Department of all suspected or active tuberculosis (TB) cases to ensure coordination of care, correct utilization and timely delivery of medical care. Health Net's Medi-Cal Health Services staff communicates with the Medi-Cal TB Control Program nurse manager and the PCP concerning these cases. When necessary, Health Net's public programs administrators obtain referral information from Health Net's Medi-Cal Health Services staff, affiliated health plans and local health departments to ensure accurate tracking of TB cases.

PCPs need to contact the Local Health Department (LHD) TB nurse manager and the Health Net Medi-Cal Health Services Department for care management services for members who are repeated no-shows for appointments. The Health Net Medi-Cal Health Services staff attempts to contact the member. If no contact is made, the Health Net Medi-Cal Health Services staff notifies the PCP and coordinates with the LHD. The Health Net Medi-Cal Health Services staff updates the LHD TB nurse manager when members change providers.

The local TB Control Program reports to the PCP when the member does not respond to treatment or when the member experiences an adverse reaction to medication.

The LHD TB nurse manager is responsible for providing follow-up information concerning contact investigations, verifying and collecting additional information, and communicating with PCPs and Health Net's care managers.

Classification System for Tuberculosis

Class	Type	Description
0	No TB exposure Not infected	No history of exposure. Negative reaction to tuberculin skin test.
1	TB exposure No evidence of infection	History of exposure. Negative reaction to tuberculin skin test.
2	TB infection No TB disease	Positive reaction to tuberculin skin test. Negative bacteriologic studies (if done). No clinical, bacteriological, or radiological evidence of active TB.
3	Current TB disease	Meets current laboratory criteria (for example, a positive culture) or criteria for current clinical case definition.
4	Previous TB disease (not current)	Medical history of TB disease or abnormal but stable. X-ray findings for a person who has a positive reaction to the tuberculin skin test, negative bacteriologic examination (if done), and no clinical or X-ray evidence of current TB disease.
5	TB suspected	Signs and symptoms of TB disease, but evaluation not complete (diagnosis pending).

Direct Observation Therapy for Tuberculosis

Direct observation therapy (DOT) services are offered by local health departments (LHDs) to monitor members with clinically active tuberculosis (TB) who have been identified by their primary care physician (PCP) as at risk for potential noncompliance with the treatment regimen. DOT is a measure to ensure adherence to tuberculosis treatment for members at risk for noncompliance in taking medications or who are unable to follow the treatment regimen and to protect the public health. DOT is a process by which a health care worker observes the patient swallowing anti-TB medications. The purpose of DOT is to assure that the entire course of medication is taken in the correct dose, at the correct time and for the complete period of therapy.

DOT services are carved-out under the Health Net Medi-Cal managed care program, but the member remains enrolled with Health Net for the purpose of receiving primary care and services unrelated to DOT.

The responsibility for paying for DOT services for a member enrolled in managed care rests with the LHD rather than the health plan.

Dosage Recommendations

Refer to the CDHS/CTCA Joint Guidelines for the Treatment of Active Tuberculosis Disease (PDF) for appropriate dosage recommendations for the detection and treatment of tuberculosis.

DOT Referrals to Local Health Departments

When a primary care physician (PCP) identifies a member with tuberculosis (TB) who is at risk for nonadherence with the treatment regimen, the PCP must fax a copy of the DOT referral form (PDF) to the local health department (LHD) TB control officer. A copy of the referral form must also be faxed to Health Net's public programs administrator and the participating physician group (PPG) case manager.

The LHD must be notified when the PCP has reasonable grounds to believe that a member has ceased treatment, failed to keep an appointment, has adverse drug reactions, or has relocated without transferring or discontinuing care.

The following members must be referred for direct observation therapy (DOT) services:

- members having multiple drug resistance (defined as resistance to Isoniazid and Rifampin)
- members whose treatment has failed
- members who have relapsed after completing a prior regimen
- children
- adolescents
- noncompliant individuals

Members with the following conditions should be considered for referral:

- substance abuse
- major psychiatric, memory or cognitive disorders
- elderly
- homeless
- formerly incarcerated

- slow sputum conversion
- slow or questionable clinical adherence
- adverse reaction to TB medications
- poor understanding of their disease process and management
- language or cultural barriers

Follow-Up Care

Primary care physicians (PCPs) are required to coordinate with the local health department (LHD) tuberculosis (TB) control officer and provide follow-up care to all members receiving direct observation therapy (DOT) services. PCPs need to inform the LHD TB Control Program of any changes in the member's response to the treatment or drug therapy.

PCPs receive a periodic report from the LHD TB Control Program to advise them of members' treatment status. On completion of the DOT services, the LHD TB Control Program faxes a copy of the member's medical record and final status report to the PCP.

The PCP then arranges an appointment to develop a follow-up treatment plan for the member. The PCP's staff calls or mails the appointment schedule slip to the member. If the member does not show up for the scheduled appointment, a follow-up telephone call or letter should be initiated. If there is no response, the PCP notifies the LHD TB Control Program.

Health Education

The Health Net Medi-Cal Health Services Department makes a referral to the Health Net Health Education Department when a member is identified with tuberculosis (TB). Members are then thoroughly educated regarding TB. Effective health education programs and materials are available to members in a variety of languages. These services are provided through participating physician groups (PPGs), providers, participating hospitals, the LHD TB Control program, and Health Net.

Hospital Transfer or Discharge

Health Net requires participating primary care physicians (PCPs) to obtain the LHD TB Control Program office's approval prior to hospital transfer or discharge of any member with known or suspected tuberculosis (TB). The LHD TB Control Program office reviews requests for hospital transfer or discharge within 24 hours of receipt. Coordination of the treatment plan and discharge planning include the acute care facility, the Health Net Medi-Cal Health Services Department and the LHD TB Control program.

Initial Health Appointment

All Medi-Cal members must receive an initial health appointment (IHA) (complete history and physical examination) within 120 days of the date of enrollment, unless the member's primary care physician (PCP) determines that the member's medical record contains complete and current information consistent with the assessment requirements within periodicity time requirements. Tuberculosis (TB) testing must be included if members are identified in specific targeted or at-risk groups.

Investigation of Contacts

It is the responsibility of the local health department (LHD) to investigate tuberculosis (TB) contacts. When contacts with positive TB members are identified, the primary care physician (PCP) notifies the TB Control Program or the Health Net Medi-Cal Health Services Department of the actual or potential contact with a TB-diagnosed Health Net member. PCPs are required to provide examinations within seven days to their assigned members identified by TB Control Program as contacts. Examination results must also be reported in a timely manner back to the local TB Control Program office.

Laboratory Services

Health Net uses laboratories that conform to legal and Centers for Disease Control and Prevention (CDC) guidelines.

Medical Director Responsibilities

The Health Net Medi-Cal medical directors confer, as needed, with the local Tuberculosis (TB) Control Program nurse manager to ensure coordination of care and to correct identified deficiencies. Health Net's Medi-Cal medical directors, Health Services staff, public programs administrators, and the local TB Control Program collaborate in monitoring and evaluating care and services provided to potential and active TB cases.

PCP Responsibilities

Primary care physicians (PCPs) are responsible for acting as the primary caregiver for the member and submitting the required tuberculosis (TB) reporting to the local TB Control Program office within one working day of identifying a TB case. Upon receipt by the local TB Control Program office, co-management of treatment is discussed. TB-diagnosed members are identified by PCPs during the normal course of practice and by specialists during consultation and treatment. The Health Net Medi-Cal Health Services Department is also notified for care management needs and tracking.

Problem Resolution

Conflicts that arise between LHD TB Control Programs and Health Net or a participating provider are resolved by Health Net's public programs administrators.

Referrals

Primary care physicians (PCPs) who identify Class 3 and Class 5 TB cases refer them to the LHD TB Control Program for treatment.

The local health department (LHD) must be notified when the PCP has reasonable grounds to believe that a member has ceased treatment, failed to keep an appointment, had adverse medication reactions, relocated without transferring care, or discontinued care.

PCPs who elect not to refer the member identified with Class 3 or 5 TB to the LHD TB Control Program for treatment are bound by the requirements of California law in the identification, reporting, treatment, and coordination of care for these members.

Screening for Tuberculosis Infection

Screening is performed to identify infected people at high risk for disease who would benefit from treatment for latent tuberculosis infection (LTBI). It is also done to identify people with clinically active tuberculosis (TB) who need treatment. The following are at high risk for TB and need to be screened with a tuberculin skin test:

- those with HIV infection
- those in close contact with someone having an infectious TB case
- those with medical conditions that increase the risk of TB
- foreign-born people from high TB-prevalence countries
- low-income people
- high-risk minorities
- persons with alcohol or substance use disorders
- residents and employees of long-term care facilities (including prisons)
- populations identified locally as being at increased risk for TB (for example, health care workers in some areas)

Health Net collaborates with local refugee health programs to identify refugees who are possible candidates for local refugee health clinic services. Guidelines for this referral coordination may be found in the discussion of Refugee Health Programs.

TB screening, testing, interpretation of testing and coordination of referral, treatment and follow-up for children through age 20, are to be provided in accordance with the American Academy of Pediatrics (AAP) Bright Futures Recommendations for Periodic Preventive Health Care and the California Department of Public Health Tuberculosis Control Branch. A TB exposure risk assessment is required during preventive well-child screening exams at the ages recommended by the most current (AAP) Recommendations for Periodic Preventive Health Care and testing should be performed on recognition of high-risk factors.

Screening for members ages 18 and older

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

- Adult members who receive primary care services in a facility, clinic, center, office, or other setting where primary care services are provided, **shall be offered a TB risk assessment and TB screening test**, if TB risk factors are identified, based on the latest screening indications recommended by the U.S. Preventive Services Task Force, unless the provider reasonably believes that one of the following conditions applies:
    - The member is being treated for a life-threatening emergency.

- The member has previously been offered or has been the subject of a TB risk assessment, TB screening test, or both, and has no new TB risk factors since the last TB risk assessment or TB screening test, unless the provider determines that they should be offered again.
- The member has a documented, previously positive Interferon-Gamma Release Assays test or has previously tested positive for a latent tuberculosis infection (LTBI).
- The member lacks capacity to consent to the assessment or test and/or consent cannot be obtained from a person legally authorized to make medical decisions on the patient's behalf.
- The member is being treated in the emergency department of a general acute care hospital.

- If a member accepts the offer of the TB screening test and the test is positive, providers are required to offer the member follow-up care or refer the member to a provider who can provide follow-up care.

Skin Test Interpretation

Classification of the tuberculin skin test reaction:

AN INDURATION OF 0 TO 4 MILLIMETERS	AN INDURATION OF 5 TO 9 MILLIMETERS	AN INDURATION OF 10 OR MORE MILLIMETERS
Considered negative (insignificant reaction)	Considered positive for one or more of the following: • HIV-infected persons • close contacts of a person with infectious TB • persons who have abnormal chest radiographs • persons who inject drugs and whose HIV status is unknown	Considered positive (significant reaction)

Tuberculosis Reporting Requirements

Primary care physicians (PCPs) are responsible for reporting to the LHD TB Control Program all confirmed or suspected tuberculosis (TB) cases within one working day of diagnosis. Information reportable to the local health department (LHD) includes:

- member information (name, age, address, home phone number, date of birth, gender, ethnicity, and marital status)
- locating information (employer, work address and phone number)
- disease information (disease diagnosed, date of onset, symptoms, laboratory results, and prescribed medications)

Reports to the local TB Control Program must be made using the Tuberculosis Suspect Case Report form.

In addition, suspected and confirmed cases of TB must also be reported as a communicable disease within one day of diagnosis to the Communicable Disease Report Division of the Local Health Department. This report must be made using the Confidential Morbidity Report form (PDF). Refer to Tuberculosis Reporting and Cases Management in the Communicable Disease Reporting discussion in Compliance and Regulations for specific information.

Documentation of the report to the LHD must be included in the member's medical record. Any necessary medical information must be provided to the LHD for members receiving direct observation therapy (DOT) services.

PCPs are required to collaborate with the local TB Control Program on treatment plans for members and promptly submit treatment plans to the local TB Control Program office with updates. Until treatment is completed, requests for updates may be monthly, unless otherwise determined by the local TB Control program office. The local TB Control Program office obtains monthly sputum smears and cultures and then reports the results to the PCP until the results become negative. Radiographs may be requested after several months of treatment.

Tuberculosis Skin Testing Protocols

Mantoux tuberculin skin testing is the standard method of identifying persons infected with M. tuberculosis. The Mantoux test must be administered and read by qualified staff. Steps of tuberculin skin testing are as follows:

1. Inject intradermal Mantoux test (i.e., 0.1 ml of 5 TU purified protein derivative [PPD] tuberculin) into the volar or dorsal surface of the forearm.
2. Read the reaction to the test 48 to 72 hours after injection.
3. Measure the area of induration (palpable swelling) around the site of injection.
4. Record the diameter of the indurated area (measured across the forearm) in millimeters.

If the test is positive, a chest radiography must be done. If the chest radiography is negative, consider the person infected. As a positive tuberculosis (TB) test does not necessarily indicate the presence of active TB disease, an individual showing a positive TB test requires further screening with other diagnostic procedures.

Therapy Compliance

Noncompliance is a major problem in tuberculosis (TB) control. A health care professional aware of a nonadherent TB member needs to contact the local TB Control Program office for intervention. The local TB Control Program official then meets with the member to determine why the member is nonadherent and takes necessary action.

Members not receiving direct observation therapy (DOT) should be asked about adherence at routine follow-up visits. Routine pill counts should be taken and urine tests should be used to check for the presence of drug metabolites. If the member's sputum remains positive after two months of treatment, DOT should be considered.

Tracking and Coordination of Care

Health Net's Medi-Cal medical directors confer, as needed, with the local Tuberculosis (TB) Control Program to provide coordination of care and to correct any identified deficiencies. They are available to care managers to assist with proper member management and member compliance problems.

When requested by the primary care physician (PCP) or the Health Net public programs administrator, the Health Net Medi-Cal Health Services Department is available to provide assistance with the coordination of the member's care.

Treatment of Latent Tuberculosis Infection

The following classes of people may be eligible for the treatment of latent tuberculosis infection (LTBI) if they have not received a prior course of antituberculosis (TB) treatment. Before starting treatment for LTBI, clinically active TB must first be excluded. It is essential to obtain a chest radiograph when evaluating a person for TB. Bacteriological studies need to be obtained for all persons with an abnormal chest radiograph.

- TB Class 3 (clinically active TB) - M. tuberculosis cultured (if done), or positive reaction to TB skin test, and clinical or radiographic evidence of current disease
- TB Class 5 (TB suspected) - Diagnosis pending

The definition of a positive tuberculin skin test is as follows:

- induration between 5 mm and 10 mm
  - people known or suspected to have HIV infection
  - contact with someone having an infectious case of TB
  - person with an abnormal chest radiograph, but no evidence of active TB (TB Class IV)
- induration between 10 mm and 15 mm
  - all except those listed above
- induration of 15 mm or more
  - in California, this cutoff is not recognized by public health departments. Tuberculin skin tests are not recommended for those at low risk for TB infection

  Tuberculin skin test conversion is defined as an increase of at least 10 mm of induration from less than 10 mm to 10 mm or more within 24 months from a documented negative to a positive tuberculin skin test.

People in the following categories are to be considered for treatment for LTBI if their tuberculin skin test is positive and they have not previously completed a course of anti-TB treatment:

- those known or suspected to have HIV infection, regardless of age
- those with an abnormal chest radiograph suggestive of TB and classified into ATS Class IV, regardless of age
- close contact with a person having an infectious TB case, regardless of age
- all tuberculin skin test converters, regardless of age

People with the following conditions that have been associated with an increased risk of TB must be started on a treatment for LTBI, regardless of age:

- drug abuse (especially with injecting drug use)
- diabetes mellitus (especially insulin-dependent)
- silicosis
- prolonged corticosteroid therapy

- other immunosuppressive therapy
- cancer of the head and neck
- hematological and reticuloendothelial disease
- end-stage renal disease (ESRD)
- intestinal bypass or gastrectomy
- chronic malabsorption
- low body weight (10% or more under ideal body weight)
- malnutrition and clinical situations associated with rapid weight loss
- persons with positive tuberculin skin test

Close contacts with a tuberculin skin test under 5 mm should receive a chest radiograph and, once clinically active TB is excluded, should start the treatment for LTBI if:

- Circumstances suggest a high probability of infection.
- Evaluation of other contacts with a similar degree of exposure demonstrates a high prevalence of infection.
- The contact is a child (especially if under age four), is infected with HIV or is otherwise immunocompromised.
- For those who are started on a treatment for LTBI with a PPD less than 5 mm, a repeat tuberculin skin test should be performed 8 to 12 weeks after contact with the infectious person has been broken to determine if skin test conversion has occurred. A decision on continuing treatment for LTBI can be made once the result of the repeat skin test is available.

Tuberculosis Control Strategy

Health Net collaborates, communicates and contracts with local health departments (LHDs) in public health coordination, education, referrals, screening, treatment, direct observation therapy (DOT), care management, and related services.

Classification System for TB

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

Class	Type	Description
0	No TB exposure Not infected	No history of exposure. Negative reaction to tuberculin skin test.
1	TB exposure No evidence of infection	History of exposure. Negative reaction to tuberculin skin test.

Class	Type	Description
2	TB infection No TB disease	Positive reaction to tuberculin skin test. Negative bacteriologic studies (if done). No clinical, bacteriological, or radiological evidence of active TB.
3	Current TB disease	Meets current laboratory criteria (for example, a positive culture) or criteria for current clinical case definition.
4	Previous TB disease (not current)	Medical history of TB disease or abnormal but stable. X-ray findings for a person who has a positive reaction to the tuberculin skin test, negative bacteriologic examination (if done), and no clinical or X-ray evidence of current TB disease.
5	TB suspected	Signs and symptoms of TB disease, but evaluation not complete (diagnosis pending).

Direct Observation Therapy for Tuberculosis

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

Direct observation therapy (DOT) services are offered by local health departments (LHDs) to monitor members with clinically active tuberculosis (TB) who have been identified by their primary care physician (PCP) as at risk for potential noncompliance with the treatment regimen. DOT is a measure to ensure adherence to tuberculosis treatment for members at risk for noncompliance in taking medications or who are unable to follow the treatment regimen and to protect the public health. DOT is a process by which a health care worker observes the patient swallowing anti-TB medications. The purpose of DOT is to assure that the entire course of medication is taken in the correct dose, at the correct time and for the complete period of therapy.

DOT services are carved-out under the Health Net Medi-Cal managed care program, but the member remains enrolled with Health Net for the purpose of receiving primary care and services unrelated to DOT.

The responsibility for paying for DOT services for a member enrolled in managed care rests with the LHD rather than the health plan.

WIC

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

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) is a 100 percent federally funded program that provides nutritious food (via prescriptive checks), individual counseling and nutrition education, breastfeeding promotion and support, and referrals to other needed services to at-risk, low-to-moderate income (up to 185 percent of the federal poverty level) women and children up to age 5. The purpose of WIC is to prevent infant mortality, low birth weight and other poor birth outcomes, and to improve the nutrition and health of participants. Primary care physicians (PCPs) inform eligible members of the availability of WIC services during office visits. Refer to the Contacts section in the Provider Library for a listing of WIC office telephone numbers and addresses.

Biochemical Data Collection

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) applicants and participants are required to provide the following information when applying for WIC services:

Category	Type of Certification	Height/Length and Weight	Hemoglobin (Hgb) or Hematocrit (Hct) Test
Women • prenatal • breastfeeding • postpartum (non-breastfeeding)	Enrollment and subsequent certification	• Height/length and weight are required. • Data must be current within 60 days of certification. • Measures are taken in clinic only if not doing so presents a barrier to services. Whenever possible, WIC	• Blood work must be provided within 90 days of certification. Blood work must be specific to category (for example, a postpartum woman provides results of a blood test taken after delivery).

Category	Type of Certification	Height/Length and Weight	Hemoglobin (Hgb) or Hematocrit (Hct) Test
		appointments are rescheduled to allow clients more time to get medical referrals completed by the health care provider.	
Infants under age 9 months	Enrollment	• Height/length and weight are required. • Birth data recorded on birth certificate or medical record may be used for enrollment in the first 60 days after birth. Orally declared birth data is not acceptable. • Measurements are taken at WIC if not otherwise provided.	• Hgb or Hct test is not required.
Infants 9 months and older and children ages 1 to 5	Enrollment	• Height/length and weight are required. • Data must be current within 60 days of enrollment. • Certification period may not be shortened	• Hgb or Hct testing is required. • Blood work must be provided within 90 days of enrollment.

Category	Type of Certification	Height/Length and Weight	Hemoglobin (Hgb) or Hematocrit (Hct) Test
		based on the date of anthropometric data. • Measurements are taken in clinic if not otherwise obtainable.	• Certification periods may not be shortened based on the date of biochemical data.
Children ages 1 to 5	Subsequent certification	• Height/length and weight are required. • Data used for recertification must be current within 60 days of recertification appointment. • Measures are taken in clinic only if not doing so presents a barrier to services. Whenever possible, WIC appointments are rescheduled to allow clients more time to get medical referrals completed by the health care provider.	• Hgb or Hct is required once every 12 months, at a minimum, if Hgb was equal to or greater than 11g/dl or Hct was equal to or greater than 33% at the previous certification. • Data must be presented within 90 days of certification. • Hgb or Hct is required once every six months, if the Hgb was less than 11 g/dl or Hct was less than 33%. • Data used for recertification must be taken during the certification period. If the child's blood values were

Category	Type of Certification	Height/Length and Weight	Hemoglobin (Hgb) or Hematocrit (Hct) Test
			abnormal at the initial certification, and a follow-up blood test was done during the initial certification period, the follow-up blood test may be used for the following recertification.

Identifying Eligible Members

Health Net's Medi-Cal members are eligible for Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) services if they are:

- pregnant
- breastfeeding (up to one year after childbirth)
- non-breastfeeding women up to six months after termination of pregnancy (live birth, still birth, fetal death, or miscarriage)
- children under age 5
- determined by a WIC nutritionist to be at nutritional risk

Medi-Cal members must also:

- Receive regular medical check-ups.
- Meet income guidelines.
- Reside in a local agency's service area.

Medical Documentation

Providers must document Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) referrals in the member's medical record. The documentation can be a copy of the referral in the member's file or notes in the member's file documenting the visit and subsequent referral.

WIC considers findings and recommendations of WIC referrals to be confidential and declines to share information regarding individual referral findings. WIC has agreed to share aggregate data pending clarification regarding confidentiality from the Department of Agriculture. Until clarification is made, primary care physicians

(PCPs) should encourage members to inform PCPs of the outcome of their WIC visits, thereby allowing PCPs to provide appropriate and consistent follow-up and documentation of the outcome of the referral.

County Relations/Service Coordination

The Health Net Medi-Cal County Relations/Service Coordination Department negotiates a memorandum of understanding (MOU) with local Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) agencies to ensure coordination and communication between Health Net and the WIC agency. Health Net's County Relations/Service Coordination administrators also work with WIC agency liaisons to resolve any conflicts that might arise between the WIC agency and a Health Net provider or Health Net.

Referrals to WIC

Primary care physicians (PCPs) are responsible for referring eligible members to Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) programs, providing required documentation with each referral and coordinating follow-up care. On request, Health Net or the subcontractor assists in coordinating the WIC referral, including assistance with appointment scheduling in urgent situations.

Referrals for WIC services must be made on one of the following forms:

- WIC Pediatric Referral form (CDPH-247A) (PDF)
- WIC Referral for Pregnant Woman form (PM247) (PDF)
- WIC Referral for Postpartum/Breastfeeding Woman form (PM247((PDF)
- Completed photocopy of page seven of the Comprehensive Perinatal Services Program (CPSP) Prenatal Combined Assessment/Reassessment
- Physician prescription pad

WIC requires hemoglobin or hematocrit test values at initial enrollment and when participants are recertified. These values are used in assessing eligibility for the WIC program.

WIC Program Services

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) participants receive a packet of food vouchers each month that they can redeem at the local retail market of their choice for supplemental foods, such as milk, eggs, cheese, cereal, and juice, which provide nutrients essential for healthy pregnancies and children. WIC participants attend monthly nutrition and health education classes and receive nutrition counseling from registered dietitians and nutrition program assistants. WIC also refers participants to other health and social service programs. Federal law requires the WIC program to promote and support breastfeeding.

WIC does not provide medical nutrition therapy. This is the primary care physician's (PCP's) responsibility. WIC does, however, provide nutrition counseling consistent with the physician's plan of care.

WIC does not provide medically necessary or medically indicated formulas to participants enrolled in Medi-Cal managed care plans. Such formulas, which are referred to as therapeutic formulas by WIC, are a benefit under the Medi-Cal managed care program. When prescribing a medically necessary/therapeutic formula, providers must request authorization from their participating physician group (PPG) or Health Net.

Quality Improvement

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

This section contains general information on Health Net's quality improvement (QI) programs, procedures and policies.

Select any subject below:

- Disease Management Programs
- Facility Site Review
- Language Assistance Program and Cultural Competency
- Medi-Cal Quality Improvement Programs
- Health Education
- Quality Improvement and Health Equity Transformation Program

Disease Management Programs

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

This section contains general information on Health Net's disease management programs.

Select any subject below:

- Disease Management *Be In Charge* Program

Disease Management *Be In Charge* Program

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

The Disease Management - *Be In Charge!*^{SM} program addresses lifestyle management needs such as exercise*, nutrition, stress*, and weight management; tobacco cessation and puff free pregnancy. Disease Management also provides health coaching for members with asthma, COPD*, diabetes, and heart failure* (HF). The goals of the program are to:

- Improve member knowledge and self-management of these diseases leading to improved quality of life, better functional status and reduced disease complications
- Enhance the effectiveness of care provided to members by:
    - Improving physician knowledge of their assigned members with the identified diagnosis

- Improving physician and member compliance with evidence-based screening and treatment guidelines
- Improving member compliance with evidence-based screening and treatment guidelines through targeted annual mailings, telephonic coaching and interactive voice response (IVR) reminder calls

- Decrease preventable hospitalization and inappropriate emergency room utilization
- Meet the contractual requirements as defined by the Health Net contract with the Department of Health Care Services

Health Net's Disease Management - *Be In Charge!* program follows the NCQA best practice four step model of population identification, stratification, education, and intensive coaching for high-risk members. Services are excluded for members with certain conditions and diagnosis and conditions such as:

- Gestational Diabetes
- High Risk Pregnancy
- Hospice and/or no longer receiving curative care

Identification and Stratification

Data from multiple sources is integrated to identify members who may benefit from disease management. The report used to identify members for disease management includes, but is not limited to:

- Member prioritization report - member screening information and other existing data is included in the Disease Management Prioritization Report, which leverages seven core Disease Management Conditions in combination with the CM implacability model.
- These seven conditions include diabetes, asthma, COPD, heart failure, coronary artery disease (including hypertension and ischemic heart disease), lifestyle (obesity and tobacco use).
- Screening for Depression is part of the Disease Management/Health Coaching initial assessment, and the member is referred to a specialist if an intervention is indicated.

**Adult programs only*

Materials are tailored to the diverse clinical, cultural and linguistic needs of Medi-Cal members.

Member and Practitioner Outreach and Resources

Health Net mails educational materials, an action plan, information about the program, and contact numbers for the Health Net Nurse Advice Line and disease management program to members enrolled in the Disease Management - *Be In Charge!* program. Health Net conducts outbound telephonic interventions and referrals to complex case management for members identified as being at high risk for hospitalizations or poor outcomes. Members also have access to the Health Net Health Education Department. Providers can also refer a member for complex case management by using the Care Management Referral Fax Form – Medi-Cal (PDF), Care Management Referral Fax Form – Community Health Plan of Imperial Valley (PDF) or Care Management Referral Fax Form – CalViva Health (PDF) members.

Twice a year, Health Net sends primary care physicians (PCPs) lists of their Health Net, Community Health Plan of Imperial Valley or CalViva Health members enrolled in the disease management program and each member's risk category following identification and stratification activities.

Providers should contact the Health Net Health Education Department when referring members who have asthma, diabetes or heart failure, and are not currently in the program. Members may also self-refer into the program or may opt out of this program at any time by contacting the Health Education Department.

Coordination with California Children's Services

For Medi-Cal members with diabetes under age 21, all related diabetes care, including medications and case management services, is arranged by California Children's Services (CCS). Health Net's health assessment coordinators and utilization management nursing staff work with providers and members to make sure that appropriate CCS referrals are made for all type 1 and type 2 diabetic members. CCS has its own network of providers. To access case management services and obtain authorization for services, providers must submit a Service Authorization Request (SAR) to the county CCS program. Diabetic members under age 21 are not included in Health Net's disease management program.

Coordination with California Children's Services

Medi-Cal members under age 21 with a chronic pulmonary condition that causes significant reduction of lung volume or anatomical morphology, such as bilateral pulmonary dysplasia, receive care arranged by CCS. The care includes medications and case management services through CCS' network of providers. Members with asthma under age five are not included in the Disease Management - *Be In Charge!* program.

Facility Site Review

Provider Type: Physicians | Participating Physician Groups (PPG)

Prior to enrolling Medi-Cal beneficiaries with a primary care physician (PCP), the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS) require Health Net to perform a facility site review (FSR) as part of the initial credentialing process. Re-audits are conducted at least every three years as part of the recredentialing process. DHCS reviews the results of Health Net's site reviews and may also audit a random sample of provider offices to ensure they meet DHCS standards.

In an effort to decrease duplicative FSRs and minimize the disruption of member care at provider offices, Health Net and all other managed care health plans are required to collaborate in conducting FSRs. On a county-by-county basis, the plans cooperatively determine which plan is responsible for performing a single audit of a PCP and administering a corrective action plan (CAP) when necessary. The responsible plan shares the audit results and CAP with the other participating health plans.

Scope of the Review

Health Net conducts PCP office facility site reviews and medical record reviews using the DHCS Managed Care Quality and Monitoring Division (MCQMD) tools and standards and other Health Net resource materials. Refer to the following samples:

- Facility Site Review Tool (PDF)
- Facility Site Review (FSR) Standards (PDF).
- Medical Record Review Tool (PDF).
- Medical Record Review (MRR) Standards (PDF).
- Facility Site & Medical Record Review Preparation List – Health Net (PDF).
- Facility Site & Medical Record Review Preparation List – CalViva Health (PDF).
- Facility Site & Medical Record Review Preparation List – Community Health Plan of Imperial Valley (PDF).

Refer to definition of facility site review for more information.

Reference and Training Materials

Health Net offers the following reference and training materials to help PCPs and their office staff prepare for office site visits:

Tab #	Attachments:	Medi-Cal Facility Site Criteria Policy and Procedures & Forms
		Provider Policy Adoption Form
		Access/Safety (Section 1)
1.		**Site Accessibility by Individuals with Physical Disabilities Policy & Procedure (PDF)**
2.		**Clean and Sanitary Environment Policy & Procedure (PDF)**
	2a.	Office Cleaning Schedule (PDF)
	2b.	Office Cleaning Log/Schedule Year (PDF)
3.		**Fire Safety and Prevention and Emergency Non-Medical Procedures Policy & Procedure (PDF)**

Tab #	Attachments:	Medi-Cal Facility Site Criteria Policy and Procedures & Forms
	3a.	Workplace Violence Protocol (PDF)
	3b.	Emergency Earthquake Plan (PDF)
	3c.	Emergency Fire Plan (PDF)
	3d.	Sample Site Evacuation Plan (PDF)
4.		**Medical and Lab Equipment Maintenance Policy & Procedure (PDF)**
5.		**Emergency Health Care Services Policy & Procedure (PDF)**
	5a.	Emergency Medication Dosage Chart (Sample A) (PDF) Emergency Medications Dosage Chart (Sample B) (PDF)
	5b.	Emergency Protocol (PDF)
	5c.	Emergency Equipment and Medication Replacement Log (Sample) (PDF)
	5d.	Emergency Supplies Inventory Checklist (PDF)

Tab #	Attachments:	Medi-Cal Facility Site Criteria Policy and Procedures & Forms
	5e.	Emergency Medication and Laboratory Supplies Inventory Checklist (PDF)
		Personnel (Section 2)
6.		**Staff Qualifications Policy & Procedure (PDF)**
	6a.	Medical Board of California Notice to Consumers re: Medical Doctors (English) (PDF) Medical Board of California Notice to Consumers re: Medical Doctors (Spanish) (PDF) Medical Board of California Notice to Consumers re: Medical Doctors (Chinese) (PDF)
	6b.	Notice to Consumers re: Physician Assistants Licensure (PDF)
7.		**Non-Physician Medical Practitioners Policy & Procedure (PDF)**
	7a.	Delegation of Services Agreement - Physician Assistants (PDF)
	7b.	Supervising PA PAC Document (PDF)

Tab #	Attachments:	Medi-Cal Facility Site Criteria Policy and Procedures & Forms
	7c.	Standardized Procedures Requirements for Nurse Practitioners Practice (PDF)
8.		**Unlicensed Personnel Policy & Procedure (PDF)**
	8a.	Medical Assistant Training Letter (PDF)
	8b.	Medical Assistant Certification (PDF)
	8c.	Medical Assistant Venipuncture Certification (PDF)
9.		**Staff Education Training Policy & Procedure (PDF)**
	9a.	Staff Education Checklist (PDF)
	9b.	Health Net Provider Library Resource – Health Net (PDF) Health Net Provider Library Resource – CalViva Health (PDF) Health Net Provider Library Resource – Community Health Plan of Imperial Valley (PDF)
	9c.	Medi-Cal Member Rights & Responsibilities
	9d.	Disability Rights and Provider Obligations (PDF)

Tab #	Attachments:	Medi-Cal Facility Site Criteria Policy and Procedures & Forms
	9e.	How to Provide Culturally Competent Care for Patients with Disabilities – Health Net (PDF) How to Provide Culturally Competent Care for Patients with Disabilities – CalViva Health (PDF) How to Provide Culturally Competent Care for Patients with Disabilities – Community Health Plan of Imperial Valley (PDF)
	9f.	Achieve Health Equity Through Culturally Competent Care for BIPOC Patients – Health Net (PDF) Achieve Health Equity Through Culturally Competent Care for BIPOC Patients – CalViva Health (PDF) Achieve Health Equity Through Culturally Competent Care for BIPOC Patients – Community Health Plan of Imperial Valley (PDF)
	9g.	Improve Quality and Inclusive Care for LGBTQ+ Patients – Health Net (PDF) Improve Quality and Inclusive Care for LGBTQ+ Patients – CalViva Health (PDF) Improve Quality and Inclusive Care for LGBTQ+ Patients – Community Health Plan of Imperial Valley (PDF)
10.		**Child Abuse Reporting Policy & Procedure (PDF)**

Tab #	Attachments:	Medi-Cal Facility Site Criteria Policy and Procedures & Forms
	10a.	Suspected Child Abuse Report (PDF)
11.		**Elder Abuse Reporting Policy & Procedure (PDF)**
	11a.	Report of Suspected Dependent Adult/Elder Abuse General Instructions and Form (PDF)
12.		**Intimate Partner/Domestic Violence Reporting Policy & Procedure (PDF)**
	12a.	Report of Suspicious Injury Form (PDF)
	12b.	Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings (PDF)
	12c.	Hurt, Insulted, Threatened with Harm and Screamed (HITS) Domestic Violence Screening Tool (PDF)
13.		**Informed Consent and Human Sterilization Consent Policy & Procedure (PDF)**
14.		**Minor's Rights Policy & Procedure (PDF)**

Tab #	Attachments:	Medi-Cal Facility Site Criteria Policy and Procedures & Forms
	14a.	Consent to Treatment of Minor (PDF)
15.		**Prior Authorizations/ Referrals Policy & Procedure (PDF)**
	15a.	Referral Tracking Log (PDF)
		Office Management and Medical Records (Section 3)
16.		**Member Grievances/ Complaints Policy & Procedure (PDF)**
	16a.	Complaint Log (PDF)
.	16b-r.	Member Grievances/ Complaints Forms (Threshold languages): 16b. Member Grievance-Complaint-English (PDF) 16b. Member Grievance/ Complaint-English – CalViva Health (PDF) 16n. Member Grievance/ Complaint Form – Spanish (PDF) 16n. Member Grievance/ Complaint Form – Spanish – CalViva Health (PDF) 16c. Member Grievance/ Complaint – Hmong (PDF)

Tab #	Attachments:	Medi-Cal Facility Site Criteria Policy and Procedures & Forms
		16c. Member Grievance/ Complaint – Hmong – CalViva Health (PDF) 16q. Member Grievance/ Complaint Form – Chinese (PDF) 16e. Member Grievance/ Complaint Form – Arabic (PDF) 16f. Member Grievance/ Complaint Form – Armenian (PDF) 16g. Member Grievance/ Complaint Form – Farsi (PDF) 16h. Member Grievance/ Complaint Form – Hindi (PDF) 16i. Member Grievance/ Complaint Form – Japanese (PDF) 16j. Member Grievance/ Complaint Form – Khmer (PDF) 16k. Member Grievance/ Complaint Form – Korean (PDF) 16l. Member Grievance/ Complaint Form – Laotian (PDF) 16m. Member Grievance/ Complaint Form – Punjabi (PDF) 16m. Member Grievance/ Complaint Form – Punjabi – CalViva Health (PDF)

Tab #	Attachments:	Medi-Cal Facility Site Criteria Policy and Procedures & Forms
		16d. Member Grievance/ Complaint Form – Russian (PDF) 16o. Member Grievance/ Complaint Form – Tagalog (PDF) 16p. Member Grievance/ Complaint Form – Thai (PDF) 16r. Member Grievance/ Complaint Form – Vietnamese (PDF)
17.		**Interpreter Services Policy & Procedure (PDF)**
	17a.	No-Cost Interpreter Services Available 24/7 for Your Patients – Health Net (PDF) No-Cost Interpreter Services Available 24/7 for Your Patients – CalViva Health (PDF) No-Cost Interpreter Services Available 24/7 for Your Patients – Community Health Plan of Imperial Valley (PDF)
	17b.	Health Plan Interpreter Phone Numbers (PDF)
	17c.	Interpreter Services Language Poster – Health Net (PDF) Interpreter Services Language Poster – CalViva Health (PDF) Interpreter Services Language Poster– Community Health Plan of Imperial Valley (PDF)

Tab #	Attachments:	Medi-Cal Facility Site Criteria Policy and Procedures & Forms
	17d.	Interpreter Quality Standards Guidance (PDF)
	17e.	Language Proficiency Assessment Resources (PDF)
18.		**Medical Records Policy & Procedure (PDF)**
	18a.	Advance Health Care Directives Info Sheet for English/Spanish (PDF)
	18b.	Staff Signature Document (PDF)
	18c.	Initial Health Appointment Tip Sheet – Health Net (PDF) Initial Health Appointment Tip Sheet – CalViva Health (PDF) Initial Health Appointment Tip Sheet – Community Health Plan of Imperial Valley (PDF)
	18d.	Pediatric Health Maintenance Checklist (PDF)
	18e.	Pediatric Immunization Schedule (PDF)
	18f.	Pediatric Health Maintenance Periodicity Schedule (PDF)

Tab #	Attachments:	Medi-Cal Facility Site Criteria Policy and Procedures & Forms
	18g.	Adult Health Maintenance Checklist (PDF)
	18h.	Adult Immunization Schedule
	18i.	Adult Vaccine Administration Record (PDF)
	18j.	Adult Health Maintenance Periodicity Schedule (PDF)
	18k	CAIR California's Immunization Registry (PDF)
19.		**Appointments and Patient Recall Policy & Procedure (PDF)**
	19a.	Timely Access to Office Requirements – Health Net (PDF) Timely Access to Office Requirements – CalViva Health (PDF) Timely Access to Office Requirements – Community Health Plan of Imperial Valley (PDF)
20.		**Provision of Services 24 Hours a Day Policy & Procedure (PDF)**
21.		**Triage Policy & Procedure (PDF)**
		Clinical Services (Section 4)

Tab #	Attachments:	Medi-Cal Facility Site Criteria Policy and Procedures & Forms
22.		Laboratory Services Policy & Procedure (PDF)
23.		Pharmaceutical Services Policy & Procedure (PDF)
23a.		Sample Medication Policy, Procedure, and Logs (PDF)
	23b.	CDC - Questions about Multi-dose Vials
	23c.	Controlled Substance Log - Sample Form (PDF)
	23d.	VFC Refrigerator Management Plan (PDF)
	23e.	Refrigerator Temperature Log (Fahrenheit) (PDF)
	23f.	Refrigerator Temperature Log (Celsius) (PDF)
	23g.	Freezer Temperature Log (Fahrenheit) (PDF)
	23h.	Freezer Temperature Log (Celsius) (PDF)
	23i.	Checklist for Safe Vaccine Storage and Handling (PDF)
	23j.	Emergency Response Worksheet (PDF)

Tab #	Attachments:	Medi-Cal Facility Site Criteria Policy and Procedures & Forms
24.		**Radiology Services Policy & Procedure (PDF)**
	24a.	CDPH Notice to Employees (PDF)
	24b.	Dexa Scanner (PDF)
	24c.	Radiologic Health Branch Contact Info (PDF)
		Preventive Services (Section 5)
25.		**Screening and Equipment Policy & Procedure (PDF)**
	25a.	Visual Acuity Screening Tips (PDF)
	25b.	Audiology Form (PDF)
26.		**Health Education Materials Policy & Procedure (PDF)**
	26a.	Health Education Printed Materials Online Order Form
		Infection Control (Section 6)
27.		**Bloodborne Pathogens and Waste Management Policy & Procedure (PDF)**

Tab #	Attachments:	Medi-Cal Facility Site Criteria Policy and Procedures & Forms
	27a.	Blood and Body Fluid Exposure Report Form (PDF)
	27b.	Sharps Injury Log (PDF)
	27c.	Spill Kit Information (PDF)
	27d.	Medical Waste Log Sheet (PDF)
	27e.	Medical Waste Collection Tracking Log (PDF)
28.		**Decontamination of Surfaces Policy & Procedure (PDF)**
	28a-c.	28a. Clorox Product Information (FORM A): Understanding Bleach (PDF) 28b. Clorox Product Information (FORM B): Clorox Regular Bleach (PDF) 28c. Clorox Product Information (FORM C): Ultra Clorox Germicidal Bleach (PDF)
	28d.	FDA Cleared Sterilants and High-Level Disinfection
29.		**Standard and Universal Precautions Policy & Procedure (PDF)**
30.		**Instrument Sterilization Policy & Procedure (PDF)**

Tab #	Attachments:	Medi-Cal Facility Site Criteria Policy and Procedures & Forms
	30a.	Autoclave Maintenance and Run Log (PDF)
	30b.	Equipment Transfer Log for Sterilization (PDF)
	30c.	Cold Sterilization or High Level Disinfection Log (PDF)
		Miscellaneous Resources and Sample Forms (Section 7)
31.		**Autism Screening Tool M-CHAT**
31a.		Standard of Care Guidelines for Childhood Lead Screening (PDF)
31b.		Oral Assessment Documentation and Referral (PDF)
31c.		Oral Health Risk Assessment Tool (PDF)
31d.		Fluoride Varnish (PDF)
31e.		Patient Health Questionnaire for Adolescents (PHQ-A) (PDF)
31f.		Suicide Risk Screening Tools (English/Spanish) (PDF)

Tab #	Attachments:	Medi-Cal Facility Site Criteria Policy and Procedures & Forms
31g.		Improve Postpartum Care – Health Net (PDF) Improve Postpartum Care – CalViva Health (PDF) Improve Postpartum Care – Community Health Plan of Imperial Valley (PDF)
31h.		Edinburgh Perinatal/Postnatal Depression Scale (EPDS) Questionnaire (PDF)
31i.		Cardiac Risk Assessment (English/Spanish) (PDF)
31j.		Pediatric Sudden Cardiac Death Risk Assessment Form (PDF)
31k.		Childhood Immunizations – Health Net (PDF) Childhood Immunizations – CalViva Health (PDF) Childhood Immunizations – Community Health Plan of Imperial Valley (PDF)
31l.		Adverse Childhood Experiences – Health Net (PDF) Adverse Childhood Experiences – CalViva Health (PDF) Adverse Childhood Experiences – Community Health Plan of Imperial Valley (PDF)
32.		Breast Cancer Screening Tip Sheet – Health Net(PDF)

Tab #	Attachments:	Medi-Cal Facility Site Criteria Policy and Procedures & Forms
		Breast Cancer Screening Tip Sheet – CalViva Health (PDF) Breast Cancer Screening Tip Sheet – Community Health Plan of Imperial Valley (PDF)
32a.		Patient Health Questionnaire-9 (PHQ-9) with scoring (PDF)
32b.		Improve Diabetes Management – Health Net (PDF) Improve Diabetes Management – CalViva Health (PDF) Improve Diabetes Management – Community Health Plan of Imperial Valley (PDF)
32c.		Women's Folic Acid (PDF)
32d.		Hepatitis Risk Assessment Tool (PDF)
33e.		Skin Cancer Screening Form (PDF)
32f.		TB Risk Assessment Tool (English/Spanish) (PDF)
33.		**Psychosocial Assessment (PDF)**
33a.		Social Needs Screening Tool (PDF)

Tab #	Attachments:	Medi-Cal Facility Site Criteria Policy and Procedures & Forms
		Preventive Care Sample Physical Exam Forms (Section 8)
		Under 1 month (PDF)
		1 – 2 months (PDF)
		3 – 4 months (PDF)
		5 – 6 months (PDF)
		7 – 9 months (PDF)
		12 – 15 months (PDF)
		16 – 23 months (PDF)
		2 years (PDF)
		2 ½ years (30 months) (PDF)
		3 years (PDF)
		4 – 5 years (PDF)
		6 – 8 years (PDF)
		9 – 12 years (PDF)
		13 – 16 years (PDF)

Tab #	Attachments:	Medi-Cal Facility Site Criteria Policy and Procedures & Forms
		17 – 20 years (PDF)
		21 – 39 years female (PDF)
		21 – 39 years male (PDF)
		40 – 49 years female (PDF)
		40 – 49 years male (PDF)
		50+ years female (PDF)
		50+ years male (PDF)

Additional resources are in the provider library under Topics located in the left navigation bar. Search under Education, Training and Other Materials to support better health outcomes, or find provider notices under Updates and Letters.

Health Net's FSR Compliance Department promotes immunization services that meet the DHCS requirements. Refer to Administration of Immunizations for more resources.

Facility Site Review Scheduling, Frequency, Scoring, and Compliance

Health Net and all other Medi-Cal managed care health plans are required to collaborate in conducting facility site reviews (FSRs). On a county-by-county basis, the plans cooperatively determine which plan is responsible for performing a single audit of a primary care physician (PCP) site. Copies of the FSR and related regulatory requirements are available online at the DHCS website and the All Plan Letter (APL) 22-017 (PDF)or the most current APL.

Representatives from the responsible plan contact the provider office prior to the FSR to discuss audit policies and procedures. A packet containing educational materials to help the office prepare, is provided to the office prior to the site review to enable the provider office to prepare for the site visit. Preliminary office site review findings are communicated at the time of the review. In addition, written results are sent to the provider by the responsible health plan. The Health Net Medi-Cal Facility Site Review Compliance Department is responsible for conducting collaborative review process for Health Net.

An FSR is conducted as part of the credentialing process for new providers. New providers must receive a passing score of at least 80 percent prior to being admitted into the plan's provider network. Facility site review audit results are shared among Medi-Cal managed care plans. Sites receiving a non-passing score on any audit from one plan are considered to have a non-passing score by all other Medi-Cal managed care plans. A medical record review (MRR) is also conducted on new provider offices three to six months following inclusion in the network and assignment of members. The minimum passing score for the MRR is also 80 percent. Like the FSR results, MRR results are also shared and handled uniformly among participating plans.

Cap Submission and Implementation

Providers must correct deficiencies in critical elements within 10 business days following the date of the review. Providers scoring 90 percent or greater on the facility site review are not required to submit a corrective action plan (CAP) unless deficiencies are found in critical elements, including pharmaceutical services or infection control. Providers scoring 89 percent or less are required to submit a CAP. CAPs must be submitted to the plan administering the review within 30 calendar days from the date of the review.

Providers may be re-reviewed in 12 months or sooner, if deemed appropriate to assess compliance with the CAP. New members are not assigned to a PCP who receives a non-passing score until corrections are verified and the CAP is closed.

After the initial audit, participating providers are re-audited at least every three years. A full-scope site audit, which includes both the FSR and MRR, is conducted at this time. Providers must receive a passing score of at least 80 percent on both reviews. Sites receiving a non-passing score from one plan are considered to have a non-passing score by all other Medi-Cal managed care plans. New members are not assigned to a PCP who receives a non-passing score until corrections are verified and the CAP is closed. Providers who do not comply with the CAP within the established time frames are required to be removed from the network per current APL.

Practitioners who do not comply with a CAP or fail to meet threshold scores on a FSR or MRR are forwarded to Health Net's Credentialing Committee for administrative termination. The termination is applicable to the Medi-Cal contracting lines of business and practice locations and remains in effect for three years from the date of the committee's final decision. The provider must undergo an initial site review at the time of reapplication.

Provider sites that score below 80 percent in either the FSR or MRR for two consecutive reviews must score a minimum of 80 percent during the next site review in both the FSR and MRR, including sites with open CAPs in place. Sites that do not score a minimum of 80 percent in the FSR and MRR, despite ongoing monitoring, are removed from the network and members are appropriately reassigned to other providers. Health Net must notify affected members in writing 30 calendar days in advance of any provider terminations.

Health Net re-audits the provider within 12 months if the provider scores below 80 percent on FSR or MRR on a full scope audit.

Sterilization of Instruments

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

This section contains general information and instruction for the sterilization of instruments.

Autoclaves Maintenance and Spore Testing

Autoclaves must be maintained according to the manufacturer's written instructions. The periodic maintenance schedule must be followed by a competent technician to check gauges, steam lines and seals. Reports of these inspections must be maintained by the person responsible for the autoclave.

A log must be maintained for each autoclave load and contain the following (a sample autoclave log (PDF) is available):

- Date, time, steam pressure, and duration of each run
- Dates and results of autoclave calibration
- Results of routine spore testing, at least monthly

Biological control spore ampules must be used to check the effectiveness of sterilization. Biological testing of steam sterilization loads must be conducted monthly. Following the sterilization cycle, the control spore must be incubated according to the manufacturer's recommendations. The results of these tests must be maintained as a permanent record. If a positive result is obtained, the sterilizer must be taken out of service until it is inspected and repaired and the results of retesting are negative.

Cold and Liquid Chemical Sterilization

Instruments must be thoroughly cleaned and dried prior to immersion in the cold sterilization solution. Any organic matter creates a barrier on the instrument against the solution. Wet items dilute the solution.

The cold sterilization solution used must be able to kill HIV, hepatitis B virus and tuberculosis (TB) according to the standards set forth by the Department of Health Care Services (DHCS).

The cold sterilization solution must be used, tested and discarded according to manufacturer's written recommendations. Most cold sterilizing solutions are effective for a specific period of time; therefore, the manufacturer's instructions must be followed when preparing the solution and calculating the expiration date. Testing should be conducted regularly following the manufacturer's recommended frequency.

Use sterile gloves or forceps to remove items from cold sterilization solutions. Instruments must be rinsed thoroughly with sterile distilled water to avoid tissue damage prior to use on a member (refer to sample Cold Sterilization Log (PDF)).

Instrument Sterilization, Preparation and Handling

Instruments must be thoroughly cleaned and dried before they can be wrapped for sterilization. Soiled instruments must be cleaned as soon as possible after use to prevent blood and other substances from drying on the surfaces or in the crevices.

Complete removal of all soil from the serrations and crevices of instruments is required prior to autoclaving

Wrappers and Packaging

Instrument packaging must resist tearing or puncture and should be free of pinholes. It must also be moisture resistant. A wrapper must be flexible and memory free to allow easy aseptic presentation with assurance of no particulate contamination when the package is opened. It must establish a barrier to microorganisms and their vehicles.

If textile wrappers are used, they must be laundered between sterilization exposures to ensure sufficient moisture content in the fibers. All wrappers must be checked for tears and holes before they are used. Wrappers with defects may not be used in the sterilization process.

A chemical indicator strip must be inserted into each package prior to autoclaving (these darken to indicate that the package has been exposed to the physical conditions of an autoclave cycle).

Pressure-sensitive autoclave tape must be used to hold wrappers in place on packages and to indicate that the packages have been exposed to an autoclave cycle.

Every package intended for sterile use should be printed or labeled with the date autoclaved, run number and the contents.

Sterile Package Handling

Sterile packages must be handled with care and as little as possible.

Sterile packages must be stored in clean, dry, dustproof, and vermin-proof areas that are well ventilated. Closed cabinets and drawers are the preferable storage places.

Sterile packages are considered sterile for any length of time unless the packing shows any signs of damage, including, but not limited to, yellowing, brittle packaging, water damage, pin holes, cracks, tears, or any break in the packaging integrity.

If packaging is found to be compromised upon inspection, materials may be repackaged and sterilized for continued storage and use.

Medical Waste Management

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

This section provides guidelines for segregating medical waste from other waste products and establishing proper handling and disposal procedures in accordance with the Medical Waste Management Act, California Health and Safety Code, Division 20, Chapter 6.1.

Health Net recommends segregating medical waste at the point of generation and handling the waste properly using trained staff, protective equipment and good work practices.

Refer to definition of medical waste management materials for additional information.

Administration and Record Keeping

Offices with on-site waste treatment must keep an informational document that states how waste is contained, stored, treated, and disposed. Treatment facility operating records must be kept on-site for three years.

Offices using a hazardous waste hauler for off-site waste treatment must have an informational document that states how waste is contained, stored, treated, and disposed. Records of the quantity and type of waste transported, date transported, and the name of the registered hazardous waste hauler must also be maintained. These tracking documents must be maintained on-site for three years.

A small quantity medical waste generator or parent organization that employs health care professionals who generate medical waste may transport medical waste generated in limited quantities up to 35.2 pounds to the central location of accumulation, provided that all of the following are met:

1. The principal business of the generator is not to transport or treat regulated medical waste.
2. The generator shall adhere to the conditions and requirements set forth in the materials of trade exception, as specified in Section 173.6 of Title 49 of the Code of Federal Regulations.
3. A person transporting medical waste pursuant to this section shall provide a form or log to the receiving facility, and the receiving facility shall maintain the form or log for a period of two years, containing all of the following information:
    - The name of the person transporting the medical waste.
    - The number of containers of medical waste transported.
    - The date the medical waste was transported.

A generator transporting medical waste pursuant to this section must not be regulated as a hazardous waste hauler pursuant to Section 117660.

Containment and Storage of Medical Waste

When storing medical waste, the following guidelines must be observed:

1. Contain medical waste separately from other waste at the point of origin.
2. Contain biohazardous waste in a biohazard bag conspicuously labeled with the words "BIOHAZARDOUS WASTE" or with the international biohazard symbol and the word "BIOHAZARD."
3. Sharps containers must be rigid and puncture and leak resistant when sealed, cannot be reopened without great difficulty, and properly labeled.
4. No bagged medical waste is to be removed from the bags.

When containing biohazardous waste in a biohazard bag, the following steps must be taken:

1. Tie bags to prevent leakage or expulsion of contents during all future storage, handling or transport.
2. Place biohazardous bags in a rigid or disposable container for storage, handling or transport. The containers must be:
    1. leak-resistant and fitted with tight covers
    2. sanitary and in good repair
    3. labeled with the words "BIOHAZARDOUS WASTE" or with the international biohazard symbol and the word "BIOHAZARD" on the lid and sides so as to be visible from any lateral direction
    4. washed and decontaminated each time they are emptied. Approved methods of decontamination include:
        1. exposure to hot water at 180 degrees F for a minimum of 15 seconds

2. rinsing or immersing in Hypochlorite solution (500 ppm available chlorine), phenolic solution (500 ppm active agent), iodoform solution (100 ppm available iodine), or quaternary ammonium solution (400 ppm active agent) for a minimum of three minutes

When containerizing sharps, take the following steps:

1. Place all sharps into a Sharps container.
2. Tape closed or tighten the lid of the full sharps containers to prevent spills and prepare for disposal.
3. Label sharps containers with the words "SHARPS WASTE," the international biohazard symbol and the word "BIOHAZARD."

Storage enclosures must be clean and orderly, secured to deny access to unauthorized persons and posted with a warning sign stating "CAUTION - BIOHAZARDOUS WASTE STORAGE AREA - UNAUTHORIZED PERSONS KEEP OUT," and, "CUIDADO - ZONA DE RESIDUOS - BIOLOGICOS PELIGROSOS - PROHIBIDA LA ENTRADA A PERSONAS NO AUTORIZADAS."

Handling and Treatment

Staff handling medical waste must wear the correct type of personal protective equipment (for example, gloves, goggles and lab coats).

Trash chutes, laundry chutes, compactors, and grinders must not be used to transfer or process untreated medical waste.

Recognizable human anatomical remains must be incinerated or buried (teeth are exempt).

Medical Waste Hauling

In accordance with the Department of Health Care Services (DHCS) facility site inspection requirements, providers must have a medical waste management hauler contract.

On-Site Waste Treatment Operating Procedures

Any facility planning to treat medical waste on-site using an autoclave, incinerator or microwave technology must obtain a permit from the local enforcement agency prior to commencing operations. Treated medical waste becomes solid waste and is no longer hazardous. An emergency action plan must be in place at locations where medical waste is being treated.

Any facility treating medical waste on-site using autoclaves or similar forms of sterilization must adhere to the following guidelines:

1. Follow standard written operating procedures for each steam sterilizer, including time, temperature, pressure, type of waste, type of container, pattern of loading, water content, closure on containers, and maximum leak quantity.
2. Check recording or indicating thermometers during each complete cycle to ensure 250 degrees F (121 degrees C) for 30 minutes or longer. Check thermometers for calibration at least annually. Operating parameters for each autoclave load must be documented.

3. Use heat-sensitive tape or other device for each container that is processed to indicate attainment of adequate sterilization conditions.
4. Use bacillus stearothermophilus placed at the center of a load processed under standard operating conditions at least once a month to check adequate sterilization.
5. Maintain records of procedures specified in one, two and four for a period of not less than three years.

Storage Time

Biohazardous waste less than 20 pounds may be stored on-site for up to 30 days above 0 degrees C or up to 90 days below 0 degrees C in a non-member secured area. Full Sharps containers ready for disposal and any biohazardous waste of 20 pounds or more may be stored on-site for up to seven days (longer storage times may be requested from the local enforcement agency). Biohazardous waste stored inside an office must be picked up by a licensed waste hauler every seven days.

Licensing Requirements for Equipment, Facility and Staff

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

Equipment

Equipment must be licensed or registered as required by law. X-ray equipment must be registered must have a current physicist's report. Equipment must be maintained as recommended by the manufacturer and receive maintenance as the manufacturer requires. Equipment must be calibrated according to manufacturing guidelines. All maintenance activities must be documented (refer to Equipment Calibration Log (PDF)).

Facility

Facilities must be licensed in accordance with all applicable codes and regulations. X-ray and laboratory licenses are included in this requirement. If X-rays are performed in the office, there must be a supervising physician's certificate.

Safety procedures must be available in the provider's office. Refer to the Safety discussion for more information.

Staff

The following are licensing requirements for office staff:

1. Staff for whom licensure is required must have a valid, current license verified by the employer or facility. The facility must maintain a method of tracking expiration of staff licenses.
2. All individuals delivering emergency care need to be skilled in use of the equipment and knowledgeable about the treatment procedures employed. Documentation should be maintained regarding training in emergency procedures and equipment use.
3. Nurse practitioners (NPs) are to practice under standard procedures signed by the supervising physician.
4. Physician assistants (PAs) should practice under written guidelines signed by the PA and the supervising physician.
5. Registered nurses (RNs), certified medical assistants (CMAs) and licensed vocational nurses (LVNs), must provide a copy of their license, certification or training certificate.
6. Medical assistants must be trained and certified in accordance with California Business and Professions Code sections 2069-2070 (16 CCR, 1366-1366.1).

Providers must have job descriptions for their staff that include qualifications and duties for each licensed and non-licensed category.

Health Net makes template policies and procedures, including Staff Qualifications (PDF), Non-Physician Medical Practitioners (PDF), and Notice to Consumers (physicians assistance (PDF), physicians (PDF)) available for practitioners' use.

Safety

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

Health Net requires that all facilities serving Medi-Cal and Cal MediConnect members strictly adhere to all regulatory agency rules and regulations regarding fire and safety. Each facility must have evidence of being fire safe as evidenced by the fire department and state fire marshal's office.

Facility Responsibilities

Supervisors or designated staff are responsible for ensuring that emergency and fire protection policies and procedures are adhered to within their areas of responsibility and that fire hazards are reported and eliminated. Evacuation routes must be clearly posted and all telephones should be marked with emergency numbers.

Monthly inspections of fire extinguishers must be performed by supervisors or designated staff and a log documenting the inspections maintained. Records of fire inspections must also be maintained.

Fire Safety Training

All new employees must be trained in facility-specific fire safety measures. A set of fire safety procedures must be issued to, read and signed by the employees, indicating their understanding of the procedures. A log documenting this training is to be kept.

Employee Responsibilities

Employees are responsible for reporting the following potential fire hazards:

1. defective or inoperable emergency equipment (for example, fire extinguishers and blocked emergency exits)
2. housekeeping hazards (over-accumulation of trash, rags and other combustibles)
3. defective heat-producing equipment (for example, malfunctioning heaters, furnaces or ovens)
4. misuse or mishandling of biohazardous materials
5. electrical hazards (for example, exposed wires on appliances)

Outside Agency Responsibilities

Local fire department representatives perform periodic inspections to ensure compliance with codes and regulations. Copies of deficiency and hazard reports are forwarded to the facility manager. Maintenance of portable fire extinguishers is performed by contractors licensed by the California state fire marshal.

Fire Emergency Procedures

Whenever a fire occurs that could result in a threat to life or property, immediately call the fire department (911) and notify the designated department in the facility.

Consult the provider facility's building management staff and follow the prescribed reporting sequence:

- Remove yourself and others in any immediate danger.
- Call the fire department or facility response team or pull alarm as specified in the facility.
- Close doors in the fire area.
- Evacuate in accordance with the facility evacuation plan.

General Fire Safety Regulations

The following safety regulations must be followed at all times:

1. Smoking is prohibited in work and common areas as designated by California and local laws, wherever an area is posted as a non-smoking area, and within 25 feet of any flammable materials storage area.
2. Corridors, passageways, roadways, stairways, and any walkways leading to and from an exit must remain clear and free of any obstructions.
3. The minimum width of an exit aisle is 28 inches.
4. A minimum clear space of 36 inches and clear access must be maintained around sprinkler system control valves, fire alarm devices, fire ladders, fire hose stations, extinguishers, and electrical switch boxes and panels.
5. Fire doors must be kept closed at all times.
6. Combustible waste or refuse must be properly stored or disposed of to prevent unsafe conditions.

7. Use of sawdust or similar combustible materials to soak up combustible or flammable liquids spilled or dropped from machinery or processes on any floor is prohibited.
8. A minimum clearance of 18 inches must be maintained between the top of stored materials and sprinkler deflectors.

Storage of Flammable and Combustible Liquids

Flammable and combustible liquids must be stored in accordance with the following:

1. Flammable and combustible liquids must be contained in Underwriter's Laboratory (UL) approved containers and properly labeled, and the date of purchase must be indicated on the container face.
2. Flammable and combustible liquids must be kept in approved storage cabinets marked "FLAMMABLE - KEEP FIRE AWAY." Up to 60 gallons of Class I and Class II flammable or combustible liquids may be stored in storage cabinets UL approved for flammable liquids.
3. Containers of flammable liquids must not be stored near steam coils or any other source of heat.
4. Stored liquids must not physically obstruct an exit.
5. Minimum aisle width of three feet must be maintained wherever flammable materials are stored.

Flammable and combustible liquids must not be stored with incompatible materials, such as acids and alkalis or with any material that reacts violently with water.

Electrical Appliances

All electrical appliances must bear the Underwriter's Laboratory (UL) or Factory Mutual (FM) approval. Further, all electrical equipment must be turned off or disconnected at the end of shift unless directed otherwise by the manufacturer.

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).

Health Education

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

This section contains general information about health education services.

Health Education Materials

Information for Medi-Cal members must be provided at a 6th-grade (or lower) reading level and must be in an easy-to-read format. Health Net health education brochures and fact sheets for Medi-Cal members are written at this level. Diverse cultural backgrounds are taken into consideration when these materials are created and translated. The Health Net Health Equity Department reviews these materials for accuracy of translation, cultural content and reading level.

Providers are required to have educational materials available in approved threshold languages. Health Net evaluates member materials with the assistance of experts, community advisory committees, focus groups, and individual and group interviews. For information on threshold language requirements, refer to Access to Care requirements under Compliance and Regulations.

Health Net health education printed materials may be ordered by by completing the online order form.

Health Education Program and Requirements

Some participating physician groups (PPGs) provide additional health education services for members.

Medi-Cal providers must provide health education materials, services and resources in approved threshold languages and at no cost to Health Net members. Subject matter should address the needs of the general membership population. Information on the following subjects must be available:

- Age-specific anticipatory guidance (Medi-Cal only) - Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- Alcohol and drug use
- Appropriate use of health care services
- Asthma
- Complementary and alternative care
- Dental health
- Diabetes
- Exercise
- Family planning
- Health education services
- HIV and sexually transmitted infection (STI) prevention
- Hypertension
- Immunizations
- Injury prevention
- Managed health care
- Nutrition, weight control and physical activity
- Obstetrical care
- Parenting
- Perinatal health
- Preventive and primary health care
- Risk reduction and healthy lifestyles
- Substance abuse
- Tobacco prevention and cessation
- Tuberculosis (TB)

- Unintended pregnancy prevention

The Health Net Health Education Department offers no-cost informational materials, programs and other services on a variety of topics to promote healthy lifestyles and health improvement to Health Net members.

Health Net members and providers may call the Health Net Medi-Cal Health Education Department to request educational materials in different languages, information about health education programs available through Health Net, community and national health education programs and services, and to obtain toll-free health information phone numbers.

Program Monitoring

Providers are responsible for documenting health education referrals and provision of health education materials in the member's medical record. Health Net uses the following methods to monitor and assess the quality of preventive care and health education services offered by providers and participating physician groups (PPGs):

- Primary care facility site reviews conducted for new providers applying to Health Net to become Medi-Cal managed care providers and recertification reviews conducted for continuing providers.
- Health education program evaluations conducted through member satisfaction surveys as a follow-up to health education material requests and program and class referrals and participation.
- Healthcare Effectiveness Data and Information Set (HEDIS®) measures and focused review studies.

Resources Available to Providers

Health Net provides education to primary care physicians (PCPs) and participating physician groups (PPGs) on Health Net's health education programs and services through the following methods:

- On-site provider education visits - Conducted by Health Net health promotion consultants and the Health Net Facility Site Review (FSR) Compliance Department nurses, these visits focus on the health education resources available to PCPs and are an opportunity for Health Net to distribute the health education resource material and promote preventive care screenings and education.
- Provider Updates - Used to inform providers of new health education policies, programs and services.

Health Net Quality Improvement Department

The Health Net Quality Improvement Department establishes programs to meet the regulatory requirements of the Centers for Medicare and MediCaid Services (CMS), Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC). These programs include clinical and service quality improvement activities, Healthcare Effectiveness Data and Information Set (HEDIS®) performance measures, member satisfaction and access surveys, Medi-Cal facility site certification, and medical record audits, along with any necessary follow-up quality action plans. This department monitors the results of quality improvement (QI) activities to quantify baseline data, identify opportunities for improvement, develop strong interventions to improve performance, and conduct re-measurements to evaluate effectiveness. The department is also

responsible for preparation and implementation of any identified corrective actions based on findings of the CMS, DHCS and DMHC audits and findings identified through quarterly CMS, DHCS and DMHC reviews.

The department is staffed by quality improvement specialists (QIS') who are responsible for ensuring compliance with DHCS standards for facility reviews, medical record audits and quality action plans. The QIS' are responsible for incorporating new accreditation and regulatory standards and implementing new programs to meet those standards. In addition, a QI program manager is responsible for ensuring compliance with all CMS, DHCS and DMHC access to care standards, monitoring processes and access to care action plans.

For more information, select any subject below:

- Health Education Program, Services and Resources
- CalViva Health Education Program, Services and Resources
- Molina
- Tobacco Cessation Program

Health Education Program, Services and Resources

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

The following interventions and resources are available at no cost to Medi-Cal members. Members and providers may obtain more information by contacting the Medi-Cal Member Services Department (Health Net, Community Health Plan of Imperial Valley or CalViva Health) or following the links below. Members are directed to the appropriate service or resource based on their needs. Telephonic and website-based services are available 24/7. Print educational resources are sent to members within four weeks of request.

- Healthy Pregnancy – Pregnant members receive educational resources to help them achieve a successful pregnancy and healthy baby. Educational resources include materials on monitoring the baby's movement, and handbooks on planning a healthy pregnancy, caring for your baby, and teen parenting. High risk pregnancies receive additional case management services.
- Tobacco cessation program – Kick It California (formerly California Smokers' Helpline) is a no-cost, state-wide quit smoking and vaping program for members ages 13 years and older. The program is based on clinical research and proven to help you quit. Kick It California offers:

Telephonic quit coach:

- Customized one-on-one coaching with a quit coach over the phone in six languages (English, Spanish, Cantonese, Mandarin, Korean and Vietnamese).
- Tailored quit plan to member’s unique circumstances.

- Available Monday–Friday, 7 a.m.–9 p.m., and Saturday 9 a.m.–5 p.m.
- To enroll, members may use an online web form, or call directly at 800-300-8086 (English) or 800-600-8191 (Spanish).

Automated texting program

- Receive helpful tips at critical points during your quit journey. Quit coaches respond to questions within one business day.
- Text “Quit Smoking” or “Quit Vaping” to 66819.
- Texto “Dejar de Fumar” o “No Vapear” al 66819.

Chat with a quit coach:

- Kickitca.org/chat.
- Alternative option for both members and heath care providers.
- Platform allows members quick responses to inquiries such as available services and free nicotine patch evaluation.
- Health care providers may use the chat to find answers to cessation-related questions. Available in English only, Monday–Friday, 7 a.m.–9 p.m., and Saturday 9 a.m.–5 p.m.

Mobile app:

- Kick It Quit Smoking/Vaping app designed to help people quit smoking and vaping.
- Features tools such as personal log of smoking triggers, motivational reminders and links to helpful resources.
- Available for download on the App Store® and Google Play®.
- Visit Kick It California for more details.

Diabetes Prevention Program – Eligible members ages 18 and older with prediabetes can participate in a year-long evidence-based, lifestyle change program. The program promotes and emphasizes weight loss through exercise, healthy eating and behavior modification. It is designed to assist Medi-Cal members in preventing or delaying the onset of type 2 diabetes.

- Digital Health Education: Members have access to online and digital resources for health education through our Krames Staywell Health Library – Resource library to help you learn about your health and how to stay healthy.
    - Health and Medications – Easy access to more than 4,000 health sheets.
    - Wellness and Lifestyle Improvements – We have a set of assessments and tools to help you.

- MyStrength Program – Available in English and Spanish, members have access to an evidence-based, self-help resource to improve their mental health. It offers interactive, personalized modules that empower members to help manage their depression, anxiety, stress, substance use, pain, sleep problems and many other mental health conditions. This program is available for Health Net Medi-Cal and CalViva Health or through the myStrength mobile app.
- Health Promotion Incentive Programs – Health Education partners with the Quality Improvement department to develop, implement and evaluate incentive programs to encourage members to receive health education and to access preventive health care services.
- Community Health Education Classes – Free classes are offered to members and the community. Classes are available in various languages. Topics vary by county and are determined by the community's needs.
- Community Health Fairs – The Plan participates in health fairs and community events to promote health awareness to members and the community. Plan representatives provide screenings, presentations and/or health education materials at these events.

The following resources are available to members:

- Health Education Resources – Members or the parents of youth members may order health education materials on a wide range of topics, such as asthma, healthy eating, diabetes,

immunizations, dental care, prenatal care, exercise and more. These materials are available in several threshold languages.
- Health Education Material Order Form – Members can request health education resources by contacting the Medi-Cal Member Services Department (Health Net, Community Health Plan of Imperial Valley or CalViva Health). They can also get Plan-print resources at contracted provider offices and health education classes.
- Health Education Programs and Services Flyer – This flyer contains information on all health education interventions offered to members and information on how to access them.
- Preventive Screening Guidelines – The guidelines are provided to inform members of health screening and immunization schedules for all ages. These are available in all 12 threshold languages. They are mailed to new members and are also available online.
- Member Newsletter – Plan news is mailed to member's regularly and covers various health topics with the most up-to-date information on health education interventions.

The following resources are available to providers:

- Pediatric and Adolescent Overweight Assessment and Management Guidelines – Adapted from the Child and Adolescent Obesity Provider Toolkit produced by the California Medical Association (CMA) Foundation, the downloadable Pediatric and Adolescent Overweight Management Guidelines (PDF) flip chart gives providers practical, point-of-care guidance on the prevention and treatment of overweight and obesity. Additionally, it outlines new requirements related to the use of World Health Organization (WHO) growth charts for children under age 2.
- Body Mass Index (BMI) Training – Commonly used as a refresher course, Health Net's BMI in-person training provides participants with an in-depth review on calculating height, weight and BMI percentile. A cultural awareness segment is also included to introduce staff to communication practices within diverse populations.
- Health Education Material Order Form – Providers can request printed health education materials by using the Health Education Material Order Form found online.

A number of resources are available via the Internet to help physicians calculate BMI, determine percentiles and obtain additional information and tools regarding obesity in children and adults:

- The Centers for Disease Control and Prevention's (CDC's) National Center for Chronic Disease Prevention and Health Promotion BMI web page includes a BMI calculator, information on BMI specific for children and teens and links to the CDC's growth charts and training modules.
- The CDC's website provides the downloadable BMI-for-age clinical growth charts.
- The National Heart, Lung, and Blood Institute offers healthy weight assessment tools and health professional resources.
- The online training modules developed by the CDC and the U.S. Health and Human Services Maternal and Child Health Bureau (MCHB) teach how to use and interpret the CDC growth charts.

CalViva Health Education Program, Services and Resources

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

The following information applies to Fresno, Kings and Madera counties only.

The following interventions and resources are available at no cost to CalViva Health Medi-Cal members through self-referral or a referral from their primary care physician (PCP). Members and providers may obtain more information by contacting the toll-free CalViva Health Member Services Department. Members are directed to the appropriate service or resource based on their needs. Telephonic and website based services are available 24/7.

- Pregnancy Program - Pregnant members receive educational resources to help them achieve a successful pregnancy and healthy baby. Educational resources include materials on monitoring the baby's movement and handbooks on planning a healthy pregnancy and caring for your baby. High risk pregnancies receive additional case management services.
- Tobacco Cessation Program – Kick It California (formerly known as the California Smokers' Helpline is a no-cost, stop smoking and vaping program for members of all ages. This program can double one's chance of quitting for good. Kick It California offers:

Telephonic quit coach

- Customized one-on-one coaching with a quit coach over the phone in 6 languages (English, Spanish, Cantonese, Mandarin, Korean and Vietnamese).
- Tailored quit plan to member's unique circumstances.
- Available Monday–Friday, 7 a.m.–9 p.m., and Saturday 9 a.m.–5 p.m.
- To enroll, members may use an online web form, or call directly at 800-300-8086 (English) or 800-600-8191 (Spanish).

Automated Texting Program

- Receive helpful tips at critical points during your quit journey. Quit coaches respond to questions within one business day.
- Text "Quit Smoking" or "Quit Vaping" to 66819.
- Texto "Dejar de Fumar" o "No Vapear" al 66819.

Chat with a quit coach:

- Kickitca.org/chat
- Alternative option for both members and heath care providers.
- Platform allows members quick responses to inquiries such as available services free nicotine patch evaluation.
- Health care providers may use the chat to find answers to cessation-related questions.
- Available in English only, Monday–Friday, 7 a.m.–9 p.m., and Saturday 9 a.m.–5 p.m.

Mobile apps

- Kick It Quit Smoking/Vaping apps designed to help people quit smoking and vaping.
- Features tools such as personal log of smoking triggers, motivational reminders and links to helpful resources.
- Available for download on the App Store® and Google Play®.
- Visit Kick It California for more details.

- Diabetes Prevention Program - Eligible members ages 18 and older with prediabetes can participate in a year-long evidence-based, lifestyle change program. The program promotes and emphasizes weight loss through exercise, healthy eating and behavior modification. It is designed to assist Medi-Cal members in preventing or delaying the onset of type 2 diabetes.

- High Blood Pressure and Heart Health – Members have access to resources to guide them in lowering their blood pressure and having better heart health.

- Digital Health Education – Members have access to online and digital resources for health education through our Krames Staywell Health Library – Resource Library to help them learn about their health and how to stay healthy.
    - Health and Medications– Easy access to more than 4,000 health sheets.
    - Wellness and Lifestyles Improvements – We have a set of assessments and tools to help them.

- MyStrength Program: Available in English and Spanish, members have access to an evidence-based, self-help resource to improve their mental health. It offers interactive, personalized modules that empower members to help manage their depression, anxiety, stress, substance use, pain, sleep problems and many other mental health conditions. This program is available at MyStrength Program or through the myStrength mobile app.

- Health Promotion Incentive Programs - Health Education partners with the Quality Improvement department to develop, implement and evaluate incentive programs to encourage members to receive health education and to access preventive health care services.
- Community Health Education Classes - Free classes are offered to members and the community. Classes are available in various languages. Topics vary by county and are determined by the community's needs.
- Community Health Fairs - CalViva Health participates in health fairs and community events to promote health awareness to members and the community. CalViva Health representatives provide, presentations, and/or health education materials at these events.

The following resources are available to members:

- Health Education Resources - Members or the parents of youth members may order health education materials on a wide range of topics, such as asthma, healthy eating, diabetes, immunizations, baby bottle-induced tooth decay, prenatal care, exercise and more. These materials are available in threshold languages.
- Health Education Programs and Services Flyer - This flyer contains information on all health education interventions offered to members and information on how to access them.
- Preventive Screening Guidelines - The guidelines are provided to inform members of health screening and immunization schedules for all ages. These are available in threshold languages. They are mailed to new members and are also available on www.CalvivaHealth.org.
- Member Newsletter - CalViva Health News is mailed to members regularly and covers various health topics and the most up-to-date information on health education interventions.

The following resources are available to providers:

- Pediatric and Adolescent Overweight Assessment and Management Guidelines - Adapted from the Child and Adolescent Obesity Provider Toolkit produced by the California Medical Association (CMA) Foundation, CalViva Health's Pediatric and Adolescent Overweight Management Guidelines (PDF) flip chart gives providers practical, point-of-care guidance on the prevention and treatment of overweight and obesity. Additionally, it outlines new requirements related to the use of World Health Organization (WHO) growth charts for children under age two

A number of resources are available via the Internet to help physicians calculate body mass index (BMI), determine percentiles and obtain additional information and tools regarding obesity in children and adults:

- www.cdc.gov/nccdphp/dnpa/bmi - The Centers for Disease Control and Prevention's (CDC's) National Center for Chronic Disease Prevention and Health Promotion BMI Web page includes a BMI calculator, information on BMI specific for children and teens and links to the CDC's growth charts and training modules
- www.cdc.gov/growthcharts - The CDC's website provides the downloadable BMI-for-age clinical growth charts
- https://www.nhlbi.nih.gov/health/educational/lose_wt/ - The National Heart, Lung, and Blood Institute offers healthy weight assessment tools and health professional resources.
- www.depts.washington.edu/growth - The online training modules developed by the CDC and the U.S. Health and Human Services Maternal and Child Health Bureau (MCHB) teach how to use and interpret the CDC growth charts.

Molina

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

The following information applies to Los Angeles County only.

Health Net and its subcontracting health plan, Molina Healthcare (in Los Angeles County only), offer health education programs, services and information sources for members.

Providers participating through Molina must use the health education resources offered through their affiliated plan.

Health Education Services

Molina Healthcare (MHC) delegates the provision of health education services to independent physician association (IPA) affiliated medical groups under the Medi-Cal managed care contract. Molina also supports all participating providers, by offering the following:

- Health education member information materials written in many languages that are culturally appropriate for various target populations in key subject areas. The most appropriate setting for a member to receive written literature is from their primary care physician (PCP) with a brief discussion. Participating physicians may download or print health education materials from the Molina provider website at www.molinahealthcare.com/providers/ca/medicaid/comm/Pages/Health-Education-Materials.aspx.
- For more information, contact MHC Health Education. Materials in alternate formats, including large font of at least 18-point print, braille or audio, should be offered for MHC Seniors and Persons with Disabilities (SPD) members with low vision or who are blind. Participating providers may request materials in alternative formats, by contacting the MHC Member Services Department.

Interpreter Services

Molina Healthcare offers members with limited English proficiency 24-hour access to qualified interpreter services at no cost. Molina also provides sign language interpreters for members who are deaf or hard of hearing.

- Providers or members can contact Interpreter Services, Monday-Friday, 24 hours a day, seven days a week. Sign language interpreters may require at least five business days' notice.
- For after hours and weekends, contact Molina's Nurse Advice Line (English or Spanish available).
- To speak to members who are deaf, hard of hearing, or have a speech difficulty on the telephone, providers may use the California Relay Service, dial 711 and give the relay operator (RO)/ communication assistant (CA) the member's area code and telephone number. The RO/CA will connect and communicate via the member's preferred type of communication (TTY, VCO, Internet, or ASCII).

Tobacco Cessation Program

Provider Type: Physicians | Participating Physician Groups (PPG)

Kick It California (formerly California Smokers' Helpline) is a tobacco cessation program available to Health Net, Community Health Plan of Imperial Valley and CalViva Health Medi-Cal members. The program offers specialized services for teens, pregnant smokers, individuals who chew tobacco, and e-cigarette users, and extends information on how to help a friend or family member quit tobacco use.

Health Net will cover tobacco cessation counseling for at least two separate quit attempts per year, without prior authorization, and with no mandatory break between quit attempts. Non-pregnant adult members are eligible for a 90-day regimen of any Food and Drug Administration- (FDA-) approved tobacco cessation medication. This includes over-the-counter medications with a prescription from the provider. At least one FDA-approved medication will be made available without prior authorization.

Telephonic quit coaching

- Customized one-on-one coaching with a quit coach over the phone in 6 languages (English, Spanish, Cantonese, Mandarin, Korean and Vietnamese).
- Tailored quit plan to member’s unique circumstances.
- Available Monday–Friday, 7 a.m.–9 p.m., and Saturday 9 a.m.–5 p.m.
- To enroll, members may use an online web form, or call directly at 800-300-8086 (English) or 800-600-8191 (Spanish).

Texting program

- Texting program for smoking or vaping in English and Spanish.
- Designed to give extra support to quit cigarettes or vapes during the six months after enrollment.
- Messages deal with motivation, planning, getting support, self-talk, recovering from slips and more.
- Incorporate both automated messaging and personalized support. Quit coaches respond to questions within two business days.

Chat coaching

- Alternative option for both members and heath care providers.

- Platform allows members quick responses to inquiries such as available services and free nicotine patch evaluation.
- Health care providers may use the chat to find answers to cessation-related questions.
- Available in English only, Monday–Friday, 7 a.m.–9 p.m., and Saturday 9 a.m.–5 p.m.

Mobile apps

- Kick It Quit Smoking/Vaping app designed to help people quit smoking and vaping.
- Features tools such as personal log of smoking triggers, motivational reminders and links to helpful resources.
- Available for download on the App Store® and Google Play®.

Visit Kick It California for more details.

Medi-Cal Quality Improvement Programs

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

The Health Net Quality Improvement Department establishes programs to meet the regulatory requirements of the Centers for Medicare and Medicaid Services (CMS), Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC). These programs include clinical and service quality improvement activities, Healthcare Effectiveness Data and Information Set (HEDIS®) performance measures, member satisfaction and access surveys, Medi-Cal facility site certification, and medical record audits, along with any necessary follow-up quality action plans.

This department monitors the results of quality improvement (QI) activities to quantify baseline data, identify opportunities for improvement, develop strong interventions to improve performance, and conduct re-measurements to evaluate effectiveness. The department is also responsible for preparation and implementation of any identified corrective actions based on findings of the CMS, DHCS and DMHC audits and findings identified through quarterly CMS, DHCS and DMHC reviews.

The department is staffed by individuals who are responsible for ensuring compliance with DHCS standards for facility reviews, medical record audits and quality action plans. Assigned Team members are responsible for incorporating new accreditation and regulatory standards and implementing new programs to meet those standards. In addition, they are responsible for ensuring compliance with all CMS, DHCS and DMHC access to care standards, monitoring processes and access-to-care action plans.

For more information, select any subject below:

- Community Advisory Committee
- Facility Site Review Compliance Department

Community Advisory Committee

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

Health Net has established local and regional Community Advisory Committees (CACs) for each County in which we participate as a Medi-Cal plan. The Committees' purpose is to help Health Net understand the communities' needs.

Some of the duties of a CAC include but are not limited to:

- Accessing health care and services, including preventive care services
- The Cultural and Linguistic Services Program
- Population health
- Children's services
- Discuss improvement opportunities with an emphasis on health equity and social drivers of health in order to support people living with disabilities, justice involved persons, foster youth, LGBTQIA, and other populations
- Health equity and health gaps
- Important Health Net projects

A CAC is a forum for the community to directly connect with Health Net and share their ideas and concerns. Feedback from the Committee will inform future planning for the Medi-Cal program.

A CAC comprises Medi-Cal Members, County Department representatives, Community Providers, Community Based Organizations (CBOs), Community Advocates, and Health Net staff. The Committees meet quarterly and new members are welcome.

If you're interested in joining one of our advisory committees, please register here and a Health Net representative will contact you.

Facility Site Review Compliance Department

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

The Health Net Facility Site Review (FSR) Compliance Department is responsible for conducting facility site and medical record reviews of participating primary care physicians (PCPs), and for educating and helping providers so that they may be compliant with all regulatory agency requirements and standards of practice, including preventive care, continuity of care and health education.

The Health Net FSR Compliance Department continually develops and offers materials to simplify the documentation process. Refer to Facility Site Review to obtain materials about legal and regulatory requirements on providers' responsibilities.

Health Net's FSR Compliance nurses support and educate PCPs and their staff to meet the legal and contractual requirements for Medi-Cal members. They are designated by the Department of Health Care Services (DHCS) as certified FSR reviewers. They develop tools, forms and training packets for the providers' use in documentation of medical record criteria, preventive care services, continuity of care, health education, and other clinical interventions. On request, they offer educational material for disease management and public health programs.

The FSR Compliance nurses coordinate and conduct on-site visits for individual providers, clinics and participating physician groups (PPGs) who provide primary care services. Reasons for on-site visits include:

- Requests from providers and PPGs.
- Referral from the Health Net Quality Improvement Department following facility site and medical record audits.
- Referrals from Health Net medical directors.
- Efforts to facilitate coordination of care between primary care physicians (PCPs) and state health programs.
- DHCS contractual requirements.
- Promotion of health education programs.
- Grievance visits.

The Health Net FSR Compliance Department provides the following services and resources:

- Office system consultation and assistance with quality action plans (following facility and medical record audits).
- Individualized in-service and educational programs for providers and PPGs.
- Adult and pediatric (Medi-Cal only) medical record documentation tools - A comprehensive compilation of sample forms and tools designed to help PCPs comply with DHCS documentation requirements.
- Provider education resource packets - These packets contain copies of member handouts, references to additional resources, and sample medical management documentation tools. Topic examples available include asthma, diabetes and healthy lifestyles.
- Quick Tips for Medi-Cal managed care state health programs- Customized by county, these cards contain key concepts of many public health programs with which Medi-Cal managed care providers interact. Reference numbers and focus points assist office staff in coordinating services with these agencies.

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
- Community Supports Data Sharing and Access
- Enhanced Care Management Data Sharing and Access
- Health Net Quality Improvement and Health Equity Committees

Overview - Quality Improvement

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

The Health Net Quality Improvement (QI) program includes the development and implementation of standards for clinical care and service, the measurement of compliance to the standards and implementation of actions to improve performance. The scope of these activities considers the enrolled populations' demographics and health risk characteristics, as well as current national, state and regional public health goals.

Health Net's Population Health Management strategy provides usage risk stratification data compiled from a variety of data sources to help teams target the right members with the right resources to address member health and social determinants of health (needs at all stages of life. The QI program impacts the following:

1. **Health Net members** in all demographic groups and in all service areas in which Health Net is licensed.
2. **Network Providers**, including physicians, facilities, hospitals, ancillary providers, and any other contracted or subcontracted provider types.
3. **Aspects of Care**, including level of care, health promotion, wellness, chronic conditions management, care management, continuity of care, appropriateness, timeliness, and clinical effectiveness of care and services covered by Health Net.
4. **Health Disparities** by supporting activities and initiatives that improve the delivery of health care services, patient outcomes, and reduce health inequities.
5. **Communication** to meet the cultural and linguistic needs of all members.
6. **Behavioral Health Aspects of Care** integration by monitoring and evaluating the care and service provided to improve behavioral health care in coordination with other medical conditions.
7. **Provider/Provider Performance** relating to professional licensing, accessibility and availability of care, quality and safety of care and service, including practitioner and office associate behavior, medical record keeping practices, environmental safety and health, and health promotion.
8. **Services Covered by Health Net**, including preventive care; primary care; specialty care; telehealth, ancillary care; emergency services; behavioral health services; diagnostic services; pharmaceutical services; skilled nursing care; home health care; long term care (LTC), Long-Term Services and Supports (LTSS): Community Based Adult Services (CBAS) which meets the special, cultural and linguistic, complex or chronic needs of all members.
9. **Internal Administrative Processes** which are related to service and quality of care, including customer service, enrollment services, provider relations, practitioner and provider qualifications and selection, confidential handling of medical records and information, case management services, utilization review activities, preventive services, health education, information services, and quality improvement.

Except for Molina, Health Net does not delegate its QI program or oversight responsibilities to PPGs, participating providers, hospitals, or ancillary providers. PPGs, participating providers, hospitals, and ancillary providers are required to comply with the standards and requirements set forth by Health Net, included in this operations manual.

Health Net regularly communicates information about Health Net's QI program goals, processes and outcomes as they relate to member care through provider updates, committee meetings and other forums. QI program information is also available to providers by request through Health Net's Provider Services Center (Commercial, Medicare Advantage, Medi-Cal, CalViva Health, Community Health Plan of Imperial Valley).

Community Supports Data Sharing and Access

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

Bidirectional data sharing between Health Net and Community Supports (CS) providers is an important component for effective member interaction in the California Advancing and Innovating Medi-Cal (CalAIM) program. In addition to data confidentiality provisions under the *Participating Provider Agreement* (*PPA*) and requirements in relevant state and federal laws, the following establishes the terms and conditions for sharing data bidirectionally between the two parties. The manner in which data is shared and accessed by both Health Net and the CS provider includes the following information:

1) **Terminology and Common Language –** In order to ensure clarity and effective communication, this program establishes the use of common language and terminology between Health Net and the CS provider. Both parties shall make reasonable efforts to use consistent terminology and eliminate any ambiguity while referring to shared data and related concepts.

2) **Types of data include, but are not limited to**:

Data to be shared will vary depending on the criteria set by the Department of Health Care Services (DHCS) policy for each of the CS services:

1. Asthma Remediation
2. Housing Transition Navigation Services
3. Housing Deposit
4. Housing Tenancy and Sustaining Services
5. Short-Term Post-Hospitalization Housing
6. Recuperative Care (Medical Respite)
7. Respite Services
8. Day Habilitation Services
9. Nursing Facility Transition/Diversion to Assisted Living Facilities
10. Community Transition Services/Nursing Facility Transition to Home
11. Personal Care and Homemaker Services
12. Environmental Accessibility Adaptation (Home Modification)
13. Medically Supportive Food/Meals/Medically Tailored Meals

Parties de-identify data when applicable. Health Net prioritizes the data based on the criteria in the DHCS Community Supports Policy Guide. Additionally, data elements defined by DHCS encounter data reporting standards will be shared with CS providers.

3) **Specific circumstances when Health Net grants the CS provider access to the shared data is granted include, but are not limited to**:

Based on the new DHCS CalAIM Data Guidance for CS member information sharing, Health Net is required to grant access and share member-level data with CS providers through a Community Supports Authorization Status File (CSASF), which will list members who have been assigned to that provider for service delivery and members the CS provider referred to Health Net for authorization consideration (as applicable).

4) **Specific circumstances when the CS provider grants Health Net access to the shared data is granted include, but are not limited to**:

The CS provider is required to share timely updates about service delivery to Health Net through the Community Supports Provider Return Transmission File (CSPRTF).

5) **Individuals or staff roles within Health Net and the CS provider who will have authorized access to the shared data**.

a) Health Net individuals or staff roles who will have authorized access to CS provider's shared data include, but are not limited to:

- Director, Reporting & Business Analytics
- Supervisor, Reporting & Data Analysis

b) CS provider individuals or staff roles who will have authorized access to Health Net's shared data include, but are not limited to:

- Chief Executive Officer/Executive Director
- Chief Operating officer/Director of Operations
- CS Program Director
- CS Program Manager

6) **Tracking Referral Status –** The methods and/or tools to be used for tracking referral status (i.e., shared database or software system, etc.), the responsibilities of each party in updating and maintaining the referral status information, and the frequency of sharing updates with each party.

a) Methods and/or tools used to track the status of referrals by Health Net include but are not limited to:

Health Net expanded its partnership with findhelp, formerly known as Aunt Bertha, to support CS providers to access a closed-loop referral process. Findhelp is a network of social programs across the United States and is the largest online platform used to identify local resources, support staff, and community partners when searching for local services. Through our partnership, Health Net developed program cards for contracted CS providers and their services for visibility, referral and tracking. The platform helps create an efficiency for providers and members to search directly for no-cost or low-cost CS programs to support members with social determinants of health needs.

b) Methods and/or tools used to track the status of referrals by CS Provider include but are not limited to:

The CS provider can track all of its referrals through findhelp which is the primary referral tools for providers. Health Net encourages providers who receive referrals through phone, fax or email, to log their referrals in findhelp for tracking and reporting purposes.

c) Health Net's updating and maintaining referral status information include:

Findhelp has built-in data analytics that is updated daily where Health Net has the ability to monitor referrals and statuses on a regularly basis. Health Net and findhelp provide technical assistance and support to help providers update and maintain their referral statues.

d) CS provider's updating and maintaining referral status information include:

Within the findhelp platform, CS providers are required to and have the ability to update the statuses of the member which notifies the referring entity. There are several statuses that are available to use on the platform. A few examples below:

- **Eligible** – The member is eligible to receive services but has not received them yet.
- **Pending** – This status is usually made by a program and often means that the referral is being processed.
- **No longer interested** – The member has indicated they no longer need or are interested in this program. The next step is to follow up with the member and make sure their underlying need has been met.
- **Got help** – The member received services and got the help they needed.

e) The frequency at which Health Net will update and share referral status updates:

As part of the findhelp functionality, if statuses of a referral haven't been updated in a week, the provider and member would receive a referral reminder email, if email was the preferred and/or best way to reach them. Health Net also references the data on a regular basis to track referral status and follow up as needed. Additionally, Health Net developed a utilization report monthly to share with points of contacts for CS providers as another way to educate and provide technical assistance.

f) The frequency at which the CS provider will update and share referral status updates:

CS providers are trained and encouraged to update the status as soon as a status needs to be updated or changed to inform the referring entity the status of the member. Health Net has the ability to pull that data directly from findhelp through the site's analytic feature.

7) Collaborative Evaluation

Both Health Net and the CS provider will engage in a yearly bidirectional evaluation process aimed at supporting joint quality improvement objectives. The partnership evaluation process will provide an opportunity for both organizations to assess and improve the effectiveness of the partnership for both staff and the individuals who Health Net and the CS provider serve. Collaborative improvement will involve both Health Net and the CS provider organizations in the evaluation process.

a) Health Net and the CS provider will collaborate to evaluate the effectiveness of its partnership:

There are several ways Health Net partners with CS providers to evaluate necessary improvements to the program.

- Each CS provider is assigned a point of contact where they meet regularly to discuss referrals, authorization, claims/billing, etc. This provides an opportunity for CS providers to bring up challenges and potential solutions or recommendations to improve processes.
- Health Net has hosted monthly office hours on several topics (i.e., findhelp, authorization and claims) for CS providers, which allowed providers to ask questions, get clarification and make recommendations for improvements.

- Health Net engages CS providers through an anonymous survey to capture where we are effective in supporting providers and where we can improve.

b) Upon completion of the collaborative evaluation on the effectiveness of the partnership, Health Net and the CS provider may use findings to inform any necessary improvements of the partnership to drive continuous quality improvement. Improvements may include but are not limited to:

Improvements focused on the infrastructure of the program specifically around IT infrastructure, including but not limited to authorization and billing as well as improvements and interoperability with findhelp. Additional improvements to the CS infrastructure includes adequate staffing and training to support providers.

Enhanced Care Management Data Sharing and Access

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

Bidirectional data sharing between Health Net and Enhanced Care Management (ECM) providers is an important component for effective member interaction in the California Advancing and Innovating Medi-Cal (CalAIM) program. In addition to data confidentiality provisions under the *Participating Provider Agreement* (*PPA*) and requirements in relevant state and federal laws, the following establishes the terms and conditions for sharing data bidirectionally between the two parties. The manner in which data is shared and accessed by both Health Net and the ECM provider includes the following information:

1) Terminology and Common Language – In order to ensure clarity and effective communication, this program establishes the use of common language and terminology between Health Net and the ECM provider. Both parties shall make reasonable efforts to use consistent terminology and eliminate any ambiguity while referring to shared data and related concepts.

2) Types of data include, but are not limited to:

Data to be shared will vary depending on the criteria set by the Department of Health Care Services (DHCS) policy for each of the ECM Populations of Focus:

ECM Populations of Focus		Adults	Children & Youth
1a	• Individuals Experiencing Homelessness: • Adults without Dependent Children/Youth Living with Them	X	

	Experiencing Homelessness		
1b	• Individuals Experiencing Homelessness: • Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness	X	X
2	• Individuals At Risk for Avoidable Hospital or ED Utilization (Formerly “High Utilizers”)	X	X
3	• Individuals with Serious Mental Health and/or SUD Needs	X	X
4	• Individuals Transitioning from Incarceration	X	X
5	• Adults Living in the Community and At Risk for LTC Institutionalization	X	

6	• Adult Nursing Facility Residents Transitioning to the Community	X	
7	• Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition		X
8	• Children and Youth Involved in Child Welfare		X
9	• Birth Equity Population of Focus	X	X

Parties de-identify data when applicable. Health Net prioritizes the data based on the criteria in the Enhanced Care Management Policy Guide and DHCS CalAIM Data Guidance on Member-Level Information Sharing Between MCPs and ECM Providers. Admit, Discharge and Transfer (ADT) data will be shared with the ECM provider for the purpose of identifying best contact information and better servicing members per their need. Certain data, including diagnosis, will be shared only after member consent.

3) Specific circumstances when Health Net grants the ECM provider access to the shared data is granted include, but are not limited to:

Based on the DHCS CalAIM Data Guidance: Member-Level Information Sharing Between MCPs and ECM Providers for ECM member information sharing, Health Net is required to grant access and share member level data with ECM providers through a Member Information File (MIF), which will list members who have been assigned to that provider for service delivery.

4) Specific circumstances when the ECM provider grants Health Net access to the shared data is granted include, but are not limited to:

The ECM provider is required to share timely updates about service delivery to Health Net through the Return Transmission File (RTF) and Outreach Transition File (OTF).

5) The individuals or staff roles within Health Net and the ECM provider who will have authorized access to the shared data.

a) Health Net individuals or staff roles who will have authorized access to the ECM provider's shared data include, but are not limited to:

- Director, Reporting & Business Analytics
- Supervisor, Reporting & Data Analysis

b) ECM provider individuals or staff roles who will have authorized access to Health Net's shared data include, but are not limited to:

- Chief Executive Officer/Executive Director
- Chief Operating officer/Director of Operations
- ECM Program Director
- ECM Program Manager
- ECM Lead Care Managers (LCM)

6) Tracking Referral Status - The methods and/or tools to be used for tracking referral status (i.e., shared database or software system, etc.), the responsibilities of each party in updating and maintaining the referral status information, and the frequency of sharing updates with each party.

a) Methods and/or tools used to track the status of referrals by Health Net include, but are not limited to:

- Health Net provider portal

The status for members who were referred for the ECM program can be found in the Health Net secure provider portal ECM tab. Once in the portal, select the *Eligibility* tab, then select *Enhanced Care Management* on the left navigation. This includes the members status and assigned ECM provider, if applicable (see data dictionary statuses below for member status definitions).

- Health Member Information File (MIF) and Mini-MIF (Referral File).

b) Methods and/or tools used to track the status of referrals by the ECM provider include, but are not limited to:

- Health Net provider portal

The status for members who were referred for the ECM program can be found in the Health Net secure provider portal ECM tab. Once in the portal, select the *Eligibility* tab, then select *Enhanced Care Management* on the left navigation. This includes the member's status and assigned ECM provider, if applicable (see data dictionary statuses below for member status definitions).

c) Health Net's updating and maintaining referral status information include:

Based on information received from ECM providers, Health Net updates the member status to maintain up to date information and share this with providers. This information is shared with providers through the provider portal, mini-MIF (referral file), and monthly MIF file as noted above. See data dictionary definitions below for additional details.

d) ECM provider's updating and maintaining referral status information include:

Through the Return Transmission File (RTF) submitted monthly to Health Net, ECM providers are required to update the status of the member which will notify Health Net of the status change.

e) The frequency at which Health Net will update and share referral status updates:

On a monthly basis, Health Net shares the Member Information File (MIF) with the ECM provider as an update on the status of all members. Additionally, as members are enrolled in ECM, the Health Net provider portal is updated to reflect member enrollment status.

f) The frequency at which the ECM provider will update and share referral status updates:

ECM providers are required to submit their monthly RTF file which should be updated to reflect the current status of the member. For potential ECM members who were identified in the community for referral to the plan, ECM providers are encouraged to report the member's interest in the program via the provider portal or fax.

7) Collaborative Evaluation

Both Health Net and the ECM provider will engage in a yearly bidirectional evaluation process aimed at supporting joint quality improvement objectives. The partnership evaluation process will provide an opportunity for both organizations to assess and improve the effectiveness of the partnership for both staff and the individuals who Health Net and the ECM provider serve. Collaborative improvement will involve both Health Net and ECM provider organizations in the evaluation process.

a) Health Net and the ECM provider will collaborate to evaluate the effectiveness of its partnership:

There are several ways Health Net partners with ECM providers to evaluate necessary improvements to the program.

- Each ECM provider is assigned a point of contact where they meet regularly to discuss referrals, authorization, claims/billing, etc. This provides an opportunity for ECM providers to bring up challenges and potential solutions or recommendations to improve processes.
- Health Net has hosted monthly office hours on several topics (i.e., findhelp, authorization and claims, data sharing) for ECM providers, which allowed providers to ask questions, get clarification and make recommendations for improvements.
- Health Net engages ECM providers through surveys to capture where we are effective in supporting providers and where we can improve.

b) Upon completion of the collaborative evaluation on the effectiveness of the partnership, Health Net and the ECM provider may use findings to inform any necessary improvements of the partnership to drive continuous quality improvement.

Health Net Quality Improvement and Health Equity Committees

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

The Health Net Quality Improvement and Health Equity Committee (QIHEC) is responsible to ensure quality and safety of care and services rendered to Health Net members.

The QIHEC is led by Health Net's Chief Medical Directory and Chief Health Equity Officer and is overseen by Health Net's Governing Board. The QIHEC meets quarterly. External practitioners (Network Providers,

including but not limited to hospitals, clinics, county partners, physicians, subcontractors, downstream subcontractors.

Subcontractors, downstream subcontractors, and network providers must be representative of the composition of the HNCS' provider network and include, at a minimum, network providers who deliver health care services to members affected by health disparities, limited English proficiency (LEP), children with special health care needs (CSHCN), seniors and persons with disabilities (SPDs) and persons with chronic conditions participate on this committee along with representatives from Behavioral Health, Pharmacy Department, Network Management, Medical Affairs, Customer Service Operations, Credentialing, Peer Review, and Population Health & Clinical Operations (PHCO) which includes Utilization Management (UM) and Care Management.

QIHEC functions include the following:

- Annually assess UM, QI, and Health Equity activities, including areas of success and needed improvements in services rendered within the QI and Health Equity program at the regional and/or county level; Conduct a quality review of all services rendered, the results of required performance measure reporting, and the results of efforts to reduce health disparities;
    - Address activities and priorities related to the Quality Improvement and Health Equity Transformation Program (QIHETP)
    - Analyze and evaluate the results of QI and Health Equity activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys;
    - Institute actions to address performance deficiencies, including policy recommendations;
    - Ensure follow-up of identified performance deficiencies or gaps in care;
- Support efforts to align resources, strategies, and partners by place in order to reduce identified inequities (e.g., via use of Health Equity Improvement Zones);
- Identify differences in quality of care and utilization of physical and behavioral health care services for members directly managed and delegated to providers;
- Ensure that all interventions to address differences in quality of care and utilization have an equity focus, including addressing underlying factors such as SDoH;
- Review performance measure results and address deficiencies, including results and deficiencies of all fully delegated subcontractors;
- Review progress summaries from Joint Operating Meetings
- Ensure connectedness to the findings, recommendations and actions from the Quality Improvement Committee, Community Advisory Committees (CAC), and Public Policy Committee to drive universal decisions and programming;
- Ensure member confidentiality is maintained in QI discussions and avoid conflict of interest among the QIHEC members;
- The QIHEC shall provide input and advice on the following non-exclusive list of topics:
    - Population Health Management;
    - Health Delivery Systems Reforms to improve health outcomes;
    - Coordination of Care;
    - Clinical quality of physical and behavioral health care;
    - Access to primary and specialty health care Providers and services;
    - Member experience with respect to clinical quality, access, and availability, culturally and linguistically competent health care and services, and continuity and coordination of care
    - Non-Specialty Mental Health Services (NSMHS) Member and PCP Outreach & Education Plan
- QIHEC is responsible for adequately addressing recommendations put forth by the CAC and providing feedback through a dashboard that outlines progress and decisions on recommendations

    - For recommendations that the QIHEC is unable to reasonably address, a CAC may opt to escalate their recommendation to the HNCS Board of Directors for further review and consideration.
- Form and delegate authority to subcommittees when appropriate; and
- Review and reassess the adequacy of the charter annually and recommend any proposed changes to the Board for approval. The Committee shall annually review its own performance.

Subcommittees

Community Advisory Committee

- Refer to Community Advisory Committee section.

Utilization Management:

- Review and approve the annual Medi-Cal and dual-eligible Utilization and Care Management (CM) Programs, including the UM and CM Program Description, Work Plan, and Work Plan Evaluation;
- Monitor and support the activities for UM an CM programs, review the effectiveness of the programs, and make recommendations for improvement; and
- Oversee UM activities performed by delegated subcontractors and the shared services teams.

Quality Management

- Review and approve the annual Medi-Cal, dual-eligible QI Program Description, Work Plan, and Work Plan Evaluation;
- Monitor and support the activities for the QI program, evaluate the effectiveness of the Work Plan, and make recommendations for improvement; and
- Review and approve the annual Health Education Program Description, Work Plan, and Work Plan Evaluation.

Health Equity

- Review HNCS QI and QIHETP findings and required actions at the regional and/or county level;
- Review and approve the annual Health Equity Description, Work Plan, and Work Plan Evaluation;
- Monitor, support, and evaluate the activities for the QI and QIHETP programs, and make recommendations for improvements;
- Conduct an annual evaluation of the effectiveness of the language assistance services offered to support members with limited English proficiency and to mitigate potential cultural or linguistic barriers to accessing care in compliance with requirements from Centers for Medicare and Medicaid Services (CMS), Department of Health Care Services (DHCS), and Department of Managed Health Care (DMHC);
- Concentrate on eliminating identified health disparities including, structural racism and social risk, SDoH, and community needs; make recommendations to improve individual and community health outcomes.

- Review and provide status on formal recommendations presented by the HNCS CAC.

Credentialing/Peer Review Committee

The Credentialing/Peer Review Committee verifies and reviews practitioners and organizational providers who contract to render professional services to Health Net members for training, licensure, competency, and qualifications that meet established standards for credentialing and recredentialing. The Credentialing Committee ensures Health Net's credentialing and recredentialing criteria for participation in the Health Net network are met and maintained for all lines of business, as defined by the regional health plans. The QIHEC delegates authority and responsibility for credentialing and recredentialing peer reviews to this committee. This committee is also responsible for peer review activities and decisions regarding quality improvement follow-up on service and clinical matters, including quality of care cases. The committee provides a forum for instituting corrective action as necessary and assesses the effectiveness of these interventions through systematic follow-up for all lines of business for both inpatient and outpatient care and services.

This committee reports quarterly to the QIHEC and provides a summary of activities to the Health Net board of directors. Membership includes practicing medical directors or practitioners (representing primary and specialty disciplines) from PPGs representing each region (northern, central and southern California).

Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics (P&T) Committee ensures appropriate and cost-effective delivery of pharmaceutical agents to Health Net membership. Committee responsibilities include the review and approval of policies that outline pharmaceutical restrictions, preferences, management procedures, explanation of limits or quotas, the delineation of Recommended Drug List (RDL) exceptions, substitution and interchange, step-therapy protocols, and the adoption of prescription safety procedures.

The P&T Committee includes a Health Net medical director, practitioners from PPGs that represent primary care and specialty disciplines, and clinical pharmacists.

A Pharmacy and Therapeutics (P&T) Committee is comprised of actively practicing physicians, medical directors and clinical pharmacists who review the efficacy and safety data of medications using an evidence-based process in order to make clinically appropriate utilization management recommendations to health plans and pharmacy benefit managers. P&T Committee members also consider the potential for medication misuse or abuse, experimental or off-label use, and required level of laboratory or safety monitoring. P&T Committee utilization management tools include prior authorization criteria, quantity limits and step therapy.

Delegation Oversight Committee

Health Net may delegate responsibility for activities associated with utilization management (UM) and administrative services to its PPGs.

The Health Net Delegation Oversight Committee (DOC):

- Provides systematic oversight and regularly evaluates Health Net's PPGs or contracting vendors to assure compliance with delegated duties.
- Oversees PPG compliance with health plan and regulatory requirements pertaining to the delivery of care and services to members.

- Assesses and determines delegation for each component of the delegated responsibilities, including UM, claims, credentialing, and administrative services.
- Communicates in writing all delegation decisions, recommendations and requests for corrective action plans (CAPs) to the PPGs.
- Reports quarterly to the QIHEC.

Specialty Network Committee

The Specialty Network Committee sets standards for the Health Net participating transplant performance centers and bariatric performance centers, guiding members to specialty network providers, monitoring performance, issuing requests for CAPs, and reporting to HNQIC. This committee meets at least six times per year and reports annually to HNQIC.

Medi-Cal Member Survey

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

Health Net participates in the annual HEDIS® Consumer Assessment of Healthcare Providers and Systems (CAHPS) Medicaid Member Satisfaction Survey. HEDIS CAHPS results are required for NCQA Health Plan Accreditation. The California Department of Health Care Services (DHCS) also conducts an annual satisfaction survey of its Medi-Cal members that is administered by the HSAG (Health Services Advisory Group). The purpose of these surveys are to identify perceived problems in quality, availability, and accessibility of care; satisfaction with care and service; and reasons members' use out-of-network providers. The data from the survey is used to identify sources of dissatisfaction, to develop corrective action plans, and to evaluate the effects of corrective action taken.

Any necessary improvement plans are developed based on the results of these surveys.

Medi-Cal Quality Improvement Projects

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

Medi-Cal Performance Improvement Projects

Health Net conducts performance improvement projects (PIPs) according to Department of Health Care Services (DHCS) contractual requirements in

its ongoing effort to improve health outcomes of Medi-Cal members. PIPs target specific health issues that are a concern or problem for members. They may also target under-utilized health services for which intervention may potentially increase utilization and significantly enhance health outcomes.

During each DHCS initiated PIP cycle, DHCS specifies the specific topic and requirements of the project including duration of the PIP cycle.

PIPs are developed by the Health Net Quality Improvement division in collaboration with Health Net's Medi-Cal medical directors. PIPs, which may be targeted regionally and may target both members and provider, are meant to identify barriers to improving member outcomes using quality improvement tools and test interventions that address them.

Progress and results of all PIPs are reported to the Department of Health Care Services (DHCS), Health Net Quality Improvement Health Equity Committee, Health Services Advisory Group

(HSAG) - an External Quality Review Organization (EQRO), Health Net senior management, Health Net medical directors, and the Health Net board of directors.

Contact the QI Department for more information on current QIPs.

Monitoring Access Standards Compliance

Provider Type: Participating Physician Groups (PPG)

Health Net measures participating physician group (PPG) performance with timely access standards through the Provider Appointment Access survey and the Provider After-Hours Access survey. Overall member satisfaction is measured through the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey process.

Providers not meeting these standards are required to submit and follow a corrective action plan (CAP), which the Provider Network Management Department monitors. Refer to the Service and Quality Requirements discussion under the Provider Oversight topic for detailed information on access standards.

Health Net analyzes results in order to identify issues within its system of care that require improvement to promote appropriate utilization of both LTSS and emergency room services, appropriate and timely access to care, and Americans with Disabilities Act (ADA) and language assistance program compliance. Health Net reports results as required to the Centers for Medicare and Medicaid Services (CMS) and DHCS.

Quality Improvement and Health Equity Transformation Program

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

The Quality Improvement and Health Equity Transformation Program (QIHETP) is designed to monitor, evaluate, and take effective action to address any needed improvements in the quality and health equity of care of all Covered Services delivered to Health Net members, regardless of whether those services were delegated to a subcontractor, downstream subcontractor, or network provider. The QIHETP is continuous.

As a part of the QIHETP, Health Net is responsible for delivering quality care that enables all members to maintain health and improve or manage a chronic illness or disability. Health Net must ensure quality care in the following areas:

1) clinical quality of physical health care;

2) clinical quality of behavioral health care focusing on prevention, recovery, resiliency and rehabilitation;

3) access to primary and specialty health care providers and services;

4) availability and regular engagement with PCP;

5) continuity of care and care coordination across settings and at all levels of care, and

6) member experience with respect to clinical quality, access and availability, culturally and linguistically competent health care and services, continuity of care and care coordination.

Health Net must apply the principles of continuous quality improvement (CQI) to all aspects of its service delivery system through analysis, evaluation, and systematic enhancements of the quantitative and qualitative data collection and data-driven decision-making, up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources, feedback from members, community partners, network providers, and any other identified issues.

The purposes and goals of the QIHETP are to:

- Support Health Net's strategic business plan to promote safe, equitable and high quality care and services while maintaining full compliance with regulations and standards established by federal and state regulatory and accreditation agencies.
- Objectively and systematically monitor and evaluate services provided to Health Net members to ensure conformity to professionally recognized standards of practice and codes of ethics.
- Provide an integrative structure that links knowledge and processes together throughout the organization to assess and improve the quality and safety of clinical care with quality service provided to members.
- Develop and implement a Quality Improvement and Health Equity Annual Plan and continually evaluate the effectiveness of plan activities at increasing and maintaining performance of target measures, and act, as needed, to enhance performance.
- Support a partnership among members, practitioners, providers, regulators, and employers to provide effective health management, health education, disease prevention and management and facilitate appropriate use of health care resources and services.
- Design, implement and measure organization-wide programs that improve member, practitioner and provider satisfaction with Health Net's clinical delivery system. These programs are population-based ongoing clinical assessments and are evaluated to determine the effectiveness of clinical practice guidelines, preventive health guidelines and care management programs.
- Monitor and increase Health Net's performance in promoting quality of service to improve member, practitioner and provider satisfaction through the use of satisfaction surveys, focused studies, and analysis of data (e.g., administrative, primary care, high-volume specialists and specialty services, and behavioral health and chemical dependency services).
- Promote systems and business operations that provide and protect the confidentiality, privacy and security of member, practitioner and provider information while ensuring the integrity of data collection and reporting systems. This is done in accordance with state and federal requirements and accreditation guidelines.
- Anticipate, understand and respond to customer needs, be customer-driven and dedicated to a standard of excellence in all customer relationships.

- Provide a means by which members may seek resolution of perceived failure by practitioners and providers or Health Net personnel to provide appropriate services, access to care and quality of care. Identify, review and investigate potential quality of care issues and take corrective action, when appropriate.

Health Net utilizes several methods to measure access to care, including telephone-based surveys and member experience surveys. Provider satisfaction with the timeliness and usefulness of information received from other physicians and various care settings is also assessed on a regular basis to measure the coordination of care in the network. Opportunities for improvement are identified by examining provider ratings of key elements in the following functional areas: access and availability, case management, prior authorization, cultural and linguistic services, concurrent review, and discharge planning.

The QIHETP includes a written program description and a Quality Improvement and Health Equity Annual Plan that defines the activities and planned improvements for the year. The annual work plan is developed following an evaluation of the previous year's activities and accomplishments. The Health Net Quality Improvement and Health Equity Committees (QIHECs) and the Health Net board of directors (BOD) approve and monitor the annual Health Net QI and HE programs and the QI and HE work plans. A written summary of QIHEC activities, findings, recommendations, and actions are prepared after every meeting and are submitted to the board of directors.

Quality Improvement Program and Compliance and HEDIS

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

Health Net tracks and monitors quality of care and service in a number of ways, including through the Healthcare Effectiveness Data and Information Set (HEDIS®). HEDIS was developed and is maintained by the National Committee for Quality Assurance (NCQA), a not-for-profit organization committed to assessing, reporting on and improving the quality of service and quality of care provided by organized delivery systems. It is the most widely used set of performance measures in the managed care industry. Participation in this effort allows health care purchasers and providers to compare Health Net's performance relative to other health plans and to identify opportunities for improvement.

In addition, Health Net participates in various quality improvement collaboratives, including:

- California Quality Collaborative (CQC), a program that seeks to improve clinical care and service for all Californians by providing strategies at the point of care. Various programs are available to providers to improve chronic disease care, patient satisfaction and efficiency. For a listing of educational programs and patient satisfaction and condition management resources, providers can visit www.calquality.org.
- The Leapfrog Group: Health Net works closely with The Leapfrog Group, purchases their data, and promotes their ratings and standards to network hospitals, members and the community.
- Cal Hospital Compare: Health Net collaborates with Cal Hospital Compare on a range of issues and contracts with them to obtain Poor Performer and Honor Roll reports and associated data files to inform hospital quality initiatives. .

Quality of Care Issues

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

Potential quality of care issues are reviewed by a Health Net medical director and, based on findings, are given a severity level and, as indicated, submitted to the peer review committee (PRC) for appropriate resolution. At a minimum annually, the number, severity, actions taken, and trends noted are aggregated and reported to the Health Net Quality Improvement Committee.

Providers use the Potential Quality Issue (PQI) Referral form Health Net Referral Form (PDF), Potential Quality Issue (PQI) Referral form – Community Health Plan of Imperial Valley (PDF) or CalViva Health Referral Form (PDF) to fax reports of potential or suspected deviation from standards of care that cannot be justified without additional review or investigation.

Referrals

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

This section contains general information on referrals.

Select any subject below:

- Investigational and Experimental Treatment
- Molina Healthcare Lab Referrals
- Molina Healthcare Service Request Form
- Primary Care Services
- Receipt of Specialist's Report
- Referral Tracking
- Referrals for Specialty Consultation
- Referrals to Specialists
- Services Not Requiring Referral or Prior Authorization
- Standing Referrals to a Specialist

Investigational and Experimental Treatment

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

Medi-Cal indicates:

1. Experimental services are not covered.

2. Investigational services are not covered except when it is clearly documented that all of the following apply:
    1. Conventional therapy does not adequately treat the intended patient's condition.
    2. Conventional therapy does not prevent progressive disability or premature death.
    3. The provider of the proposed service has a record of safety and success with the investigational service equivalent or superior to that of other providers of the service.
    4. The investigational service is the lowest cost item or service that meets the patient's medical needs and is less costly than all conventional alternatives.
    5. The service is not being performed as a part of a research study protocol.
    6. There is a reasonable expectation that the investigational service significantly prolongs the intended patient's life or maintains or restores a range of physical and social function suited to activities of daily living.

    All investigational services require prior authorization. Payment is not authorized for investigational services that do not meet the above criteria, or for associated inpatient care when a member needs to be in the hospital primarily because she or he is receiving such non-approved investigational services.

PPG Responsibilities

PPGs must immediately forward all pertinent documentation for investigational or experimental treatment service requests via fax to the Health Net Medi-Cal Health Services Department. Health Net's Medi-Cal Health Services Department has a dedicated fax number to receive and process prior authorization requests.

Molina Healthcare Lab Referrals

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

The following information applies to Los Angeles County only.

For Health Net Members assigned to Molina Healthcare, consult Molina Healthcare's operations manual.

Molina Healthcare Service Request Form

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

The following information applies to Los Angeles County only.

Molina Healthcare requires that its directly contracting primary care physicians (PCPs), staff model physicians and directly contracting medical groups adhere to the requirements in the Molina Healthcare operations manual.

Primary Care Services

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

The primary care physician (PCP) is responsible for the management and coordination of a member's medical care, including initial and primary care, maintaining continuity of care, and initiating specialist referral. The PCP refers the member to a specialist when additional knowledge or skills are required.

Health Net has delegated the referral process to some participating physician groups (PPGs). Referrals to participating and non-participating specialists for capitated members are subject to any additional rules imposed by the PPG. PPGs may not impose referral or authorization requirements that conflict with the member's right to self-refer for services.

Listed below are examples of services that are considered primary care services. A PCP is expected to have the expertise necessary to perform most of these services. The PCP must have received relevant training within the limitations of scope of practice that is consistent with state and federal rules and regulations. These guidelines are based on routine, uncomplicated cases where care is provided by a PCP. This list provides guidelines, is not intended to be all-inclusive, and should be used with discretion.

Allergy

- Treat seasonal allergies
- Treat hives
- Treat chronic rhinitis
- Allergy history
- Environmental counseling
- Minor insect bites and stings
- Asthma, active with or without co-existing infection
- Allergy testing and institute immunotherapy (if trained)
- Administer immunotherapy

Adult Cardiology

- Perform electrocardiograms
- Interpret electrocardiograms
- Evaluate chest pain
- Evaluate and treat coronary risk factors, including smoking, hyperlipidemias, diabetes, and hypertension
- Evaluate and treat uncomplicated hypertension, CHF, stable angina, non-life-threatening arrhythmias
- Evaluate single episode syncope (cardiac)
- Evaluate benign murmurs and palpitations

Dermatology

- Treat acne - acute and recurrent
- Treat painful or disabling warts with topical preparations, electrocautery and liquid nitrogen
- Diagnose and treat common rashes, including contact dermatitis, dermatophytosis, herpes genitalis, herpes zoster, impetigo, pediculosis, pityriasis rosea, psoriasis, scabies, seborrheic dermatitis, and tinea versicolor
- Screen for basal or squamous cell carcinomas
- Biopsy suspicious lesions; if trained, may do biopsy of suspicious lesions for cancer or others, such as actinic keratoses
- Punch biopsy
- Incisional biopsy
- Diagnose and treat common hair and nail problems and dermal injuries
- Common hair problems include fungal infections, ingrown hairs, virilizing causes of hirsutism, or alopecia as a result of scarring or endocrine effects
- Common nail problems include trauma, disturbances associated with other dermatoses or systemic illness, bacterial or fungal infections, and ingrown nails
- Dermal injuries include minor burns, lacerations, and treatment of bites and stings
- Counsel members regarding removal of cosmetic (non-covered) lesions
- Identify suspicious moles

Endocrinology

- Diabetic management, including type 1 and type 2 for most members
- Member education
- Supervision of home (SBGM) testing
- Medication management
- Manage DKA
- Manage thyroid nodules (order testing, scans, ultrasound)
- Diagnose and treat thyroid disorders
- Identify and treat hyperlipidemia
- Diet instruction
- Exercise instruction
- Provide member education for osteoporosis risk factors
- Identify and treat lipid disorders with diet and/or at least two medications for a minimum of six months

Gastroenterology

- Diagnose and treat lower abdominal pain
- Diagnose and treat acute diarrhea
- Occult blood testing
- Perform flexible sigmoidoscopy
- Diagnose and treat heartburn, upper abdominal pain, hiatal hernia, acid peptic disease
- Evaluate acute abdominal pain
- Diagnose and treat uncomplicated inflammatory bowel disease
- Diagnose jaundice
- Diagnose and treat ascites
- Diagnose and treat symptomatic, bleeding or prolapsed hemorrhoids

- Manage functional bowel disease
- Manage diagnosed malabsorption syndrome
- Manage mild hepatitis A

General Surgery

- Evaluate and follow small breast lumps in teenagers
- Order screening mammograms
- Aspirate cysts
- Foreign body removal
- Laceration repairs (minor)
- Local minor surgery for hemorrhoids
- Minor surgical procedures
- Diagnose gallbladder disease
- Manage inguinal hernia

Geriatrics

- Diagnose and treat impaired cognition (dementia)
- Be familiar with effects of aging on medication distribution, metabolism and interaction
- Management of advanced illness including the use of alternative levels of care
- Recognition of elder abuse

Gynecology/Obstetrics

- Perform routine pelvic exams and Pap smears
- Perform lab testing for sexually transmitted infections
- Wet mounts
- Diagnose and treat vaginitis and sexually transmitted infections
- Contraceptive counseling and management
- Normal pregnancy (if physician privileged to deliver)
- Evaluate lower abdominal pain to distinguish gynecological from gastrointestinal causes
- Diagnose irregular vaginal bleeding
- Diagnose and treat endometriosis with hormone therapy
- Manage premenstrual syndrome with non-steroidal anti-inflammatory hormones and other symptomatic treatment

Neurology

- Diagnose and treat all psychophysiological diseases, headaches, low back pain, myofascial pain syndromes, neuropathies, radiculopathies, and central nervous system disorders
- Diagnose and treat tension and migraine headaches
- Order advanced imaging procedures (MRI or CT scan for an appropriate anatomic area after an appropriate clinical evaluation and trial of conservative therapy

- Diagnose and manage syncope
- Treat seizure disorders
- Manage degenerative neurological disorders with respect to general medical care (for example, Parkinson's)
- Manage stroke and uncomplicated TIA members
- Lumbar puncture
- Treat myofacial pain syndromes

Ophthalmology

- Perform thorough ophthalmologic history including symptoms and subjective visual acuity
- Perform common eye-related services
    - Distant/near vision testing
    - Color vision testing
    - Gross visual field testing by confrontation
    - Alternate cover testing
    - Direct fundoscopy without dilation
    - Extraocular muscle function evaluation
    - Red reflex testing in pediatric members
- Remove corneal foreign bodies (except metallic)
- Treat corneal abrasions
- Perform tonometry
- Diagnose and treat common eye conditions:
    - Viral, bacterial and allergic conjunctivitis
    - Blepharitis
    - Hordeolum
    - Chalazion
    - Subconjunctival hemorrhage
    - Dacryocystitis

Orthopedics

- Treat low back pain and sciatica without neurological deficit
- Treat sprains, strains, pulled muscles, overuse symptoms
- Treat acute inflammatory conditions
- Chronic knee problems
- Manage chronic pain problems
- Diagnose and treat common foot problems: ingrown nails, corns, callouses, bunions
- Closed emergency reduction of dislocation: digit, patella, shoulder
- Treatment of minor fractures
- Arthrocentesis

Otolaryngology

- Treat tonsillitis and streptococcal infections
- Perform throat cultures

- Evaluate and treat oropharyngeal infections
  - Stomatitis
  - Herpangina
  - Herpes simplex
- Treat acute otitis media
- Treat effusion
- Evaluate tympanograms/audiograms
- Treat acute and chronic sinusitis
- Treat allergic or vasomotor rhinitis
- Remove ear wax
- Treat nasal polyps
- Diagnose and treat acute parotitis and acute salivary gland infections
- Treat nasal obstruction (including foreign body)
- Treat simple epistaxis

Physical Medicine and Rehabilitation

- Coordinate care for members recovering from major trauma or CNS injury by appropriate use of various rehab professionals including PT, OT, ST, and physiatrist
- Basic understanding of effective use of common orthotic and prosthetic devices including wrist splint for CTA and AFO for foot drop

Psychiatry

- Perform complete physical and mental status examinations and extended psychosocial and developmental histories when indicated by psychiatric or somatic presentations (fatigue, anorexia, overeating, headaches, pains, digestive problems, altered sleep patterns, and acquired sexual problems)
- Diagnose physical disorders with behavioral manifestations
- Provide maintenance medication management after stabilization by a psychiatrist or if longer-term psychotherapy continues with a non-physician therapist
- Diagnose and care manage child, elder, dependent adult abuse, and domestic violence victims

Pulmonology

- Diagnose and treat asthma, acute bronchitis, pneumonia
- Diagnose and treat chronic bronchitis
- Diagnose and treat chronic obstructive pulmonary disease (COPD)
- Manage home aerosol medications and oxygen
- Work up possible tuberculosis or fungal infections
- Treat opportunistic infections
- Order chest X-rays, special views and advanced imaging

Rheumatology

- Diagnose and treat non-articular musculoskeletal problems:
  - Overuse syndromes
  - Injuries and trauma
  - Soft tissue syndromes
  - Bursitis or tendonitis
- Provide steroid injections
- Manage osteoarthritis unless there is a significant functional impairment despite treatment
- Diagnose crystal diseases
- Perform arthrocentesis
- Diagnose and treat rheumatoid arthritis
- Diagnose and treat inflammatory arthritic diseases
- Diagnose and treat uncomplicated collagen diseases

Urology/Nephrology

- Diagnose and treat initial and recurrent urinary tract infections
- Provide long term chemoprophylaxis
- Diagnose and treat urethritis
- Explain hematospermia
- Initiate evaluation of hematuria
- Evaluate incontinence
- Evaluate male factor infertility and impotence and treat readily correctable factors
- Diagnose and treat epididymitis and prostatitis
- Differentiate scrotal or peritesticular masses from testicular masses
- Evaluate prostatism and prostatic nodules
- Manage urinary stones
- Evaluate and treat renal failure
- Placement of urinary catheters
- Evaluate impotence
- Evaluate male infertility

Vascular Surgery

- Diagnose abdominal aortic aneurysm
- Diagnose and treat venous diseases
- Treat stasis ulcers
- Manage intermittent claudication
- Manage transient ischemic attacks
- Manage asymptomatic bruits

Other

- Basic life support
- Advanced life support
- Heimlich maneuver
- Endotracheal intubation

- Tracheostomy (emergency)

Hospital Procedures

- Hospital admissions and daily care
- Hospital consultations
- Pre-operative history
- Newborn evaluation and nursery care

Infectious Disease

- Human immunodeficiency virus (HIV)
- AIDS

Receipt of Specialist's Report

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

The primary care physician (PCP) must ensure timely receipt of the specialist's report. For Medi-Cal members, reports from specialty services for consultations or procedures must be in the member's chart within two weeks. If the PCP does not receive the specialist's report within two weeks, the PCP must contact the specialist to obtain the report. For urgent and emergency cases, the specialist must initiate a telephone report to the PCP as soon as possible, and a written report must be received within two weeks.

Referral Tracking

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

Health Net's participating providers are required to monitor referrals that have been authorized for medically appropriate care to ensure that the member accesses care and follows up with his or her primary care physician (PCP).

Participating physician groups (PPGs) delegated for utilization management (UM) functions are responsible for tracking referrals authorized for members assigned to PCPs within the PPG's network. The PPG is also responsible for following up with the member and PCP to ensure that the member receives a new referral for the previously authorized services if the services are still required. For additional information, refer to the PPG Responsibilities for Referral Tracking discussion under the Provider Delegation topic.

PCPs are responsible for maintaining continuity of care for Health Net members during the referral process. This entails the monitoring of referrals made for Health Net Medi-Cal members to ensure that appropriate services are accessed and pertinent specialty service reports are received for inclusion in the primary care

medical record. Refer to the Care Coordination discussion under the Utilization Management topic for additional information.

Referrals for Specialty Consultation

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

Listed below are examples of services that are referred for specialty consultation. This list provides guidelines and is not intended to be all-inclusive.

Allergy

- Chronic rhinitis if the allergic cause is indicated by IgE or nasal eosinophils or if mechanical obstruction, such as adenoids or tonsils, is obvious
- Hives if urticaria becomes chronic (six to 10 weeks or recurrent)
- Consultation if hospitalized, severe respiratory failure or member is steroid-dependent
- Asthma if difficult diagnostic dilemma, not well controlled with routine therapy, hospitalization or if severe respiratory failure has occurred or if the member has become steroid-dependent
- Significant reactions to stinging insects, chronic eczema, chronic sinusitis, and medication allergies
- Systemic allergic reactions, anaphylaxis

Cardiology - Adult

- Candidates for thrombolysis, stress testing, catheterization, angioplasty, or surgery, and life-threatening arrhythmias, or hemodynamic complications requiring invasive monitoring
- Unstable angina
- Hemodynamically complicated murmur
- Constrictive pericarditis
- Complicated hypertension (failure to respond or adverse response to conventional therapy)
- Angina despite maximal pharmacological therapy with maximally tolerated doses of nitrates, beta-blockers, and calcium channel blockers
- Intractable heart failure and arrhythmias
- Pericardial effusion
- Congenital or valvular disease for non-invasive studies and to define appropriate follow-up
- Evaluate and treat recurrent syncope (cardiac)
- Initial consultation for acute and chronic heart failure management

Cardiology - Pediatric

- Evaluate and treat any non-soft, non-systolic cardiac murmur
- Evaluate cyanosis that does not clear with crying
- Evaluate tachypnea

- Evaluate diminished pulses in any extremity
- Consultation for any member with a syndrome known to have cardiac complications (Down's, Marfan's, etc.)

Dermatology

- Acne that has not resolved or improved after three months
- Severe cystic acne
- Suspicious lesion suggesting melanoma
- Basal or squamous cell carcinomas
- Biopsy of suspicious lesions

Endocrinology

- Coma not rapidly reversible by glucose
- Instability in an established management program
- Brittle diabetes
- Diabetic complications, including retinopathy and nephropathy
- Exophthalmos, moderately severe or symptomatic
- Fine-needle aspiration of thyroid nodules
- Suspected disorders of calcium metabolism, adrenal, gonadal, or pituitary dysfunction
- Growth retardation (non-familial)
- Hyperlipidemia (no response to diet and medication, including two different medications, within one year)
- Radioactive iodine therapy

Gastroenterology

- Bowel obstruction diagnosed
- Polyps or other abnormalities
- Chronic bleeding, acute GI hemorrhage
- Undiagnosed hepatocellular disease or biliary obstruction
- Jaundice complicated by fever
- Severe acute and chronic hepatitis
- Ascites when peritoneal fluid is an exudate, chylous or intractable or if fever persists
- Severely symptomatic hemorrhoids refractory to treatment, may be referred for additional nonsurgical treatment
- Complex inflammatory bowel disease
- Chemotherapy for carcinoma

General Surgery

- Gallbladder disease, if significantly symptomatic
- Recurrent cysts, lumps or suspicious mammograms

Neurology/Neurosurgery

- Myofascial pain syndromes if there is no improvement and an uncertain diagnosis after six to eight weeks of conservative treatment or a progressive neurological deficit
- Seizures that are recurrent or refractory to treatment
- Degenerative neurological disorders
- Confirmation of diagnoses and/or intermittent consultation
- Ischemic attack that is associated with a carotid lesion
- CNS malignancies
- Persistent cervical or lumbosacral herniated nucleus pulposa resistant to conservative management

Obstetrics/Gynecology

- Ectopic pregnancy
- Uncertain clinical diagnosis
- Higher risk members (for example, over-age)
- Menometrorrhagia

Ophthalmology

- High index of suspicion for herpes
- Metallic foreign bodies
- Sudden visual change or loss
- Visual change accompanied by pain
- Sudden onset of flashing lights and floaters
- Any eye symptom not responding to treatment
- Unexplained abnormality on fundoscopic exam
- Sudden visual change or loss
- Pediatric members with dysconjugate gaze
- Lens opacification if associated with intolerable visual impairment

Orthopedics

- Fracture
- Locked knee
- Unstable knee
- Foot problems (deep abscess, gangrene, osteomyelitis)
- Any diabetic foot
- Obvious or apparent ligament tear
- Progressive disability of the knee despite conservative treatment and X-ray showing joint narrowing or gross destruction of the articular surface

Otolaryngology

- Tonsillectomy if three documented episodes within four months or six documented episodes within one year
- Tonsillar obstruction or recurrent peritonsillar abscess
- Acute otitis media, member toxic for 48 hours despite treatment
- Persistent middle ear effusion lasting more than three months with continuous treatment, or persistent infection after three courses of different antibiotics
- Persistent hearing loss or delayed speech and articulation in children under the age of 3
- Persistent retraction of tympanic membranes
- Recurrent epistaxis
- Acute and chronic sinusitis after treatment with antibiotics for 20 days or if infection not responsive in 72 hours
- Nasal obstruction after three months of treatment
- Parotid masses
- Acute or persistent hearing loss not attributable to fluid or wax
- Hoarseness that persists for more than three weeks

Psychiatry

- Diagnose, treat, and recommend medication regimen in difficult/complex cases, for example:
  - Depressions that does not respond to 60-day trial of selective serotonin re-uptake inhibitor (SSRI) medications or other antidepressants
  - Members who report feeling suicidal or homicidal
  - Panic disorders
- For example, continued:
  - Severe anxiety states
  - Clear somatoform disorders
  - Schizophrenic disorders where clozapine or risperidone are being considered
  - Bipolar disorder where lithium, carbamazepine or chlorpromazine may be needed

Psychologist

- Diagnosis, treatment and consultation regarding management of clearly emotional issues for which the member or PCP feels the need for consultation
- Psychological testing for clarification of diagnosis to establish a treatment plan

Pulmonology

- Respiratory failure
- Percutaneous lung biopsies
- Pleural biopsies
- Supraclavicular node biopsies
- Pleural effusions not due to heart failure or acute pneumonia

- Unresolved pneumonia
- Neonatal lung disease
- Cystic fibrosis
- Lung masses
- Hemoptysis
- Interstitial disease
- Sarcoidosis
- Tuberculosis
- Unusual infections
- Dyspnea of uncertain etiology
- Sleep disorders
- Complicated asthma, advanced COPD, pulmonary vascular disease, including pulmonary hypertension vasculitis and pulmonary embolism

Rheumatology

- Osteoarthritis, if no response to treatment after three months
- Rheumatoid arthritis if manifestations are not controlled on the treatment program or treatment plan to include surgery
- Collagen vascular diseases depending on the extent and severity of manifestations or complications

Social Workers/Other Credentialed Providers

- Brief psychotherapy, including post-traumatic stress disorder (PTSD), grief, recent losses

Urology/Nephrology

- Scrotal mass, testicular, or does not transilluminate
- Undescended tests
- Prostate suspicious for malignancy or obstructive symptoms that may lead to surgical treatment
- Urinary stones that do not pass in a week (4 mm or less)
- Larger or proximal stones for consideration of removal, stenting or lithotripsy
- Male infertility
- Erectile dysfunction not obviously psychogenic
- Acute renal failure
- Obstructive uropathy
- 50 percent reduction in creatinine clearance
- Nephrotic syndrome
- Circumcision with recurrent balanitis or foreskin problems

Vascular Surgery

- Arterial problems, such as gangrene, ischemic ulcers or ischemic rest pain

- Venous insufficiency with stasis ulcers
- Abdominal aortic aneurysms that are symptomatic, enlarging, or greater than 5 cm in diameter

Infectious Disease

- Human immunodeficiency virus (HIV)
- AIDS

Referrals to Specialists

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

A referral is required for cases that are difficult to manage or when care is beyond the primary care physician's (PCP's) scope of practice. Refer to the Referral for Specialty Consultation discussion for a summary of some of the services that may be referred to a specialist.

Health Net delegates the referral process to full and shared-risk participating physician groups (PPGs). Referrals to participating and non-participating specialists for members assigned to a capitated PPG are subject to any additional rules imposed by the PPG. PPGs may not impose referral or authorization requirements that conflict with the member's right to self-refer.

Los Angeles County

When referring a member for specialty care, the PCP must follow the guidelines outlined below, as well as those dictated by the PPG:

- Select a specialist from a list of participating providers in the PPG
- Follow the PPG's referral guidelines
- When scheduling an appointment, the wait time for specialty care must not exceed 15 business days and must be coordinated with the PCP based on the severity of the member's condition
- The specialist treats the member as indicated on the referral and notifies the PCP of the findings
- The specialist may order diagnostic tests, X-ray and laboratory services, and durable medical equipment (DME). The specialist must follow the PPG's referral guidelines and use the participating provider network when referring for lab, X-ray, DME, and other ancillary services
- If the member requires treatment beyond the services requested by the PCP, the specialist must contact the PCP for an additional referral, as required by PPG guidelines
- Referrals are only valid between participating providers. Any referrals to non-participating providers require prior authorization from the PPG or Health Net or its affiliated health plans, depending on the PCP's contract affiliation
    - If an out-of-network referral is necessary, due to medical necessity or patient need, even if a participating provider is closer, the referral benefit is at the member's in-network cost of share.

health net

All Other Counties

When referring a member for specialty care, the PCP must follow the guidelines outlined below:

- Select a specialist from the list of participating providers in Health Net's Medi-Cal provider listing or from a list of participating providers in the PPG
- For services with an out-of-network specialist, PCPs participating directly with Health Net must complete and fax the Inpatient Califonria Medi-Cal Prior Authorization Form (PDF) or the Outpatient California Medi-Cal Authoirization Form (PDF) to the specialist with the authorization number attached. PCPs participating through a PPG must follow the PPG's referral guidelines
    - If an out-of-network referral is necessary, due to medical necessity or patient need, even if a participating provider is closer, the referral benefit is at the member's in-network cost of share.
- For specialty visits with participating specialists, there is no need to complete a prior authorization form or notify Health Net; however, many specialists prefer an authorization number prior to performing services. As a courtesy to the specialist, Health Net provides the PCP with an authorization number upon request from the PCP or specialist
- When scheduling an appointment, the wait time for specialty care must not exceed 15 business days and must be coordinated with the PCP based on the severity of the condition
- The specialist treats the member as indicated on the Prior Authorization Request form and notifies the PCP of the findings
- The specialist may order diagnostic tests, X-ray and laboratory services, and durable medical equipment (DME) (some services may require prior authorization)
- If the member requires treatment beyond the services requested by the PCP, the specialist must contact the PCP for an additional referral
- Referrals are only valid between participating providers. Any referrals to nonparticipating providers require prior authorization from Health Net or the PPG, with the exception of those services for which members may self-refer without prior authorization

Referrals between specialists are not covered. When a specialist determines that referral to another specialist is needed, the PCP must be notified and requested to make the referral.

Referrals for Specialty Consultation

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

Listed below are examples of services that are referred for specialty consultation. This list provides guidelines and is not intended to be all-inclusive.

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- Significant reactions to stinging insects, chronic eczema, chronic sinusitis, and medication allergies
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- Candidates for thrombolysis, stress testing, catheterization, angioplasty, or surgery, and life-threatening arrhythmias, or hemodynamic complications requiring invasive monitoring
- Unstable angina
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- Complicated hypertension (failure to respond or adverse response to conventional therapy)
- Angina despite maximal pharmacological therapy with maximally tolerated doses of nitrates, beta-blockers, and calcium channel blockers
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- Evaluate and treat recurrent syncope (cardiac)
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- Evaluate and treat any non-soft, non-systolic cardiac murmur
- Evaluate cyanosis that does not clear with crying
- Evaluate tachypnea
- Evaluate diminished pulses in any extremity
- Consultation for any member with a syndrome known to have cardiac complications (Down's, Marfan's, etc.)

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- Acne that has not resolved or improved after three months
- Severe cystic acne
- Suspicious lesion suggesting melanoma
- Basal or squamous cell carcinomas
- Biopsy of suspicious lesions

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- Coma not rapidly reversible by glucose
- Instability in an established management program
- Brittle diabetes

- Diabetic complications, including retinopathy and nephropathy
- Exophthalmos, moderately severe or symptomatic
- Fine-needle aspiration of thyroid nodules
- Suspected disorders of calcium metabolism, adrenal, gonadal, or pituitary dysfunction
- Growth retardation (non-familial)
- Hyperlipidemia (no response to diet and medication, including two different medications, within one year)
- Radioactive iodine therapy

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- Bowel obstruction diagnosed
- Polyps or other abnormalities
- Chronic bleeding, acute GI hemorrhage
- Undiagnosed hepatocellular disease or biliary obstruction
- Jaundice complicated by fever
- Severe acute and chronic hepatitis
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- Higher risk members (for example, over-age)
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- Metallic foreign bodies
- Sudden visual change or loss
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- Pediatric members with dysconjugate gaze
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- Fracture
- Locked knee
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- Foot problems (deep abscess, gangrene, osteomyelitis)
- Any diabetic foot
- Obvious or apparent ligament tear
- Progressive disability of the knee despite conservative treatment and X-ray showing joint narrowing or gross destruction of the articular surface

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- Tonsillectomy if three documented episodes within four months or six documented episodes within one year
- Tonsillar obstruction or recurrent peritonsillar abscess
- Acute otitis media, member toxic for 48 hours despite treatment
- Persistent middle ear effusion lasting more than three months with continuous treatment, or persistent infection after three courses of different antibiotics
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- Recurrent epistaxis
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- Acute or persistent hearing loss not attributable to fluid or wax
- Hoarseness that persists for more than three weeks

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  - Members who report feeling suicidal or homicidal
  - Panic disorders
- For example, continued:
  - Severe anxiety states
  - Clear somatoform disorders
  - Schizophrenic disorders where clozapine or risperidone are being considered
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- Diagnosis, treatment and consultation regarding management of clearly emotional issues for which the member or PCP feels the need for consultation
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- Pleural biopsies
- Supraclavicular node biopsies
- Pleural effusions not due to heart failure or acute pneumonia
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- Lung masses
- Hemoptysis
- Interstitial disease
- Sarcoidosis
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- Unusual infections
- Dyspnea of uncertain etiology
- Sleep disorders
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- Brief psychotherapy, including post-traumatic stress disorder (PTSD), grief, recent losses

Urology/Nephrology

- Scrotal mass, testicular, or does not transilluminate
- Undescended tests
- Prostate suspicious for malignancy or obstructive symptoms that may lead to surgical treatment
- Urinary stones that do not pass in a week (4 mm or less)
- Larger or proximal stones for consideration of removal, stenting or lithotripsy
- Male infertility
- Erectile dysfunction not obviously psychogenic
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- Obstructive uropathy
- 50 percent reduction in creatinine clearance
- Nephrotic syndrome
- Circumcision with recurrent balanitis or foreskin problems

Vascular Surgery

- Arterial problems, such as gangrene, ischemic ulcers or ischemic rest pain
- Venous insufficiency with stasis ulcers
- Abdominal aortic aneurysms that are symptomatic, enlarging, or greater than 5 cm in diameter

Infectious Disease

- Human immunodeficiency virus (HIV)
- AIDS

Services Not Requiring Referral or Prior Authorization

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

Refer to the Prior Authorization section for Services Not Requiring Referral or Prior Authorization.

Standing Referrals to a Specialist

Provider Type: Physicians | Participating Physician Groups (PPG)

Health Net and its participating physician groups (PPGs) are required to have procedures for members to receive a standing referral to a specialist or specialty care center, including, but not limited to, HIV or AIDS specialists.

Definitions

Standing referral is a referral by the primary care physician (PCP) to a specialist for more than one visit to the specialist, as indicated in a treatment plan, if any, without the PCP having to provide a specific referral for each visit.

Specialty care center is defined as a center that is accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

Standing Referral to a Specialist

Health Net and its delegated PPGs provide for a standing referral to a specialist if the member's PCP determines in consultation with the specialist, if appropriate, and medical director (associated with PPG or Health Net) that the member needs continuing care from the specialist as follows:

- If a treatment plan is deemed necessary in the course of care and is approved by Health Net (or the PPG), in consultation with the PCP, specialist and member, the referral is made subject to the terms of the treatment plan.
- A treatment plan may not be necessary if Health Net (or the PPG) approved a current standing referral to a specialist.
- The treatment plan may limit the number of visits to the specialist, limit the period of time that the visits are authorized, or require that the specialist provide the PCP with regular reports on the health care provided to the member.

Prolonged Standing Referral

Health Net and its delegated PPGs provide members with standing referrals for specialized medical care over a prolonged period of time specifically for members who have conditions or diseases that are life-threatening, degenerative or disabling. These members may receive a referral to a specialist or specialty care center with expertise in treating the condition or disease for the purpose of having the specialist coordinate the member's health care as follows:

- If a treatment plan is deemed necessary in the course of care and is approved by Health Net (or the PPG), in consultation with the PCP, specialist, specialty care center, and member, the referral is made, subject to the terms of the treatment plan.
- A treatment plan may not be necessary if Health Net (or the PPG) approves the appropriate referral to a specialist or specialty care center.
- The referral is made if the PCP, in consultation with the member's specialist or specialty care center, and the PPG, determines specialized care is medically necessary for the member.

Time Limits

The determination of a standing referral request is made within three business days from receipt of request by the member or the member's PCP, and all appropriate medical records, and other information necessary is submitted.

Once Health Net or its delegated PPG make the determination, the referral authorization is issued within four business days of the date the proposed treatment plan, if any, is submitted.

Ordinarily PCPs or PPGs do not refer the member to a specialist that is not participating with the PPG or Health Net, unless there is no specialist within the PPG or Health Net's networks that are appropriate to provide treatment to the member, as determined by the member's PCP in consultation with PPG or Health Net's medical director, and documented in the treatment plan. If an out-of-network referral is necessary, benefits are provided at the in-network cost-share.

The PCP and PPG must track and monitor referrals requiring prior authorization. The tracking system must include authorized, denied, deferred, or modified referrals, the timeliness of the referrals, and referrals made to non-participating providers.

Third-Party Liability

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

This section contains general information on third-party liability responsibilities.

Select any subject below:

- Overview
- Provider Responsibilities

Overview

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

Under Health Net's Medi-Cal contracts, Health Net and its participating providers are prohibited from making any claim for recovery of the value of covered services rendered to a member when such recovery would result from an action involving the tort liability of a third party or recovery from the estates of deceased members or casualty liability insurance, including workers' compensation awards and uninsured motorist coverage.

Health Net and its participating providers are required to assist the Department of Health Care Services (DHCS) in pursuing the state's right to reimbursement from such recoveries. Health Net and its participating physician groups (PPGs) are required to notify DHCS within 10 days of the discovery of such cases. On request from DHCS for information, Health Net and PPGs must provide additional information within 30 days. Individual providers are obligated to assist Health Net and affiliated PPGs in providing the additional information on request.

Provider Responsibilities

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

How to notify and respond to a TPL request

Providers must notify Health Net or the participating physician group (PPG) in writing of all potential and confirmed third-party liability (TPL) cases that involve a Health Net Medi-Cal member. If a provider has received subpoenas from attorneys, insurers, or members for copies of bills concerning a TPL case, the provider must notify Health Net with copies of the request and copies of documents released as a result of the request. The information must also include the name, address and telephone number of the requesting party. The notification must be submitted via email.

Note: In all third-party tort liability cases, providers must bill Health Net or the PPG as usual, and give all details regarding the injury or illness. Health Net pays usual benefits, and refers the case to DHCS to pursue the recovery.

Requests from Health Net for TPL

If the Department of Health Care Services (DHCS) requests information regarding an individual TPL case, Health Net will send providers a letter to request TPL claims information and an itemized list of services for affected members. Providers are responsible for supplying Health Net with copies of the requested documents in the time frame described in the letter in order for Health Net to deliver the information to DHCS no later than 30 calendar days of the DHCS request. Providers must submit the information to the Health Net Third-Party Liability Department.

Pursuant to DHCS All Plan Letter 21-007, the claims data must meet the standard reporting requirements set forth by DHCS. DHCS requires the use of a DHCS-approved Excel worksheet to submit and receive TPL claims data. All claims data submissions must include the following data elements in the approved Excel format below.

Note: An approved Excel worksheet will be provided by Health Net along with the request for TPL claims data. The PPG must follow the instructions in the TPL claims data request.

Field	Description
MCP/IPA	Name of the PPG or independent physician association (IPA) (the name of the business entity owned by a network of independent physicians)
Member name	The name of the Medi-Cal member
Date of birth	The Medi-Cal member's date of birth
CIN	The Client Index Number (CIN) 9-digit character on the Medi-Cal Benefits Identification Card. It starts with the number “9” and ends with an alpha (A-Z).
Date of injury	The Medi-Cal member's date of injury
CCN	A Claim Control Number (CCN) uniquely identifies any processed claims within a specific plan code.
Claim line number	The last two characters of the CCN are the claim line number and they are unique for each service.
Claim type	Identifies the general type of service that was rendered
Service from date	Identifies the start date of the service on a claim
Service to date	Identifies the end date of the service on a claim

Field	Description
Provider legal name	Indicates the provider's legal name
NPI	The National Provider Identifier (NPI) is a unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare & Medicaid Services.
Diagnosis code 1	Identifies the diagnosis code for the principal condition requiring medical attention
Diagnosis code 2	Identifies the secondary diagnosis code which requires supplementary medical treatment
Drug label name	Label name of the drug (if claim is for drug)
Billed amount	Identifies amount billed to the plan from the provider
Paid amount	Identifies the actual amount paid to the provider for services
Reasonable value	Identifies the reasonable/customary value of the service provided. Absent the “Amount paid, due to capitated or other service type, the “Reasonable value” of the service must be provided, pursuant to Title 28, California Code of Regulations (CCR), section 1300.71(a)(3).
CPT code	Official CPT code used to report medical, surgical, and diagnostic procedures and services. CPT is a registered trademark of the American Medical Association.
CPT type	There are three types of CPT codes: Category 1 (procedures and contemporary medical practices), Category 2 (clinical laboratory services) and Category 3 (emerging technologies, services and procedures). CPT is a

Field	Description
	registered trademark of the American Medical Association.
Claim deny reason code 1 & description	Primary denial code and description (if claim denied)
Claim deny reason code 2 & description	Secondary denial code and description (if claim denied)

Urgent Care

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

Urgent care is required for those medical conditions that do not fit the definition of emergency, but require the member receive treatment within 48 hours (for Medi-Cal facility site review purposes, within 24 hours).

Utilization Management

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

This section describes Health Net's utilization management program and processes.

Select any subject below:

- Overview
- Nurse Advise Telephone Triage and Screening Program
- Affiliated Health Plan Delegated Utilization Management - Reporting
- Care Coordination
- Care Management
- Clinical Criteria for Medical Management Decision Making
- Clinical Criteria for Utilization and Care Management Decisions
- Concurrent and Retrospective Review
- Continuity of Care
- Hospital and Inpatient Facility Discharge Planning
- Notification of Hospital Admissions
- Out-of-Area Service
- Prescription Utilization Review
- Prior Authorization

Prior Authorization

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

Prior authorization allows the Health Net Health Services Department to review a proposed admission or procedure for coverage determination, medical necessity, level of care, length of stay, and placement prior to the delivery of services. Refer to the Prior Authorization topic for an explanation of the prior authorization process and a list of services requiring prior authorization.

Overview

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

Health Net's utilization management (UM) program is designed to ensure that members receive timely, medically necessary and cost-effective health care services at the correct level of care. The scope of the program includes all members and network providers. Prior authorization, concurrent review, discharge planning, care management, and retrospective review are elements of the UM process.

Refer to definition of medical necessity or definition of investigational services for additional information.

Nurse Advice Telephone Triage and Screening Program

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

Health Net's Nurse Advice Telephone Triage & Screening program provides 24-hours a day, 7 days a week triage or screening services by phone. The Nurse Advice Telephone Triage & Screening program is a service offered in conjunction with the primary care physician (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 phone service for urgent/emergent instructions, medical condition assessment, and advice. The Health Net Member Services Department, Community Health Plan of Imperial Valley Member Services Department or CalViva Health Medi-Cal Member Services Department (for Fresno, Kings and Madera counties) coordinates member access to the program, 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, provide self-care guidance, general health information, or recommend a visit to urgent care or the ER. Standard triage protocols are utilized, which have been written and reviewed by physicians.

Health Net ensures that phone Nurse Advice Telephone Triage & Screening program 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.

Role of Medi-Cal Member Services Department

The Health Net Medi-Cal Member Services Department's 24-hour toll-free phone number is printed on the back of the member's identification card. While assistance via the phone is the PCP's responsibility, the Health Net Medi-Cal Member Services Department can assist members in reaching their PCPs when needed. The Health Net Medi-Cal Member Services representative can either get the member in contact with the PCP or, if the PCP is not available or at the request of the member, the call can be routed to the Health Net Nurse Advice Line.

If, for any reason, a member services representative experiences problems reaching a member's PCP, the call is routed to Health Net's Nurse Advice Telephone Triage (or Molina in Los Angeles).

Role of the Program Nurse

On receipt of a call, the nurse addresses emergencies immediately by directing the member to a hospital emergency department and assisting the member in securing an ambulance, if necessary. Members who need urgent care are referred to an urgent care center if the PCP is not available. The referral record can be faxed to the emergency department or urgent care center to inform the facility of the member's condition and pending arrival.

The nurse educates the member on the role of the PCP, assists the member in scheduling an appointment with the PCP, and gives the member information on procedures to follow until they receive care from the PCP.

All interaction with hospital staff, urgent care staff, and the PCP is documented. In addition, incident reports are completed when a member does not accept the nurse's recommendations. The nurse uses a tracking mechanism to follow-up on the disposition of the member, as indicated, and notifies the PCP of any member who appears to require follow-up assistance with coordination of care.

Affiliated Health Plan Delegated Utilization Management - Reporting

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

The following information applies to Los Angeles County only.

Primary care physicians (PCPs) participating with Molina Healthcare, directly or through a participating physician group (PPG), must send utilization reports directly to Molina detailing Medi-Cal services to members in this plan. Molina then sends copies of these reports to Health Net.

Report	Frequency	Description
California Children's Services (CCS)	--	Report of Health Net members referred to CCS at time of occurrence to initiate care coordination.
Comprehensive Perinatal Services Program (CPSP)	Case-by-case at time of occurrence	Report of Health Net members referred to CPSP at time of occurrence, to initiate care management.

Care Coordination

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

Care coordination refers to the system of directing and monitoring a member's care among multiple health care providers, encounters and procedures so that the member receives timely, medically necessary health services without interruption.

The system comprises several procedural components that are required based on the extent of the severity of the member's health condition. Basic procedures required of primary care physicians (PCPs), to maintain care coordination are:

- Documentation of member encounters, missed appointments, extensions of appointment waiting time (noted that a longer waiting time for appointment will not have a detrimental impact on the health of the member), and referrals in members' medical record
- Referral of members needing specialty health services
- Forwarding summaries of pertinent medical findings to specialists
- Documentation of services provided by a specialist in the member's primary care medical record
- Monitoring members who have ongoing medical conditions
- Notifying Health Net of member referrals to specialists, care management or public health programs

Additional procedures are required of PCPs when members' health conditions require urgent, emergency or inpatient health services, including:

- Documentation in members' medical records of emergency and urgent medical care and follow-up
- Coordinated hospital discharge planning
- Post-discharge care

Health Net suggests that each provider develop protocols to maintain care coordination. A log system for tracking prior authorizations, referrals to specialists, follow-up of missed appointments, and acknowledgment and verification of such things as lab and X-ray findings is recommended. The system can be manual or computerized.

Care Management Notification

The following applies to participating physician groups (PPGs) and hospitals only.

Report all admissions with an expected length of stay (ELOS) greater than 10 days and all cases identified meeting provider stop loss criteria. Fax information to the Health Net Hospital Notification Unit.

Change in Member Status

The provider must develop office procedures to remain informed about changes in the member's status (for example, member changed primary care physicians (PCPs), has been hospitalized or has died) with notation in the medical record.

The provider may obtain this information from member enrollment data. Further, the provider should receive information regarding hospital admissions within 24 hours or by the next business day from the facility, the member or Health Net (or affiliated Molina Healthcare in Los Angeles County).

Documenting Specialist Services

Specialist Report

Specialists are required to submit written reports to the referring physician. These written reports must include the specialist's findings, recommended treatment, results of any studies, tests, procedures, and recommendations for continued and or follow-up care. The primary care physicians (PCPs) must receive the report within two weeks of the member's visit with the specialist. Emergency or urgent care reports or findings must be called to the PCP within 24 hours or by the next business day.

The PCP is required to review the specialist's findings to determine whether follow-up care is medically necessary. The PCP is responsible for directing all member care through the referral process.

Services Received in an Alternate Care Setting

The PCP should receive a report with findings, recommended treatment and results of treatment for services performed outside the PCP's office.

The provider may also receive emergency department reports, hospital discharge summaries and other information.

Home health care agencies submit treatment plans to the PCP after an authorized evaluation visit and every 30 days afterward for review of home health care and authorization.

The PCP should also receive reports regarding diagnostic or imaging services with abnormal findings or evaluations and subsequent action.

Missed Appointments and Other Procedures

The following applies to participating physician groups (PPGs) and physicians only.

Missed Appointments

Appointments may be missed due to member cancellation or no show. The Department of Health Care Services (DHCS) requires the provider to attempt to contact the member a minimum of three times when they miss an appointment. Attempts to contact must include:

1. First attempt - telephone call to member. (A written letter must be sent if the member does not have a telephone.)
2. Second attempt - if member does not respond to the first attempt, a second telephone call must be made to the member. (A written letter must be sent if the member does not have a telephone.)
3. Third attempt - if member does not respond to the second attempt, a written letter must be sent.

For members under age 21, failure to respond to the primary care physicians (PCPs) follow-up attempt must be reported to Health Net's public programs administrators.

Documentation must be noted in the member's medical record regarding any missed or canceled appointments, reschedule dates and attempts to contact. Health Net recommends the use of a rubber stamp to document this information in the chart.

Missed Procedure or Laboratory Test

Appointments for procedures or tests may be missed or canceled. The provider must contact the member by telephone or letter to reschedule. Documentation must be noted in the medical record regarding any missed or canceled procedures or tests, reschedule dates and any attempts to contact the member.

Public Health Agency Referral Notification

Providers must report to Health Net all Medi-Cal members who have been referred to public health programs, excluding those referred for sensitive services (such as HIV testing and counseling, family planning, and alcohol and drug abuse treatment). Notification to Health Net Medical Management may be made via mail or fax and must include the following information:

- Member name
- Member identification number
- Provider name
- Type of referral
- Date of referral
- For California Children's Services (CCS), include diagnosis

Specialist Designation as a Primary Care Physician

The following applies to particpating physician groups (PPGs) and physicians only.

A specialist may serve as a primary care physicians (PCPs) for Medi-Cal members who are Seniors and Persons with Disabilities (SPDs). The specialist must agree to serve as a PCP and be qualified to treat the required range of conditions of the SPD member.

SPD members may request a specialist as a PCP, as follows:

1. SPD members may contact the Health Net Medi-Cal Member Services Department, Community Health Plan of Imperial Valley Member Services Department or the CalViva Health Medi-Cal Member Services Department for assistance with PCP selection.
2. If the SPD member requests a specialist as a PCP, the Medi-Cal Member Services Department representative obtains the necessary information from the SPD member, including the specialist's name and participating physician group (PPG) affiliation (if applicable).
3. The Medi-Cal Member Services Department representative forwards the SPD member's request for a specialist as a PCP to Health Net, Molina Healthcare, or the delegated PPG's designated intake department.
4. The Health Net, Molina Healthcare or delegated PPG's designated intake representative contacts the specialist and explains the requirements for serving as a PCP (refer to PCP Responsibilities section below), including the facility site review (FSR) requirements. The representative may also contact the member to discuss the process and reassure the member that they chose specialist can continue to see the member as a specialist even if the provider does not choose to become a PCP. PPGs are encouraged to work with members to help them establish a medical home with their chosen PCP.
5. If the specialist agrees to serve as a PCP and is qualified to treat the required range of conditions of an SPD member, the Health Net, Molina Healthcare or delegated PPG's designated representative initiates the process to conduct a full-scope FSR. A member cannot be assigned to a specialist who is serving as a PCP until the specialist's office has passed the FSR.
6. After the specialist passes the FSR, the applicable Health Net, Molina Healthcare, or delegated PPG's designated representative submits the documentation to change the provider's status in Health Net's data management system from a specialist to a PCP.

Once the contracting specialist agrees to serve as, and is designated by Health Net to serve as a PCP, they are no longer designated as a contracting specialist in Health Net's network.

Care Management

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

This section contains general information on care management.

Select any subject below:

- Overview
- Referrals
- Complex Cancer Care
- Complex Case Management
- Discharging a Member from Care Management

Overview

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

The Health Net Care Management program involves identifying medical need and allocating resources. The goal of care management is to ensure that all services are medically necessary, not duplicated, safe, provided at the acceptable standard of quality as measured by the professional medical community, and at the correct level of care.

Health Net complies with applicable federal civil rights laws and ensures that all medically necessary covered services are available and accessible to all members regardless of race, color, national origin, age, mental disability, physical disability, sex (including pregnancy, sexual orientation, and gender identity), religion, ancestry, ethnic group identification, medical condition, genetic information, marital status, or gender or identification with any other persons or groups defined in Penal Code 422.56, and that all covered services are provided in a culturally and linguistically appropriate manner.

Care management is not episodic or restricted to a single practice setting, but occurs across the continuum of care and addresses ongoing individual needs.

There are two different levels of care management:

- Basic care management
- Comprehensive care management

Basic Care Management

At the basic level, care management is the responsibility of the primary care physician (PCP). The PCP is responsible for providing initial primary care management, maintaining continuity of care and initiating specialist care. This means providing care for the majority of health problems, including preventive care services, basic care management, acute and chronic conditions, and psychosocial problems.

Comprehensive Care Management

As a member's health care service needs increase in complexity because of a catastrophic or fragile medical condition, the case is referred to the Health Net Care Management Department, the participating physician group (PPG), or a county or state program for comprehensive care management.

Comprehensive care management is necessary when a member has multiple problems and diagnoses resulting in a high-risk catastrophic or fragile medical condition. Comprehensive care management is a collaborative process through which a Health Net registered nurse (RN) care manager assesses, plans,

coordinates, monitors, and evaluates the options and services needed to meet a member's health needs and promote a positive health outcome in cooperation with the entire treatment team.

Care management involves identifying medical needs and allocating resources. The goal of care management is to ensure that all services are medically necessary, not duplicated, safe, provided at the acceptable standard of quality as measured by the professional medical community, and at the correct level of care.

Complex or comprehensive care management is not delegated to Medi-Cal PPGs

Carve-Out Services

Some services, such as major organ transplant for members under 21, have been carved-out of the health plan and are not covered by Health Net under its Medi-Cal managed care contract with the California Department of Health Care Services (DHCS). Transplant cases for members under age 21 are managed by the state of California. County care management programs include California Children's Services (CCS), waiver and regional service programs. Refer to the Public Health topic for additional information on these programs. For a complete list of carve-out services refer to Member Handbook.

Problem Resolution

Disagreements that arise between Health Net's care management and public health case management are resolved by the Health Net Medical Management Department.

Referrals

Physicians | Hospitals | Participating Physician Groups (PPG)

Referrals to Health Net

The following process applies to cases that need to be referred to the Health Net Medical Management Department:

1. The referral is made to the Health Net care management intake coordinator in the Medical Management. Most cases are identified through the inpatient concurrent review process, but referrals are accepted from any source. Indicators that a member may be appropriate for care management may be based on diagnosis, potential treatment, frequent hospitalizations, extended hospitalizations, location of care, and patterns of care.
2. The case is assigned to a Health Net care manager.
3. The Health Net care manager assesses the member's medical care needs by talking with the member, family (if the member is a minor or is incapable of self-representation) and the referral source.
4. The Health Net care manager requests all pertinent medical records from the primary care physician (PCP), involved hospitals, specialists, therapists, and other treatment or referral sources.

5. The Health Net care manager notifies the referral source, member or guardian, PCP, and participating physician group (PPG), if applicable, of the member's eligibility for the Health Net care management program. If the member is not eligible for the program, the Health Net care manager may offer suggestions or alternatives for the member to pursue.
6. The Health Net care manager develops a care management plan (CMP) in collaboration with the health care team, family and member that is reviewed with the Health Net Medi-Cal medical director. If the CMP is approved, the Health Net care manager contacts the PCP and other involved health care providers to discuss implementation.
7. The CMP is followed and referrals and prior authorizations are sought within the system.
8. The PCP makes the referrals and treatment is initiated.
9. The Health Net care manager reviews the CMP and the member's progress at least once every 30 days, allowing for re-evaluation in the event of a change in medical condition. Short-term referrals, expected to last three months or less, are reviewed more frequently. Any changes in the CMP are submitted to the PCP for approval.

Referrals to State or County Care Management

When a member is identified as eligible for a county or state-supported health care program, a Health Net care manager or review nurse assists the PCP, on request, in ensuring timely referral. The PCP makes the referral and coordinates primary medical care for members who are eligible for any of the carve-out programs. Health Net's care managers also serve as liaisons between the PCP and the county carve-out services coordinator to ensure exchange of information and provision of primary health care for individual members.

Los Angeles County - Referrals to Affiliated Health Plans

PPGs to which Health Net has delegated responsibility for care management services must refer members identified as potential care management recipients to the affiliated health plan's utilization management (UM) or health care services department.

Identification of Potential Care Management Recipients

Members are referred by the primary care physician (PCP) or specialist for individual medical care management services for high-risk medical conditions. The following list of medical conditions represents the type of conditions that must be referred for comprehensive care management:

- Multiple trauma with acute extended length of stay (ELOS) greater than 10 days
- Severe neurological diseases that are chronic degenerative (for example, amyotrophic lateral sclerosis (ALS))
- Complex multi-diagnostic cases

In addition, Medi-Cal managed care members with the following medical conditions must be referred to care management for referral to the applicable state or county program:

- All transplant cases for members under age 21
- Multiple congenital birth defects
- Pre-term births, including those eligible for high-risk follow up from California Children's Services (CCS)
- Members with AIDS
- Children with special health care needs eligible for Regional Center care
- Children with CCS eligible conditions
- Children over age three with speech/language delay

Additional information regarding eligibility requirements for public health programs, such as Regional Centers and CCS, is provided in the Public Health topic.

Complex Case Management Program

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

The Complex Case Management program identifies members as being at high risk for hospitalizations or poor outcomes and who have barriers to their health care. The program utilizes an evidence-based, approach, which is member-focused and goal-directed, in developing, implementing and monitoring the care plan. Trained nurse care managers, in collaboration with a multidisciplinary team, provide coordination, education and support to the member in achieving optimal health, enhancing quality of life and accessing appropriate services.

This program supports the member, family and caregivers by coordinating care and facilitating communication between health care providers. Once a member is selected to participate in the program, a case manager contacts the member's provider to coordinate care.

Outcomes for this program include:

- Completion of a comprehensive health assessment that identifies medical needs (including primary and specialty care), medication management, durable medical equipment (DME) needs, and other psychological and social needs.
- Collaboration between the case manager, member (family and caregiver), multidisciplinary team, primary care physician (PCP), and other clinical providers to develop an individual written plan of care that is communicated to the provider and medical home.
- Coordination of care, including provision of emotional and social support, for acute and chronic illness.
- Improved member knowledge of their illnesses, self-management skills, health care options, and available services.
- Avoidance of unnecessary emergency visits and hospitalizations, seamless transitions between levels of care and the appropriate use of resources.

On an ongoing basis, Health Net evaluates the efficacy of this program by reviewing and comparing specific member outcomes and utilization before and after case management intervention.

Criteria

Members are selected for this program when they have a significant, life-limiting diagnosis with multiple comorbid conditions and critical barriers to their care. Many of these members have diagnoses that are no longer responding to typical treatment regimens or are unable to participate in aggressive treatment without additional support. Complex case management manages members who are experiencing acute and severe events, such as:

- Complex chronic conditions such as diabetes, asthma, chronic obstructive pulmonary disease (COPD), and vascular or active cancers.
- Multiple co-morbidities.
- A health event that has the potential for significant consumption of resources - (medical or financial).
- Complications relating to frail health status.
- Those experiencing frequent or prolonged hospitalizations or emergency visits.
- Multiple psychosocial factors, such as need for support system, transportation, financial resources, decision support, habilitation, or residential needs.
- Functional impairment, such as dependency for activities of daily living (ADLs) and instrumental activities of daily living (IADLs).
- Individuals who are eligible by law, such as those with mental or developmental 'disabilities.

Program Components

This program helps facilitate an appropriate personalized level of care for members, which includes:

- Telephonic interactions with a trained nurse or social worker case manager.
- Comprehensive assessment of medical, psychosocial, medication adherence, and DME needs.
- Development of an individual care treatment plan reflects the member's ongoing health care needs, abilities and preferences.
- Consolidation of treatment plans from multiple providers into a single plan of care, to avoid fragmented or duplicative care.
- Coordination of treatment plans for acute or chronic illness, including emotional and social support issues.
- Coordination of resources to promote the member's optimal health or improved functionality with referrals to other team members or programs, as appropriate.
- Education and information about medical conditions and self-management skills, compliance with the medical plan of care, and other available services to reduce readmissions and inappropriate utilization of hospital services
- Communication to the provider and medical home.

Referrals

Providers may refer members for complex case management and complete the Care Management Referral Form – Health Net (PDF), Care Management Referral Form – Community Health Plan of Imperial Valley (PDF) or Care Management Referral Form –CalViva Health (PDF). Members may self-refer to the program by calling the member services telephone number on the back of their identification (ID) card.

Discharging a Member from Care Management

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

The Health Net care manager determines when a member is to be discharged from care management. Generally, the member is discharged when the highest level of functioning within the limitations of the condition has been reached. Once the member has been discharged from care management, ongoing health care is managed by the primary care physician (PCP).

Health Education and Preventive Care Programs

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

Health education programs are incorporated into the Health Net care management plan to address the member's health needs. Primary prevention programs may include topics such as nutrition, exercise, smoking cessation, and stress reduction. These programs are designed to prevent health problems, such as pregnancy counseling and care management intervention, help to reduce premature labor or low-birth-weight infants. The Health Net care manager works closely with the Health Net health education staff to coordinate in-service education for care management members.

Disease Care Management

According to Department of Health Care Services (DHCS) contractual requirements, disease care management for Medi-Cal is provided for two chronic disease states: diabetes and asthma. These are not refer-in programs. Members are identified for inclusion in these programs twice per year, using Healthcare Effectiveness Data and Information Set (HEDIS®) definitions of asthma and diabetes. Stratification into two risk categories occurs, identifying "red" or high-risk members for outbound telephonic case management, and "green" or low-risk members who have not sought care through an emergency department or inpatient setting in the previous 12 months. The low-risk members receive annual mailings, including instructional booklets and other tools to make encourage monitoring and initiation of a care plan with their primary care physician (PCP). McKesson Health Solutions provides case management functions by telephone for these two programs, and completely controls identification, stratification, mailings, and telephonic intervention with the asthma cohort.

Episodic Care Management

Episodic care management involves treating a specific episode of a member's care that occurs following a specific set of events or diagnoses. Episodic care management usually involves the use of specialists,

discharge planners and concurrent review nurses, in addition to the primary care physician (PCP) . Episodic care management is performed by the Health Net Health Services Department, the responsible affiliated health plan's UM department or a participating physician group (PPG) with delegated utilization management functions.

Palliative Care Services

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

Eligible members (including Dual Special Needs Plans (D-SNPs)) at any age may receive covered benefits and services while receiving palliative care. The member must be diagnosed with advanced cancer, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), or liver disease. Life expectancy is 12 months or less, health status continues to worsen and the emergency department (ED) or hospital is used to manage the illness.

Members receiving palliative care may move to hospice care if they meet the hospice eligibility criteria. For members ages 21 and older, palliative care benefits and curative care are not available once the patient moves to hospice. For members under age 21, curative care is available with hospice care.

Referrals

Palliative care services provide extra support to current benefits.

Providers can refer an eligible Medi-Cal member to palliative care. Send an Outpatient California Medi-Cal Prior Authorization Form (Medi-Cal (PDF), CalViva (PDF), CHPIV (PDF)) and related medical records by email or fax to the Prior Authorization Department.

To process the prior authorization request correctly, the following information must be included on the request:

- Diagnosis code – Z51.5
- Procedure code – S0311
- Units – 6 (equals 6 months)
- Select the contracted provider of choice from the list (Medi-Cal (PDF), CalViva (PDF), CHPIV (PDF)) .

Eligibility Criteria

Members of any age are eligible to receive palliative care services if they meet all of the criteria outlined in section A. below, and at least one of the four requirements outlined in section B.

Members under age 21 who do not qualify for services based on the above criteria may become eligible for palliative care services according to the broader criteria outlined in section C. below, consistent with the provision of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.

A. General Eligibility Criteria:

1. The member is likely to, or has started to, use the hospital or emergency department as a means to manage the member's advanced disease; this refers to unanticipated decompensation and does not include elective procedures.
2. The member has an advanced illness, as defined in section B below, with appropriate documentation of continued decline in health status, and is not eligible for or declines hospice enrollment.
3. The member's death within a year would not be unexpected based on clinical status.
4. The member has either received appropriate patient-desired medical therapy or is an individual for whom patient-desired medical therapy is no longer effective. The member is not in reversible acute decompensation.
5. The member and, if applicable, the family/member-designated support person, agrees to:
    - a. Attempt, as medically/clinically appropriate, in-home, residential-based, or outpatient disease management/palliative care instead of first going to the emergency department; and
    - b.Participate in advance care planning discussions.

B. Disease-Specific Eligibility Criteria:

1. Congestive heart failure (CHF): Must meet (a) and (b)
    - a. The member is hospitalized due to CHF as the primary diagnosis with no further invasive interventions planned or meets criteria for the New York Heart Association's (NYHA) heart failure classification III or higher; and
    - b. The member has an ejection fraction of less than 30 percent for systolic failure or significant co-morbidities.
2. Chronic obstructive pulmonary disease (COPD): Must meet (a) or (b)
    - a. The member has a forced expiratory volume (FEV) of one less than 35 percent of predicted and a 24-hour oxygen requirement of less than three liters per minute; or
    - b. The member has a 24-hour oxygen requirement of greater than or equal to three liters per minute.
3. Advanced cancer: Must meet (a) and (b)
    - a. The member has a stage III or IV solid organ cancer, lymphoma, or leukemia; and
    - b. The member has a Karnofsky Performance Scale score less than or equal to 70 or has failure of two lines of standard of care therapy (chemotherapy or radiation therapy).
4. Liver disease: Must meet (a) and (b) combined or (c) alone
    - a.The member has evidence of irreversible liver damage, serum albumin less than 3.0, and international normalized ratio greater than 1.3, and
    - b. The member has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or
    - c. The member has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score greater than 19.

C. Pediatric Palliative Care Eligibility Criteria:

Must meet 1. and 2. listed below. Members under age 21 may be eligible for palliative care and hospice services concurrently with curative care.

1. The family and/or legal guardian agree to the provision of pediatric palliative care services; and
2. There is documentation of a life-threatening diagnosis. This can include, but is not limited to:
    - a. Conditions for which curative treatment is possible, but may fail (e.g., advanced or progressive cancer or complex and severe congenital or acquired heart disease); or

- b. Conditions requiring intensive long-term treatment aimed at maintaining quality of life (e.g., human immunodeficiency virus infection, cystic fibrosis, or muscular dystrophy); or
- c. Progressive conditions for which treatment is exclusively palliative after diagnosis (e.g., progressive metabolic disorders or severe forms of osteogenesis imperfecta); or
- d. Conditions involving severe, non-progressive disability, or causing extreme vulnerability to health complications (e.g., extreme prematurity, severe neurologic sequelae of infectious disease or trauma, severe cerebral palsy with recurrent infection or difficult-to-control symptoms).

If the member continues to meet the above minimum eligibility criteria or pediatric palliative care eligibility criteria, the member may continue to access both palliative care and curative care until the condition improves, stabilizes, or results in death.

PCP Responsibilities

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

The primary care physician (PCP) continues to be the principal person responsible for directing the member's care. The Health Net care manager provides the PCP with reports regarding the member's progression through the care management plan. The PCP is responsible for:

- Providing ongoing medical treatment
- Providing health care information, such as medical records and the treatment plan, to expedite health services for the member
- Maintaining complete documentation in the member's medical record
- Participating as a health care team member in the member's care management plan
- Attending care conferences to evaluate the member's progress and modify the care plan, if necessary, and/or reviewing the care management plan of care and providing feedback to the care manager.

Complex Cancer Care

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

Medi-Cal members with a qualifying complex cancer diagnosis can request a referral from their provider to get medically needed care from a contracted cancer center (Medi-Cal CalViva Health), such as a:

- National Cancer Institute (NCI)-designated comprehensive cancer center,
- Site affiliated with the NCI Community Oncology Research Program (NCORP), or
- Qualifying academic cancer center.

Members also have the option to request treatment at an out-of-network cancer treatment provider.

What is a complex cancer diagnosis?

A complex cancer diagnosis includes those listed below. These diagnoses are subject to updates.

- Blood disorders/diseases, malignancies;
- Acute leukemia;
- Advanced, relapsed, refractory non-Hodgkin lymphoma and multiple myeloma including blastic plasmacytoid dendritic cell neoplasm (BPDCN) and T-cell leukemias and lymphomas;
- Advanced stage (stage IV metastatic cancer), relapsed solid tumors refractory to standard FDA-approved treatment options; and
- Advanced stage rare solid tumors for which there is no known effective standard treatment options.

How referrals to an out-of-network cancer center work

A member can get medically needed services from an out-of-network provider but there must be a **payment agreement** in place with Health Net (i.e., letter of agreement or LOA). This includes:

- When a member requests a referral through an out-of-network NCI-designated comprehensive cancer center, out-of-network NCORP-affiliated site, or out-of-network qualifying academic cancer center, or a member chooses a different type of cancer treatment provider,

or

- When an NCI-designated comprehensive cancer center, NCORP-affiliated site, or qualifying academic cancer center refers a member diagnosed with a complex cancer to an out-of-network specialist.

Clinical Criteria for Medical Management Decision Making

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

Clinical policies are one set of guidelines used to assist in administering health plan benefits, either by prior authorization or payment rules. They include, but are not limited to, policies relating to medical necessity clinical criteria for the evaluation and treatment of specific conditions and evolving medical technologies and procedures. Clinical policies help identify whether services are medically necessary based on information found in generally accepted standards of medical practice; peer-reviewed medical literature; government agency/ program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by the policy; and other available clinical information.

Clinical polices do not constitute a description of plan benefits nor can they be construed as medical advice. These policies provide guidance as to whether or not certain services or supplies are cosmetic, medically necessary or appropriate, or experimental and investigational. The policies do not constitute authorization or guarantee coverage for a particular procedure, device, medication, service, or supply. In the event a conflict of information is present between a clinical policy, member benefits, legal and regulatory mandates and requirements, Medicare or Medicaid (as applicable) and any plan document under which a member is entitled

to covered services, the plan document and regulatory requirements take precedence. Plan documents include, but are not limited to, subscriber contracts, summary plan documents and other coverage documents.

Clinical policies may have either a Health Net Health Plan or a “Centene” heading. Health Net utilizes InterQual® criteria for those medical technologies, procedures or pharmaceutical treatments for which a specific health clinical policy does not exist. InterQual is a nationally recognized evidence-based decision support tool. Clinical policies are reviewed annually and more frequently as new clinical information becomes available.

Clinical Criteria for Utilization and Care Management Decisions

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

To determine medical appropriateness, the Health Net utilization management (UM)/care management (CM) program uses recognized guidelines and criteria sets that are clearly documented, based on sound clinical evidence, and include procedures for applying criteria based on the needs of individual members and characteristics of the local delivery systems.

For the Medi-Cal program, Health Net uses criteria set forth in applicable sections of Titles 17 and 22 of the California Code of Regulations, Department of Health Care Services (DHCS) Managed Care All Plan Letters, DHCS Medi-Cal Provider Manuals, and Hayes evidence-based resources.

These criteria are used to appropriately and consistently evaluate clinical services for medical necessity when approving, modifying or denying requests for services. Health Net also uses InterQual® Care Planning Criteria along with other company-wide evidence-based medical policies, which are approved and updated by the Health Net Medical Advisory Council (MAC).

These UM criteria guide the assessment of medical necessity for pre-service outpatient requests, admissions and concurrent stay review in acute and skilled facilities. If conflicting criteria exist, Health Net considers Title 22 to prevail.

When applying criteria to a specific individual case, Health Net considers at least the following factors:

- Age
- Comorbidities
- Complications
- Progress of treatment
- Psychosocial situation
- Home environment, when applicable
- Characteristics of the local delivery system (if clinically necessary care is not available within the local delivery system, Health Net assists the member and practitioner to determine an alternate appropriate delivery system):
    - Ability of local hospitals to provide all recommended services within the estimated length of stay
    - Availability of skilled nursing facilities or subacute care facilities
    - Availability of other care appropriate to meet the member's individual needs

To ensure that the criteria used are consistently current, Health Net at least annually:

- Renews license agreements for the latest versions of the appropriate criteria sets, clinical practice guidelines and technology assessments
- Analyzes and updates medical criteria changes based on information collected from the previous year

The Health Net MAC and Quality Improvement and Health Equity Committee (QIHEC) are responsible for the review, revision and approval of all criteria.

Health Net makes many of the clinical criteria sets, including Health Net's medical policies, available to participating providers.

Concurrent and Retrospective Review

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

Concurrent Review

Concurrent review is the process of monitoring delivery of medical services at the time the care is being rendered (inpatient admissions). Concurrent review consists of pre-admission review, continued-stay review and discharge planning.

Concurrent review is initiated at the time prior authorization is requested for an inpatient admission or on notification to the Health Net Medical Management Department that a member has been admitted (in the case of an urgent or emergency admission). Concurrent review includes an evaluation of:

- Quality of care
- Plan of treatment
- Severity of illness
- Intensity of treatment
- Length of stay
- Level of care
- Discharge plan

Based on the concurrent review process, the hospital stay is approved or denied. If the stay is approved, the hospital receives a prior authorization number. The authorization number must be indicated on the hospital claim to Health Net.

All potentially non-approved services identified by the Health Net care manager (registered nurse (RN) reviewer) are reviewed with a Health Net medical director or a specialty advisor. Physicians and members have the right of appeal all un-approved services. Care cannot be discontinued until the treating provider has been notified and agreed to an appropriate discharge or transition of care plan.

Retrospective Review

Retrospective review is review of the quality and necessity of medical services after care has been rendered. Retrospective professional review involves an evaluation of services that fall outside Health Net's established guidelines for coverage. These claims are reviewed by Health Net's professional review specialists (RN reviewers) and a Health Net medical director or a specialty advisor where the initial reviewer recommends that a claim be denied for lack of medical necessity.

Continuity of Care

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

Under Health Net's continuity of care (COC) policy, there are two types of COC, non clinical and clinical COC.

Non-Clinical COC

All new Medi-Cal members who have been receiving care that meets certain criteria may continue with their existing out-of-network providers for up to 12 months. An existing relationship means the member has seen the non-participating provider at least once during the previous 12 months for non-emergency condition prior to the date of their initial enrollment with Health Net.

Member must have a pre-existing relationship with the requested provider. A pre-existing relationship means the member has seen an out-of-network primary care provider (PCP) or specialist at least once during the 12 months prior to the date of their initial enrollment into Medi Cal for a non-emergency visit.

The health plan or the delegated entity determines if a relationship exists through use of data provided by the Department of Health Care Services (DHCS). A member or their provider may also provide information to the health plan or the delegated entity that demonstrates a pre-existing relationship with the provider.

Following identification of a pre-existing relationship, the health plan or the delegated entity determines if the provider is an in-network provider. If the provider is not an in-network provider, the health plan or the delegated entity contacts the provider and makes a good faith effort to enter into a contract, letter of agreement, single-case agreement, or other form of relationship to establish a COC relationship for the member.

- The requested provider is willing to accept the higher of contracted rates or Medi-Cal FFS rates.
- The requested provider has no quality-of-care concerns. Health Net does not exclude the provider from its provider network unless there are documented quality-of-care concerns, or state or federal exclusion requirements.
- The requested provider is a California State Plan-approved provider.
- The requested provider supplies all relevant treatment information to determine medical necessity, as well as current treatment plan.

COC services not covered for Medi-Cal members

- Other ancillary providers, such as radiology, laboratory, dialysis center; non-emergency medical transportation (NEMT); non-medical transportation (NMT); other ancillary services; and non-enrolled Medi-Cal providers.

- Out-of-network providers who do not agree to abide by Health Net's utilization management UM policies.

If the out-of-network provider does not agree to a rate, or Health Net has a documented quality-of-care issue with the provider, the member will be offered an in-network alternative and assigned to another in-network provider.

Behavioral Health

COC for mental health services is provided by Health Net. Health Net provides COC with an out-of-network specialty mental health service provider where a member's mental health condition has stabilized and the member no longer qualifies to receive specialty mental health services (SMHS) from the county mental health plan (MHP). The member then becomes eligible to receive non-specialty mental health services from Health Net. In this situation, the COC requirement only applies to psychiatrists and/or outpatient mental health providers approved to provide Medi-Cal services.

PPG Process

Health Net begins to process the non-clinical COC request within five days of receiving the request. For delegated participating physician groups (PPGs), the Public Program Specialist’s team forwards the COC request to the PPG's utilization management (UM) department.

Staff from the PPG UM works with the out-of-network provider to secure a care plan for the member. They also issue the decision and explain the process for requesting continued services beyond the first authorization and, if warranted, how to continue out-of-network services up to the allowable timeframe of 12 months.

Necessary authorizations must be processed within 30 calendar days for regular requests and 15 calendar days for more immediate cases. As soon as possible, but no longer than three calendar days for urgent requests (i.e., there is identified risk of harm to the member).

The PPG is also responsible to:

- Notify the member about the transition to a new provider 30 calendar days prior to the end of the COC period and coordinates the transition with the out-of-network provider.
- Work with the out-of-network provider to make sure they are willing to work with the PPG and Health Net. Out-of-network providers cannot refer the member to another out-of-network provider without authorization from Health Net or a delegated PPG.
- The PPG follows up with the out-of-network provider and member to confirm they have received authorization from the PPG and both understand the process for further authorization requests.

Clinical COC

All new Medi-Cal members who have been receiving care that meets certain criteria may continue with their existing out-of-network providers for up to 12 months. An existing relationship means the member has seen the non-participating provider at least once during the previous 12 months for a non-emergency condition prior to the date of their initial enrollment with Health Net or a current Medi-Cal member may also be approved to complete care with a departing Health Net provider after that provider leaves Health Net's network. Completion of covered services are provided for a period of time necessary to complete a course of treatment and to

arrange for a safe transfer to another provider, as determined by Health Net in consultation with the member and terminated provider or non-participating provider and consistent with good professional practice and:

- The provider contract is terminated with Health Net for a reason other than medical discipline, fraud or crime.
- Had a PPG change due to provider contract termination or provider leaving assigned PPG.
- Are new members in treatment for conditions listed below.

Types of clinical criteria where a member may be eligible for COC:

- Acute conditions, which include medical conditions that involve a sudden onset of symptoms due to an illness, injury or other medical problem requiring prompt medical attention with a limited duration. Services must be provided for the duration of the acute condition.
- Services for a serious chronic condition must be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by Health Net in consultation with the member and the provider and consistent with good professional practice. Coverage may not exceed 12 months from the contract termination date. Serious chronic conditions include medical conditions due to a disease, illness or other medical problem or medical disorder that is serious in nature and does either of the following:
  - Persists without full cure or worsens over an extended period of time.
  - Requires ongoing treatment to maintain remission or prevent deterioration.
- Documented pregnancies – Completion of covered pregnancy services 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 – Services are provided for the duration of the terminal illness.
- Newborn care between birth and age 36 months – Coverage may not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a new member.
- Performance of a surgery or other procedure that is authorized by the plan as part of a documented course of treatment and had been recommended and documented by the provider to occur within 180 days.

Requesting Continuity of Care

Medi Cal members, their authorized representatives on file with Medi-Cal or their providers may initiate a request for continuity of care directly from Health Net. Health Net accepts verbal or written COC requests. Refer to the Health Net Medi-Cal Member Services Department, or CalViva Health Medi-Cal Member Services Department for assistance.

Health Net completes continuity of care requests within:

- 30 calendar days from the date of receipt
- 15 calendar days if the member's medical condition requires more immediate attention, or
- Three calendar days if there is risk of harm to the member. Risk of harm is defined as an imminent and serious threat to the member’s health.

Upon completion of the COC review, the provider and the member will be notified of decision within seven calendar days.

- If a member changes Medi-Cal managed care plans, the COC period may start over one time.
- If the member changes Medi-Cal managed care plans a second time (or more), the COC does not start over, meaning the member does not have the right to a new 12 months of COC by the non-participating provider.
- If the member returns to Medi-Cal fee-for-service (FFS) and later re-enrolls in a Medi-Cal managed care plan, the COC period does not start over.
- If a member changes managed care plans, COC assistance does not extend to participating providers the member accessed through their previous managed care plan.

A request for COC is complete when:

- The member is informed of their right to continued access.
- Health Net and the non-participating FFS provider are unable to agree to a compensation rate.
- Health Net has documented quality-of-care issues.

Discharge Notification

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

Hospitals and inpatient facilities (general acute care hospitals, long-term acute care hospitals and skilled nursing facilities) must have policies and procedures in place when transitioning members from hospitals or inpatient facilities to their homes and other community-based settings to support effective care transitions.

Hospitals and inpatient facilities must notify and communicate with the member's primary care physician (PCP) and Enhanced Care Management (ECM) provider of discharge from hospitals or inpatient facilities.

Information needed for discharge summary

When notifying the member's PCP and ECM provider of a discharge, provide the information below:

- Member name
- Identification (ID) number from patient's membership ID card
- Date of birth (DOB)
- Admission and discharge dates
- Attending physician name
- Attending physician phone number
- Diagnosis
- Follow-up appointment date, if known
- Discharge destination
- Responsible party at discharge
- Level of assistance required
- Discharge planning needs including equipment, service or other special training needs
- Medications, including dosage and frequency at discharge
- Facility name and phone number

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)

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:

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- Manifest MedEx
- SacValley MedShare
- San Diego Health Connect
- Applied Research Works, Inc.
- Health Gorilla, Inc.
- Long Health, Inc.
- Orange County Partners in Health-Health Information Exchange (OCPH-HIE)
- Serving Communities Health Information Organization (SCHIO)

Requests for Authorization for Post-Stabilization Care

The requirement to request authorization applies to both in-network and out-of-network hospitals when treating members.

The hospital's request for authorization is required once the member is stabilized following their initial emergency treatment and before the hospital admits them to the hospital for inpatient post-stabilization care. A patient is "stabilized," or "stabilization" has occurred, when, in the opinion of the treating provider, the patient's medical condition is such that, within reasonable medical probability, no material deterioration of the patient's condition is likely to result from, or occur during, the release or transfer of the patient.

Hospitals are required to provide the treating physician and/or surgeon's diagnosis and any other relevant information reasonably necessary for Health Net to decide whether to authorize post-stabilization care or to assume management of the patient's care by prompt transfer.

How to request post-stabilization authorization

To request authorization for post-stabilization care, the hospital must **call** the Hospital Notification Unit.

A hospital's notification to Health Net of emergency room treatment or admission **does not** satisfy the requirement to request post-stabilization care. Post-stabilization requirements do not apply if the member has **not** been stabilized after emergency services and requires medically necessary continued stabilizing care.

A hospital's contact with any other phone or fax number or website, or the patient's participating physician group (PPG), to request authorization to provide post-stabilization care does not satisfy the requirements of the above required procedures. Do not contact the member's PPG or any other Health Net phone, fax number or website to request Health Net's authorization for post-stabilization care.

Behavioral health emergencies

- **Marketplace/IFP (Ambetter HMO and PPO) and Employer Group HMO/POS and PPO members:** Health Net covers mental health and substance use disorder treatment that includes behavioral health crisis services provided to a member by a 988 crisis call center, mobile crisis team or other behavioral health crisis services providers, regardless of whether that provider or facility is in network or out of network. Hospitals must call the Hospital Notification Unit to request authorization for members' post-stabilization care once they are deemed stable but require facility-based care.
- **Medi-Cal members:** For post-stabilization care related to behavioral health for Medi-Cal members, Health Net oversees medical evaluation, stabilization and initial care. However, ongoing care in a facility following a behavioral health emergency falls under the responsibility of County Mental Health Plans. To ensure continuity of care, please contact your County Mental Health Plan for authorization of all facility-based services. They will coordinate and manage continued care once the member has been stabilized and is ready for transition.

County Mental Health Plan information is available through the Department of Health Care Services. Health Net will coordinate with the County Mental Health Plan to transition the member once appropriate.

Response time to requests

Health Net must approve or disapprove a request for post-stabilization care within 30 minutes. The post-stabilization care must be medically necessary for covered medical care. If the response to approve or disapprove the request is not given within 30 minutes, the post-stabilization care request is considered authorized.

Failure to request post-stabilization authorization

Health Net may contest or deny claims for post-stabilization care following treatment in the emergency department or following an admission through a hospital's emergency department when Health Net does not have a record of the hospital's request for post-stabilization care via phone or a record that Health Net provided the hospital an authorization for such services.

CCS-eligible conditions (Medi-Cal members)

If a patient's Health Net identification (ID) card indicates enrollment through Medi-Cal, the member is under age 21, and services are related to a California Children's Services (CCS)-eligible condition, the hospital should still request post-stabilization authorization from Health Net's HNU using the procedure described above.

Required documentation

All requests for authorization, and responses to requests, must be documented. The documentation must include, but is not limited to:

- Date and time of the request.
- Name of the provider making the request.

- Name of the Health Net representative responding to the request.

Conditions of financial responsibility

Health Net is financially responsible for post-stabilization care services that are not pre-authorized, but are administered to maintain, improve, or resolve the member's stabilized condition if the Plan:

- Does not approve or disapprove a request for post-stabilization care within 30 minutes.
- Cannot be contacted.
- Is unable to reach an agreement with the treating provider concerning the member's care and a Plan physician is not available for consultation.

If this situation applies, the Plan must give the treating provider the opportunity to consult with a Plan physician. The treating provider may continue with care of the member until a Plan physician is reached or one of the following criteria is met:

- A Plan physician with privileges at the treating provider's hospital assumes responsibility for the member's care;
- A Plan physician assumes responsibility for the member's care through transfer;
- The Plan and the treating provider reach an agreement concerning the member's care; or
- The member is discharged

Out-of-Area Service

Physicians | Hospitals | Participating Physician Groups (PPG)

Health Net provides prior authorization, concurrent, retrospective utilization review, and care management assistance to members who receive care outside the service area. Health Net Utilization Management (UM) Department initiates concurrent and medical necessity review when applicable. Health Net then notifies the primary care physician (PCP) of the member's location and clinical condition. The UM Department in collaboration with the physician and the out-of-area provider determines if the member can safely be transferred. Members are encouraged to contact their PCP or participating physician group (PPG) to determine the best plan for obtaining medical care and follow-up.

Prescription Utilization Review

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

Prescription utilization is examined in aggregate monthly and quarterly to determine the types of medications that primary care physicians (PCPs) and specialists prescribe to members. Review of medications for California Children's Services (CCS)-eligible conditions are conducted monthly with Health Net's pharmacy team and Health Net Medi-Cal medical directors.

Potential cases of abuse are brought to the attention of the Special Investigation Unit for investigation..

Plan-Specific Review

Prescription utilization for the health plan is analyzed quarterly by Health Net's Pharmacy and Therapeutics (P&T) Committee and the Health Net Quality Improvement Health Equity Committees (HNQIC and HNCS QIHEC).

Utilization is separated by geographical area to address potential differences in practice patterns and for comparison purposes.

Pharmacy representatives participate in all aspects of utilization review that pertain to medications, including input from:

- Pharmacy and Therapeutics Advisory Board.
- Medical management.
- Health Net Community Solutions Quality Improvement Health Equity Committee (HNCS QIHEC).
- Specially designed studies as requested by these committees or as deemed necessary by the health plan or by Pharmacy Services.

Separation of Medical Decisions and Financial Concerns

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

Under California Health & Safety Code Section 1367(g), medical decisions regarding the nature and level of care to be provided to a member, including the decision of who renders the service (for example, primary care physician (PCP) instead of specialist or in-network provider instead of out-of-network provider) must be made by qualified medical providers, unhindered by fiscal or administrative concerns. Utilization management (UM) decisions are, therefore, made by medical staff and based solely on medical necessity. Providers may openly discuss treatment alternatives (regardless of coverage limitations) with members without being penalized for discussing medically necessary care with the member. Health Net requires that each participating physician group (PPG) and hospital's UM program include provisions to ensure that financial and administrative concerns do not affect UM decisions.

Utilization Management Program Components

Physicians | Participating Physician Groups (PPG)

Utilization management (UM) is provided through a comprehensive, multi-level and flexible managed care delivery system. Health Net delegates the UM function to participating physician groups (PPGs) and Molina Health Care in Los Angeles County for Medi-Cal. Following an evaluation of the operational capabilities of their UM program, Health Net's decision to delegate UM is based on results of pre-delegation reviews and committee approval. Health Net does not delegate UM functions to individual participating providers. Health Net staff perform UM functions when operational functions are not delegated.

When Health Net delegates UM operational functions to PPGs, or Molina Health Care in Los Angeles County, PPGs (or Molina as applicable) are required to establish a formal UM program that describes how the delegated UM processes are performed and monitored. Health Net evaluates the effectiveness of the PPG program via ongoing monthly performance reporting, quarterly system validation reviews and annual reviews. Corrective actions are issued for below standard performance and when necessary, decisions regarding continued delegation will be reviewed by the Health Net Delegation Oversight Committee.

Health Net regional medical directors and clinical program managers are the principal liaisons between Health Net medical management and PPGs. Health Net UM and QI staff located in the corporate and regional offices support these directors and managers. They play an integral part in helping PPGs meet the expectations of Health Net and its members.

Contacts in Alphabetical Order

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

A

- Access to Interpreter Services
- AIDS Waiver Program
- Alcohol and Drug Treatment Services
- American Specialty Health Plans
- Animas Diabetes Care, LLC
- Apria Healthcare, Inc
- ATG Rehab Specialists, Inc

B

- Behavioral Health Provider Services
- Byram Healthcare Centers, Inc.

C

- California Department of Social Services
- California Children's Services Program
- California Children's Services Paneling Inquiries
- California Smokers' Helpline
- CalViva Health Medi-Cal Member Services Department
- CalViva Health Medi-Cal Provider Services Center
- CalViva Health Nurse Advice Line
- Case Management Department
- Centene Vison services
- Children's Medical Services
- Communicable Disease Reporting
- Community-Based Adult Services Centers
- Community-Based Adult Services Face-to-Face Request Line
- Community Health Plan of Imperial Valley Medi-Cal Member Services Department
- Community Health Plan of Imperial Valley Medi-Cal Provider Services Center
- Community Health Plan of Imperial Valley Nurse Advice Line
- Comprehensive Perinatal Services Program
- Connect Hearing, Inc

- County Mental Health Plan
- County Relations/Service Coordination
- Custom Rehab Network

D

- Denti-Cal
- Department of Health Care Services
- Department of Managed Health Care
- Department of Social Services (DSS)

E

- Electronic Claims Clearinghouse Information
- EviCore Healthcare
- Evolent Specialty Services, Inc.

F

Financial Oversight Department

G

H

- Health Care Options (HCO)
- Health Net Credentialing Department
- Health Net Delegation Oversight Department
- Health Net EDI Claims Department
- Health Net Encounter Department
- Health Net Fraud Hotline
- Health Net Health Education Department
- Health Net Health Equity Department
- Health Net Hospital Notification Unit
- Health Net Long-Term Care Intake Line
- Health Net Medi-Cal Claims
- Health Net Medi-Cal Facility Site Review Compliance Department
- Health Net Medi-Cal Management Department
- Health Net Medi-Cal Member Appeals and Grievances Department
- Health Net Medi-Cal Member Services Department

- Health Net Medi-Cal Provider Appeals and Grievances
- Health Net Medi-Cal Provider Services Center
- Health Net Prior Authorization Department
- Health Net Provider Communications Department
- Health Net Nurse Advice Line
- Health Net Overpayment Recovery Department
- Health Net Program Accreditation Department
- Health Net Quality Improvement Department
- Health Net's Regional Medical Directors
- Health Net Third-Party Liability Department
- Hearing Healthcare Providers
- HNI Corporate Address
- Hoveround, Inc

I

In-Home Operations

J

J&B Medical Supply Company, Inc

K

Kick It California

L

- LabCorp
- Linkia, LLC
- Los Angeles Department of Public Social Services

M

- Managed Care Ombudsman
- March Vision Care
- Medical Board of California
- Medi-Cal Provider Contested Claims
- Medi-Cal Rx Customer Services Center
- Member Rights Information

- MiniMed Distribution Corp, Inc
- Modivcare
- Molina Behavioral Health Services
- Molina Claims Department
- Molina Credentialing and Facility Site Review Department
- Moina Encounter Department
- Molina Healthcare Education Department
- Molina Healthcare Provider Resolutions Department
- Molina Interactive Voice Response
- Molina Member Services
- Molina Nurse Advice Line
- Molina Pharmacy Department
- Molina PM160 INF Forms
- Molina Provider Services Department
- Molina Quality Improvement Department
- Molina Utilization Management Department
- Multipurpose Senior Services

N

- National Seating and Mobility

O

P

- Peer-to-Peer Review Request Line
- Pharmacy Services
- Provider Disputes and Appeals - Commercial
- Provider Network Management Department
- Provider Relations Department

Q

Quest Diagnostics

R

- Regional Centers
- River City Medical Group

- Roche

S

- San Diego County Aging and Independence Services
- San Francisco Medi-Cal Field Office
- Sonus
- Special Supplemental Nutrition Program for WIC
- State Hearing Division

T

- Transplant Team
- Transitional Care Services
- Tuberculosis Control Program

U

V

W

X

Y

Z

Glossary